NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

NEW THEATRES AND WARD OPEN

CHRIS HOLLINS VISITS ROH FOR WELLBEING WEEK

HSJ TRUST OF THE YEAR FINALIST

THE ROYAL ORTHOPAEDIC HOSPITAL

ANNUAL REPORT

2019-2020

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The Royal Orthopaedic Hospital NHS Foundation Trust

Annual Report & Accounts 2019/20

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The Royal Orthopaedic Hospital NHS Foundation Trust

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Chair and Chief Executive's introduction

2019/20 has been another overall very positive year at the Royal Orthopaedic Hospital, where we have seen some really good progress made in some new areas, most notably the plans to achieve an ambition to be 'The Health and Wellbeing Hospital'. The year ended in very challenging times, as the Trust, along with all healthcare organisations, responded to the unprecedented times created by the Coronovirus global pandemic. The impact of this crisis across the world and the UK's healthcare system has been significant and has required a great number of adaptations to organisations' usual working practices and patient care. The same has been true at the ROH and while these have been the principal focus during the final months of the year, it is important that these do not overshadow the incredibly important and ground-breaking work that has been delivered.

As it is every year now, the Trust was inspected by the Care Quality Commission, with the unannounced inspection being in October 2019, with a planned assessment against the well led domain in November 2019. The unannounced inspection covered three core services: medicine (the ward environment mainly), Surgery and Critical Care (High Dependency Unit). The inspection report was published in December 2019 and it consolidated the Trust's overall rating of 'Good' across all domains, but notably lifted the 'Inadequate' for Safe in Critical Care to 'Good' and improved the ratings across all other domains covering our High Dependency Unit to 'Good'. The only area on the CQC matrix that remains at 'Requires Improvement' is in Outpatients, a service not inspected by the CQC for the last two years. The overall improvement in the CQC judgements across the Trust are due entirely to the hard work of staff in areas and great thanks need to be given for this achievement.

A highlight towards the end of the year was the publication of the National Staff Survey results, which built on the positive results of the previous year, with marked improvements in areas around staff reporting incidents of poor behaviours; staff having enough staff to do their job properly; the Trust taking positive action on health and wellbeing; and receiving learning and development in the last twelve months. The completion rate for the survey at 51% was better than many other peer and local organisations, which was a good improvement on the 41% rate for 2018/19.

As with the staff survey, the results of the national inpatient survey were also very pleasing, with the Trust being categorised as having 'much better than average' rating compared to other trusts and placed us as one of the Top 8 in the country for patient feedback scores.

Work continued during the year to progress the work to move our paediatric inpatient services out of the ROH and over to Birmingham Children's Hospital (BCH), with the service transferring over on 28 June 2019 ready to start on 1 July 2019. The ROH has always sought to provide high quality safe Paediatric services and the partnership with Birmingham Women's and Children's NHS FT (BWC) has created the means to keep this important service in the region and build on

its success. The Trust celebrated 200 years of paediatric patients being treated at the ROH at a special commemorative event for staff to mark the transfer on 26 June.

Following events in autumn 2019 associated with the Paediatric oncology service that was being run at Birmingham Children's Hospital (BCH), the transfer was paused to allow for proper review and further refinement of the care pathway. The impact of the Coronavirus pandemic then created a delay in the planned resumption of services at BCH. We are grateful to NHS partners elsewhere in the country, particularly our sister hospital the Royal National Orthopaedic Hospital NHS Trust at Stanmore, for helping us treat our patients during this interim phase. Planning is now actively underway to resume services as part of the Covid restoration plans for Birmingham and Solihull.

The Trust has continued to be an active member of the Birmingham and Solihull Sustainability and Transformation Partnership (STP) over the year and has worked closely with local partners to address some of the in-year challenges. There has also been further close working with our two most significant neighbouring trusts, Birmingham Women's and Children's NHS FT and University Hospitals Birmingham NHS FT, the three trusts forming the Birmingham Hospital Alliance (BHA). It is through this alliance that there has been more work achieved to forward the development of a standardised orthopaedic pathway across the region.

In terms of the composition of the Board and Executive Team this year, Paul Athey stepped down as Acting Chief Executive, wishing to return to his finance background and was appointed as the Chief Finance Officer of the local Clinical Commissioning Group. Jo Williams, who had served as Interim Chief Operating Officer since June 2017 was successful in the recruitment and selection of the substantive Chief Executive. A recruitment process was also undertaken over the summer to fill the post of substantive Chief Operating Officer and the Board was pleased to welcome Marie Peplow into this role following her successful selection process.

The Council of Governors agreed that the terms of office for both Tim Pile, Vice Chair and Simone Jordan, Associate Non Executive Director, be extended for a further year each on the basis that their skills and experience in finance and workforce respectively would be of value as the Trust continued its financial and operational recovery and sought to address some of its challenges with workforce leadership and development. It also approved the extension of the contracts of David Gourevitch and Richard Phillips for a further three year term. Finally, the Council of Governors agreed to the recruitment of an additional Associate Non Executive, Ayodele Ajose, who joined the Board, who is a barrister and experienced lawyer specialising in commercial law.

The Trust held a number of events to mark and celebrate in 2019. The Trust marked International Nurses Day and Operating Department Practitioner (ODP) in May 2019, which was a very well received event by all those participating. Likewise, the celebration of Black History Month was well embraced in October 2019. Other events that we held during the year included a LGBT+ awareness week with a range of events and activities organised by the Equality & Diversity Network to promote the inclusive culture we value at the ROH. The Equality &

Diversity Network, chaired by research nurse Claudette Jones, has been embedded during the year and is really starting to make its mark thanks to the enthusiasm shown by its members. There was further work to underpin the Trust's equality, diversity and inclusion understanding and framework within the Trust, including a Board-level event facilitated by West Midlands Leadership Academy and Jagtar Singh OBE in February 2020.

Health and wellbeing has been a key focus for the year and the Trust celebrated for a week at the beginning of September 2019, a week of events to mark this ambition. The week was formally opened by 'Strictly Come Dancing' star, Chris Hollins, who encouraged all at the event to get on their feet and move! To support the Health and Wellbeing work, the Trust also recruited a new Health and Wellbeing Officer, Laura Tilly-Hood, whose work will be vital as we move through the Covid response and into a more restorative phase. A specific focus of Health and Wellbeing was the impact of the menopause on staff at work and to raise this issue to the forefront, the Trust marked World Menopause Day on 18 October and later in November hosted a Menopause Conference, attended by over 70 staff and then a briefing session for managers. The Trust also hosted Henry Dimbleby MBE during the year who was visiting schools and the ROH as part of his role working with the government to review the food system so it is 'safe, healthy and affordable'. We are grateful to Dr Justin Varney, the national strategic advisor on Health and Work at Public Health England for this opportunity. The food conversations extended to the Northfield Partnership Hub to which the ROH donated in excess of 30 hampers to be distributed to local residents to support them through the Christmas period.

We are delighted with some more accolades and achievements that the Trust has received during the year, the key highlight being nominated as a finalist for the Health Service Journal award for Trust of the Year. A small team presented to the judging panel on 10 September, which was followed by a site visit by the judges on 30 September, culminating in the awards ceremony on 6 November. For those back at the hospital, a special tea party was arranged to celebrate the nomination. Although the ROH did not win the award, the achievement of being nominated and reaching the final was felt across the organisation and was a great way of easing into the festive season.

We held our long service awards in May 2019 and the Trust held its annual staff awards ceremony on 7 February 2020, where we recognised our most talented and courageous staff, as well as those who had gone the extra mile in the name of the ROH. This was a very upbeat event, which was attended by nearly 300 guests, including some key sponsors including ModuleCo and Dr Doctor.

During the year we have had to say goodbye to a number of key members of staff, including Stacey Keegan, Deputy Director of Nursing who was recruited into the position of Chief Nurse at Robert Jones and Agnes Hunt NHS Foundation Trust. We wish her well with her future career. We have been fortunate to have been joined in the year by a significant number of nurses, many of whom have been recruited though open day events. Some new consultants also joined

our medical workforce, including surgeons, anaesthetists and radiologists. To all those new to the ROH family, we welcome you.

It has been a year of stability for our Council of Governors, with no new joiners or leavers. The Annual General Meeting was held in October which was again well attended by a number of our devoted members.

There was much work during the year to embed the JointCare pathway that was launched last year, with the first of the reunion meetings being held to allow patients to share their experience of their surgery and recovery, which has been valuable to allow the service to continuously evolve and become more efficient. The pathways has been very well received by patients who now spend less time in hospital, with focussed programmes of exercise to enable them to return to a more normal life more quickly. The Trust's operations was also given a real boost by the opening of the new modular theatres and ward during the winter. When the Trust adapts to the new means of operation impacted by the Covid-19 pandemic, the new areas will help to increase the capacity available for treating our elective patients in these upgraded facilities. Our ambition to pursue further innovation was further enhanced in December, by the opening of the Dubrowsky Regenerative Medicine Laboratory. This facility has been created using the generous donation from a former patient of the Trust following treatment he received here for chondrosarcoma. The opening of the laboratory was attended by local media, Trust governors and some close friends of Mr Dubrowsky to celebrate the state-of-the-art facilities now available to undertake some ground breaking research.

The end of the year echoes the start of this overview, where we reflect on the impact that the Coronavirus pandemic has had on the Trust and on the wider healthcare systems. The successes during this time have been reliant on effective system and partnership working, particularly with our largest partner, University Hospitals Birmingham NHS FT, with whom we worked to accept a cohort of patients that would usually be cared for at UHB for treatment at the ROH to allow sufficient space and focus on those patients most badly impacted by the virus at UHB.

As the Trust looks to the future and through its period of recovery from, and adaptations to, the impact of the Coronavirus pandemic, we are confident that the ROH can build on its very solid foundations of great care and clinical practice to become an exceptional leader in the delivery of ground-breaking orthopaedics, both nationally and internationally. Some truly exciting work is planned going into the coming year with continued strengthening of collaborations with key biotechnology, pharmaceutical, academic and NHS sponsors of orthopaedic research. The Trust also continues to work in partnership with the new Aston University Medical School whose first students commenced at Aston in 2018. The Trust will welcome these students in their third year for their orthopaedic placement and peri operative placements. This will see an increase of 100 medical students visiting the RO each year from September 2020, to complement our already established cohort of students from the University of Birmingham.

We would like to take this opportunity to thank all the incredibly dedicated people: patients, staff, volunteers, governors, partners and the public, who support the ROH in their different ways to make the Trust the great place that it is.

Yve Buckland, Chairman

Jo Williams, Chief Executive

PERFORMANCE REPORT

1.0 Overview of Performance

1.1 Purpose of the overview section

The purpose of the overview is to provide a short summary to be able to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

1.2 Purpose and Activities, Business Model and Organisational Structure

The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) is one of the largest providers of elective orthopaedic surgery in the UK and is one of five specialist orthopaedic centres. It offers three tiers of service:

- Routine orthopaedic operations for a local population of 4 million people in Birmingham and North Worcestershire;
- Specialist services such as spinal surgery to 5 million people who live in greater Birmingham and the West Midlands; and
- Diagnosis and treatment of malignant bone tumours.

The Trust's annual financial turnover is in the region of £90 million. It has twelve operating theatres and 109 beds on seven wards, seven of which are on a High Dependency Unit.

The Trust employs circa 1,100 staff including more than 40 Consultant medical staff, each supported by multi-disciplinary clinical teams including surgeons, nurses, anaesthetists, physiotherapists, radiologists, pathologists, occupational therapists and other clinical professionals.

Only a small amount of emergency and urgent activity is undertaken, generally in the field of spinal disorders; as the core business of the ROH is elective surgery, no trauma activity is usually undertaken in the early stages after injury. The main elective surgery activities are joint replacement surgery (arthroplasty), joint arthroscopy and reconstruction (keyhole surgery and ligament repairs), plus hand and foot surgery.

The hospital provides a specialist bone infection service. The hospital is one of five centres in England for the diagnosis and treatment of malignant bone tumours and the bone tumour service commissioned by specialised commissioning. The Trust is one of 12 centres in England for the treatment of soft tissue sarcomas.

The Trust's vision is 'to be the first choice for orthopaedic care' and there are plans in place to grow and enhance the services offered to patients via our teams of highly specialist surgeons,

many of whom are nationally and internationally recognised for their expertise. The Trust is working closely with partners in the Birmingham & Solihull STP to lead and shape the future of musculoskeletal services and orthopaedic services across the city.

1.3 Planning for the future

The Trust's five-year strategy covering the period 2014 – 2019 was refreshed during the year and a refocussed strategy developed covering the next five years until 2024. The strategy has been developed in line with the NHS Long term Plan which was published in January 2019, and in particular the following objectives which are highly relevant to the ROH:

- Short waits for routine elective surgery
- Interoperability of data and systems
- Redesign and modernisation of Outpatient services
- Continued investment in new roles, such as Nurse Associates and First Contact Practitioners
- Targeted investment in genomics

The strategy is also closely aligned to the Birmingham and Solihull STP 'Live Healthy, Live Happy' strategy and in line with the STP plans in response to NHS Long Term Plan.

The ROH is working with partners across Birmingham and Solihull STP to launch a successful Integrated Care System (ICS), and ROH will play a fundamental role in leading orthopaedic services across Birmingham & Solihull. As an ICS, we will focus on: creating a new leadership & governance model based on collaboration and collective accountability; improving outcomes & reducing variation; developing an aligned strategy for Birmingham & Solihull and; creating an integrated approach to delivery of care.

The Trust's vision to the 'The First Choice for Orthopaedic Care' and the organisations' Values of Respect, Compassion, Excellence, Pride, Innovation, Openness and Innovation remain unchanged in the strategy however the main focus of the new strategy is around five key goals, known as the 'Five Ps':

- Patients – Safe, high quality patient care
- People – A diverse, highly skilled and well supported workforce
- Partnership – Improved and integrated services
- Process – Productive and efficient processes
- Performance – A sustainable future through growth and financial stability

Underpinning the five goals is a set of enabling strategies, these being: a clinical strategy; an involvement, experience & volunteering strategy; plans to develop the estate; an IT and technology strategy; marketing strategy; people strategy; and a knowledge strategy.

Although the impact of the global Coronavirus pandemic has deferred some of the work planned in the strategy for the first year, progress is anticipated during the coming year which will be reported to the Trust Board through a quarterly update.

1.4 Brief History and Statutory Background

The ROH is situated in the south of Birmingham, five miles from Birmingham City Centre. It provides services to a population of around 1.3 million.

The ROH was established on 17 June 1817 when a Committee, chaired by the Earl of Dartmouth, was established to provide a "general institution for the relief of persons labouring under bodily deformity." It became a foundation trust in 2007.

The Trust is part of the National Orthopaedic Alliance (NOA). The NOA is an acute care collaboration (ACC) vanguard project, providing a framework for improving quality in orthopaedic care across England.

The accounts have been prepared under a direction issued by NHS Improvement under the National Health Service Act 2006.

1.5 Key Issues, Risks and Opportunities

The Trust manages its internal risks through a Corporate Risk Register and the Board Assurance Framework (BAF), the second of which highlights major risks to the delivery of the Trust's strategic objectives and organisational goals. The BAF has been restricted to be aligned to the 'Five Ps' in the Trusts strategy and the key risks discussed by the Board during the year can be summarised as:

Patients

- The current suspension of the Paediatric Oncology service at BCH creates long delays for patients requiring surgery leading to poor patient experience, clinical outcomes and disenfrachisement of the oncology consultants

People

- The Trust fails to attract and retain the skills and number of staff to secure financial sustainability and to maintain a high quality service and environment for our patients

Partnership

- The Trust fails to exert influence in the STP and on the plans to develop an Integrated Care System, leading to loss of identity and brand, which could impact on the level of referrals, lowering of staff morale and loss of key skills

- Innovation slows at the Trust as a result of reluctance to enter into commercial partnerships due to the uncertainty over the future influences of the Integrated Care System

Process

- The effectiveness of the clinical governance framework for the treatment of Children across BCH and ROH may not prove effective, causing poor patient experience, potential harm and reputational damage.
- Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.
- The Trust may experience supply chain disruption and experience an adverse impact on areas which are dependent on overseas staffing in the event of a "no-deal" Brexit, resulting in operations being cancelled and long lead times for securing overseas staff
- There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom and the Trust is vulnerable to a cyberattack.

Performance

- The Trust does not currently have a clear financial and operational plan in place that describes how the organisation will deliver sustainability over the medium to long term. The Trust is currently delivering consistent deficits and requires cash support to continue day to day operations.
- There is a risk that the Financial Control Total will not be met.
- There is a risk that the Trust fails to meet the trajectory to achieve a performance of 92% against the 18 Week RTT target as agreed with regulators.
- There is a risk that the Trust may fail to deliver the activity targets set out in the Trust's annual operational plan, leading to a shortfall against the agreed Financial Outturn position for the year and potential poor patient experience.
- There is a risk that as a consequence of the tax liability associated with pension arrangements of some senior clinical individuals that there will be a reluctance to cover additional duty hours and therefore the Trust will fall short of its activity target and financial control total.
- Inability to control the use of unfunded temporary/agency staffing.

Further information on the key risks on the BAF and the mitigating actions can be found in the Annual Governance Statement (Section 8 of this report).

Although these were the risks discussed by the Board for the majority of 2019/20, it should be highlighted that during March 2020, the Trust experienced a new set of risks with a more immediate focus, as a result of the impact of the global Coronavirus pandemic. A standalone risk register was established to monitor the impact of these risks, capture key mitigations and this was reviewed by Board members on a weekly basis as the primary risk management tool during this exceptional period.

A number of risks on the Covid risk register related to the impact of accepting a new caseload, including trauma patients into an elective setting and the workforce implications of the virus, including sickness absence and the effect of the government's guidelines on isolation and social distancing.

In terms of opportunities for the future, the Trust has the chance as part of the plans for restoration and recovery across the system, to lead a fundamental service reconfiguration for orthopaedic services and take responsibility for the entire pathway, making best use of current capacity and resources.

1.6 Performance Overview

During 2019/20, the strategic and operational performance of the Trust was delivered through our divisional structure, comprising two clinical divisions (Patient Services and Patient Support Services) and two supporting divisions (Estates & Facilities and Corporate Services). 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 ROH faced a number of significant challenges during the year which unfortunately have had an adverse impact on the financial and operational performance of the Trust, culminating in the cancellation of all elective activity during March as the Trust became a receiving unit for emergency trauma activity as part of the local system's response to the COVID-19 pandemic.

As such the Trust finished with a deficit of £10.214m, a significant underperformance against its planned deficit of £5.312m, mostly driven by lower than anticipated levels of elective activity during the first part of the year.

1.6.1 Operational Performance

The Trust treated 13,960 admitted patients and 68,877 outpatients in 2019/20, an underperformance of 5.6% and 12.3% respectively as compared to planned levels of activity.

	Performance Against 2019/20 Plan			Performance Against 18/19 Actual	
	Actual Treated 2019/20	**Plan to Treat 2019/20**	**Variance**	**Actual Treated 2018/19**	**Variance**
Inpatients	6,643	6,990	(347)	6,881	(238)
Daycases	7,317	7,794	(477)	7,563	(246)
Total Admitted Patient Care	**13,960**	**14,784**	**(824)**	**14,444**	**(484)**
First Appointment	21,195	23,853	(2,658)	22,631	(1,436)
Follow Up Appointment	41,924	48,964	(7,040)	42,811	(887)
Outpatient Procedures	5,758	5,709	49	5,293	465
Total Outpatients	**68,877**	**78,526**	**(9,649)**	**70,735**	**(1,858)**

Whilst paediatric services were successfully transferred to Birmingham Women's and Children's NHS Foundation Trust from July 2019, the trust found it difficult to re-utilise the surgical capacity released by the transfer, and additional capacity provided by the new modular development, due to short-term workforce challenges. Although this started to be recovered during January and February, with an overperformance of activity recorded in both months, this was halted in March as all elective activity was cancelled as part of the system COVID-19 response.

Key Performance Indicators

Key Performance Indicators	Target	Q1	Q2	Q3	Q4
% incomplete pathways less than 18 weeks	92%	88.42%	85.84%	83.65%	82.29%
Number of patients waiting over 52 weeks	0	0	0	0	0
% urgent cancer referrals seen within 2 weeks wait	93%	98.1%	96.4%	98.9%	98.4%
% patients treated within 31 days of decision to treat	96%	94.3%	97.8%	100%	97.5%
% patients receiving subsequent treatment within 31 days (surgery)	94%	100%	97.7%	100%	97.8%
% cancer patients treated within 62 days of urgent GP referral	85%	80.8%	93.8%	72.2%	66.7%
% patients waiting less than 6 weeks for diagnostic test	99%	99.72%	99.51%	99.31%	99.53%

Referral to Treatment

Over the past 2 years the Trust has been working to improve the 18-week referral to treatment (RTT) position towards the national 92% standard. In Q1 the trust RTT position was delivering improved performance against a trajectory agreed with NHSI/E to deliver 92%. Due to changes in the national pension in June 2019 the provision of additional sessions subsequently

reduced. This impacted significantly on the Trusts RTT position as a high proportion of capacity had historically been delivered utilising additional sessions outside of existing Consultant Job plans. As a result of the changes a full demand and capacity modelling was completed and additional Consultants were recruited along with Locums where possible, which supported increased activity in quarter 3/4 and this recruitment continues, to enable surgical capacity to deliver full utilisation of 12 theatres for 50 weeks per year and meet waiting list demand. In quarter 4 there was also a substantial impact relating to the cessation of all elective activity in March as a result of the Covid 19 pandemic response. A restoration and recovery plan is in place with a trajectory being scoped to deliver the RTT standard.

In the 2018/19 Annual Report the Trust was able to successfully treat all patients that had been waiting longer than 52 weeks. In 2019/20 despite the capacity challenges described above the Trust has continued to maintain a position where no patients have waited longer than 52 weeks for their treatment.

Cancer Standards

The 2-weeks wait Referral to First Seen target has been achieved over all four quarters. The 31-day First Treatment target was achieved in all quarters apart from Q1. During this quarter, the position was impacted by a small proportion of complex surgical cases, requiring extensive pre-surgical preparation. The 31-day Subsequent Treatment target was achieved in all quarters.

The 62-day Standard target remains challenging due to the small number of patients treated each month (an average of 4 patients per month). The Trust is one of only five specialist bone sarcoma centres in the United Kingdom and receives referrals from a wide geographical spread. Some of the patients have been referred to the Trust after a prolonged pathway and are of high complexity which makes treatment within 62 days challenging to achieve. Individual route cause analysis with detailed timelines are completed for all patients who breach the 62-day standard and discussed at the Cancer Board and as part of the trust harm review process, to capture any lessons learned and changes in process adopted. Improvements are continually being made to optimise these patient pathways.

The Trust has also been monitoring and improving the 28-day faster diagnosis standard (FDS), to ensure that the Oncology Service and our diagnostic partners are working collaboratively to improve diagnostic timelines in preparation for April 2020 when this shadow target will be monitored.

Diagnostic standards

The 6-week diagnostic standard is consistently achieved across all four quarters and the turnaround times for Imaging are also being monitored monthly and are presented monthly at

the Finance and performance committee, so that the whole imaging pathway waiting times are monitored as best practice.

1.6.2 Financial Performance

At the start of the year, the trust had planned for a deficit of £5.312m which also represented the Control Total that had been identified by our Regulators, it is therefore disappointing that the Trust is reporting an outturn position of £10.214m.

However, much of this variance (£4.902m) can be explained by the impact of several exceptional items as previously discussed, including the loss of income associated with the transfer of paediatric services (£4.161m), and additional costs relating to theatre expansion (£1.879m), which were partly mitigated by additional activity (£1.688m).

Narrative to the Accounts

This section sets out the key features of the Trust's financial performance in 2019/20. A full set of accounts is attached including:

- Statement of Comprehensive Income
- Statement of Financial Position
- Statement of Changes in Taxpayers' Equity
- Statement of Cash Flows

Statement of Comprehensive Income (SOCI)

The Trust's financial position is based on a consolidated financial position of the Trust and its Charity. This consolidated financial position is referred to as Group within in the annual accounts and this commentary. The Trust delivered a £10.214m control total deficit for 2019/20. The table overleaf reconciles the position reported in the Statement of Comprehensive Income (SOCI) to the Trust performance against its NHS Improvement Control Total.

£000s	2019/20	2018/19	2017/18
Operating Income (inc PSF)	87,937	87,460	81,979
Operating Expenses	(97,167)	(90,089)	(85,169)
Net impairment	(602)	(783)	1,554
Operating Surplus / (Deficit)	**(9,832)**	**(3,412)**	**(1,636)**
Net Finance Costs / Other gains and losses	(1,022)	(1,102)	(1,292)
Retained deficit for the year (per SOCI)	**(10,854)**	**(4,514)**	**(2,928)**
Control Total Adjustments:			
CQUIN risk reserve (16/17)			(232)
Reversal of impairments	602	783	(1,554)
Consolidation of charities	196	352	51
Donated assets	(158)	(272)	61
Control Total Deficit	**(10,214)**	**(3,651)**	**(4,602)**
FRF / PSF	-	(2,464)	(1,844)
Control Total Deficit (exc FRF/ PSF)	**(10,214)**	**(6,115)**	**(6,446)**
Control Total	(5,312)	(6,615)	(6,619)

FRF Financial Recovery Funding
PSF Provider Sustainability Funding (2018-2019)

The retained deficit of the Group in the SOCI is £10.854m. To arrive at the control total deficit (including PSF monies) of £10.214m, the following control total adjustments are made:

- Impairments (£602k). The group has been subject to a valuation of its land and buildings during the current financial year and has also made a reversal of a previous impairment as required by accounting policies. As a result, a net loss has been identified, and recognised in the accounts. This is detailed in Note 9, and shows a net loss of £602k being charged to the SOCI, whilst a £1.025m is charged to the revaluation reserve;
- Consolidation of Charities (£196k). The accounts are provided in Group form. This adjusts to show Trust transactions only; and
- Donated assets income and depreciation (£158k). This is the net impact of funding for the Regenerative Laboratory based on works completed at 31st March.

The Trust will not receive any Financial Recovery Funding in 2019/20.

The bottom of the SOCI also reflects other comprehensive income (and expenditure) that is not classified as Income and Expenditure. This includes the £1.025m charge to the revaluation reserve as discussed above.

Statement of Financial Position as at 31 March 2020 (SOFP)

The Statement of Financial Position sets out Total Assets employed by the Group and the Trust.

- Non-current assets (£2.171m reduction) - due to the revaluation;
- Current assets (£1.139m reduction) – This includes a small reduction in stock and an increase in trade receivables, whilst cash has reduced by £2.292m (the 2019/20 figure included PSF);
- Current liabilities (£18.511m increase) - DHSC and NHSI have announced that existing revenue support loans as at 31 March 2020 will be converted into PDC by September 2020. As such all DHSC loans have been moved from Long Term Liabilities to current liabilities in line with the group accounting manual. This is detailed in Note 15.2 and 15.4.
- Non-current liabilities (£9.859m reduction) – as above.

Statement of Changes in Taxpayers' Equity

This statement reflects a £11.962m decrease in the total assets of the Group from a taxpayer point of view, from £39.896m to £27.934m, due to:

- £1.025m charge to revaluation reserve;
- £22k of PDC received in year;
- £233k reduction in Charitable Fund Reserve; and
- £10.726m retained deficit for the year.

Statement of Cash Flows for the year ended 31 March 2020

The Group ended 2019/20 with a cash balance of £1.471m, a reduction of £2.292m on the previous year end cash balance.

Analytical Review of 2019/20 Annual Accounts

Review of Operating Income

The Group earned income of £87.937m in 2019/20, a rise of £477k compared to the previous year (2018/19, £87.460m), this includes the transfer of Paediatrics to Birmingham Women's and Children's NHS Foundation Trust. Of this, £82.561m arose from patient care activities, with the remaining £5.376m generated from other operating income. A significant proportion (60%) of the Group's income is sourced from its main two commissioners, Birmingham and Solihull Clinical Commissioning Group (£28.174m) and NHSE Specialised Commissioning (£24.844m).

Review of Operating Expenses

The Group incurred operating expenses of £97.167m in 2019/20, a rise of £7.078m (or 7.9%) compared to the previous year (2018/19, £90.089m). Pay costs continue to account for most of the expenditure, with £56.836m (or 58.5%) in 2019/20 (2018/19, £53.706m and 59%).

The £7.078m increase in expenditure is attributable to the following factors:

- Pay costs increased by £3.180m (5.8%) from 2018/19;
- Supplies & Services increase by £1.861m;
- Operating Lease increased by £423k; and
- Clinical negligence costs reduced by £297k.

In addition to Operating Expenditure, there is a net impairment loss of £602k.

Financial Accounts

The full set of Accounts is included within this report. The accounts have been prepared on a going concern basis and in accordance with International Financial Reporting Standards (IFRS) and the Trust's accounting policies. Their preparation has been guided by the 2019/20 NHS Trust Manual for Accounts.

The Trust's accounting policies are in accordance with directions provided by the Secretary of State for Health and follow International Financial Reporting Standards and HM Treasury's Government Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS.

Auditors' Opinion

Audit opinion is supplied by Deloitte LLP and is included within the 'Financial Statements' section of the annual accounts.

1.7 Going Concern Statement

International Accounting Standards (IAS 1) requires the directors to assess, as part of the account's preparation process, the Foundation Trust's ability to continue as a Going Concern. The formal review period to be assessed is at least 12 months from the date of approving the financial statements, i.e. up to June 2021, although the wording of the standard is the foreseeable future and is often assessed as 18 months after the year end (September 2021).

The Trust has been in a deficit position for a number of years which means it has been reliant on cash funding from the DHSC to support ongoing operations. This funding has previously been provided a loan, but in line with the recent government announcements, there has been confirmation that the outstanding balance at the year-end will be transitioned into Public Dividend Capital in 2020/21, and as such will not be expected to be repaid.

As a result of the Coronavirus pandemic, Payment by Results has been paused to simplify funding and remove administrative burden. It has been replaced instead with a block contract payment from 1st April for an initial period of 6 months based upon historic finances, with a top-up for spend relating directly to Coronavirus. It is noted that this gives a high level of certainty over income over the April-September 2020 period, and that the funding is sufficient to enable to the Trust to continue to operate. In addition, Trusts have been provided with an additional month of upfront block funding to ease cash flows and support trusts in paying their suppliers in a more timely manner. Nationally, whilst it is known that NHS funding will continue post September 2020 there is a lack of clarity at present regarding what form that funding will take.

The current shorter term arrangements have resulted in the trust having a lower reliance on future borrowing in the immediate future. If, however, it needs further funding at any point over the coming months there remains a route to funding through the DHSC. As in similar years, the agreement to any further financing will not be agreed until the month immediately preceding the requirement for cash, and thus at the time of completing the Going Concern assessment this information is not available, creating a material uncertainty that may cast significant doubt over the entity's ability to continue as a going concern.

The Trust is also required to assess going concern under the NHS Foundation Trust Annual Reporting Manual 2019/20, which states 'the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern'. The Trust is a specialist provider of orthopaedic services, treating patients not only from the local area for common procedures such as primary hip and knee surgery, but also from across the UK for some of its specialist services, such as complex spinal deformity (e.g. spinal scoliosis), orthopaedic oncology, bone infection procedures and complex revision surgery. Increases in referrals in many of these areas suggest a continuing need in the UK population that is required to be met, particularly as Coronavirus will undoubtedly place pressure on waiting lists for elective work nationally.

This guidance, in addition to discussions held with NHS Improvement, have allowed the Directors to assess that, on the basis of their enquiries, there is still a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

As such 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.

Approved by the Board of Directors on 19 June 2020

Mrs Jo Williams
Chief Executive
19 June 2020

ACCOUNTABILITY REPORT

Section 1:

Directors' Report

1.0 Directors holding office during 2019/20

The following held office throughout the period of this report:

Dame Yve Buckland – Chairman (First Term of Appointment 1 May 2014 to 30 April 2017, extended until 30 April 2020 and further extended until April 2023)

Yve Buckland started her professional life as an archivist having completed a history degree and archives training at Leeds and Liverpool Universities. She went on to have a series of managerial roles in local government working for Cheshire and Birmingham Councils before, in the early 1990s, she was appointed by Nottingham City Council as its Deputy Chief Executive and City Secretary, the first female Chief Officer in the Council since its establishment in the 1880s.

By 2000 Yve had achieved her first national role when she was appointed by the Government to set up the Health Development Agency, a body which assembled and analysed the evidence-base for tackling key public health problems such as childhood obesity and smoking-related diseases. She was awarded a DBE by the Queen for her work in this area.

Yve became the Chairman of the NHS Institute for Innovation and Improvement and for ten years between 2005 and 2015, was the Chairman of the Consumer Council for Water. She is a governor of the Kingsley School and is also a member of the independent panel advising ministers on Further Education College restructuring.

In June 2017, Yve was appointed Pro-Chancellor and Chair of the Council of Aston University. She is also currently acting as Interim Chair for Dudley Group of Hospitals NHS Foundation Trust.

Mrs Joanne Williams, Chief Executive (from 6 May 2019)

In June 2017, Jo joined the Trust on secondment from University Hospitals Birmingham NHSFT, where she was Deputy Chief Operating Officer for 3 years and Deputy Director of Partnerships for the STP (Sustainability and Transformation Partnership). She is the lead for delivery of the operational performance through the Trust Clinical Divisions.

Jo has gained significant operational experience working in a number of acute hospitals delivering and leading service transformation projects. As well as 14 years in operational management, she also worked in procurement both in the NHS and as a capital buyer for the private healthcare sector.

After an external selection and recruitment process in April 2019, Jo was appointed as substantive Chief Executive of the ROH, a post she assumed from 6 May 2019.

Mr Paul Athey – Acting Chief Executive Officer (until 3 May 2019)

Paul worked at the ROH for 13 years in a variety of finance roles. Before taking on the role of Acting Chief Executive, he was Director of Finance and Performance (2013 – 2017). He has nearly 20 years of NHS experience in a variety of provider and commissioner roles. Paul has sat on a number of national finance committees and is passionate to enhance the role that finance can play in improving patient outcomes and experience. He was proud to have had the

opportunity to lead the organisation at an exciting time for the NHS and believed that the ROH has a vital role to play in delivering high quality orthopaedic care to the population of Birmingham and beyond. Paul stepped down as Acting Chief Executive from 3 May 2019 and Jo Williams took on the substantive role of Chief Executive.

Mr Timothy Pile - Vice Chairman, Senior Independent Director – Non-Executive Director (Term of Appointment: First term of office completed 31 December 2015, extended until 31 December 2018, with further extensions year by year to December 2020)

Tim Pile is Chair of The Greater Birmingham & Solihull Local Enterprise Partnership, a non-executive director at Marshalls PLC and The Greater Birmingham Chamber of Commerce. He was previously Chief Executive of Sainsbury's Bank, Non-Executive Director of Cancer Research UK, Trustee of the Library of Birmingham and Governor of Bromsgrove School. Tim has held various management positions at Alliance & Leicester and Lloyds TSB.

Mr Rod Anthony – Non-Executive Director and Chairman of the Audit Committee (Term of Appointment: First Term of Appointment until 31 May 2017, extended until 31 May 2020 and further extended until 30 November 2020)

Rod Anthony is a Chartered Accountant and experienced Chief Finance Officer and Managing Director. He is currently Chairman of Social and Local CIC (a strategic marketing agency providing support to the public and third sectors) and a director of both Sutrue Ltd and Sirona Design Ltd, both medical devices development and design businesses.

Rod also provides consultancy and Board advisory support to a number of public sector, commercial and social enterprise businesses, primarily operating within the field of healthcare innovation and improvement. Formerly CFO and Interim Managing Director at the NHS Institute for Innovation and Improvement, CFO at the Forensic Science Service Ltd and senior executive at GlaxoWellcome Plc (now GlaxoSmithKline Plc). Previously Rod was Vice Chair of Birmingham and Solihull NHS PCT cluster and Deputy Chair at Solihull Care Trust.

Mrs Kathryn Sallah – Non-Executive Director (Term of Appointment: First term of Appointment until 31 March 2018, extended until 31 March 2021)

Kathryn Sallah worked as an independent management consultant from January 2007 following her retirement from the NHS. Her portfolio consisted of health service reviews and redesign, advice to and development of NHS Boards, policy development and providing professional coaching. Kathryn, a qualified nurse and midwife, has over 40 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 Master's in Public Health at Birmingham University. She has held three Director of Nursing posts: Walsall Manor Hospital, Birmingham Women's Hospital and Birmingham Strategic Health Authority.

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 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 Honours list.

Prof David Gourevitch – Non-Executive Director (Term of appointment: 1 February 2017 until 31 January 2020, which was further extended for a second term to 31 January 2023)

Professor David Gourevitch was appointed as a consultant surgeon in 1992 after completing his surgical training with dual accreditation in thoracic and upper GI/general surgery. Previously, he had worked in Africa (Mzuzu, Malawi, Durban, South Africa and Nqutu, Kwazulu) and written his MD thesis in vascular surgery.

Originally appointed with a particular interest in upper GI re-sectional surgery to Sandwell Hospital, his clinical practice was large and encompassed those of the neighbouring hospitals. In addition, he ran a large paediatric surgical service.

His practice was transferred to University Hospitals Birmingham NHS Foundation Trust (UHB) in 2003 when he was asked to lead the upper GI service at the teaching hospital. He subsequently established the Midland Abdominal and Retroperitoneal/Pelvic Sarcoma Unit (MARSU) in 2007 and, together with the Bone Sarcoma Service based at the ROH, formed the Birmingham Sarcoma Service.

MARSU continues to expand and operates a multispecialty unit with other surgical specialties based at UHB. The unit supports local and national sarcoma trials and contributes to the 100,000 Genome Project. It has also established a sarcoma fellowship and has close links to the sarcoma centres in Paris and Milan with whom the unit exchanges training surgeons.

Professor Gourevitch has held administrative appointments at UHB and national surgical societies, national committees and the Royal College of Surgeons.

Prof Gourevitch retired from regular clinical practice in March 2019 however he continues in a consulting capacity to QEHB and as a magistrate in the Birmingham Division.

Mr Richard Phillips - Non-Executive Director (Term of Appointment: 1 February 2017 - 31 January 2020, which was further extended for a second term to 31 January 2023)

Richard joined the Association of British Healthcare Industries as Director, Healthcare Policy in June 2015 with over 25 years' experience in the pharmaceutical and medical devices industries.

Richard holds a first degree in Sports Science from Brighton Polytechnic and a Master's in Health Economics Research and Management from Keele University. He served from 2003 until 2013 as a member of the Technology Appraisal Advisory Committee of the National Institute for Health and Care Excellence and also on the Programme Advisory Group of the Healthcare Quality and Information Authority in Ireland.

Richard is a Non-Executive Director of both the West Midlands and formerly the South West Peninsula Academic Health Science Networks, serving as Chair of the latter for most of 2015. He also chaired the Programme Board of the Small Business Research Initiative Healthcare. He is a longstanding member of the Institute of Healthcare Management.

Simone Jordan – Associate Non-Executive Director (Non-Voting) (Term of Appointment: 1 July 2017 – 30 June 2019 which was further extended for a further fixed term to 30 June 2020)

Simone is an experienced Executive, working at Board level for 20 years, as a Chief Executive, Executive and Non Executive Director. Her professional background is in Workforce, Human Resources and Organisational Development. She also has significant leadership and personal development expertise. Her UK experience includes service and hospitality sectors,

manufacturing, health, higher education and other public sector organisations. Simone's roles have included Managing Director of Health Education East Midlands, Director of Workforce for East Midlands Strategic Health Authority and Deputy Chief Executive and Chief Operating Officer for the NHS Institute for Innovation & Improvement.

Simone holds an honours degree in History and has an MBA.

Simone has led numerous major cultural and organisation change programmes across multiple organisations working in complex political environments.

Simone is an experienced leader, qualified coach, mentor and facilitator with a detailed understanding of organisation dynamics and functioning, governance and accountability frameworks.

Ayodele Ajose – Associate Non-Executive Director (Non-Voting) (Term of Appointment: 1 November 2019 – 31 October 2020)

Ayodele is a Barrister and experienced commercial lawyer, working at Board level for over 15 years as General Counsel and Legal Adviser within both the private and public sectors. In addition to commercial law, her legal background covers intellectual property, licensing, R&D, commercial software and systems integration. Her professional experience extends across a range of industry sectors as General Counsel to Forensic Science Service, legal consultant to global pharmaceutical companies Hospira Inc and Pfizer Ltd and more recently Head of IP and International for Britvic plc. Ayodele has advised CEOs and Executive Teams on corporate governance, international expansion projects and product launches within the USA, EMEA and China and advised senior executives on the handling of high-profile criminal cases involving miscarriages of justice. Ayodele has directed and led high value public sector procurement frameworks and has advised on major corporate restructuring projects.

In addition to her degree in law, Ayodele has a diploma in Marketing and an MBA.

Ayodele is currently a legal consultant to the international law firm Addleshaw Goddard LLP advising its corporate clients on all aspects of commercial law.

Mr Matthew Revell – Executive Medical Director

Matthew Revell is a Consultant Orthopaedic Surgeon with an interest in hip replacements and revisions. Matthew was appointed as Medical Director for the Royal Orthopaedic Hospital in February 2019.

He qualified in medicine from Guys Hospital and worked as a Junior Doctor at St Thomas's and in the South East of England. He undertook higher surgical training in the West Midlands and was a Cavendish Hip Fellow in Sheffield.

Since being a consultant, Matthew has maintained an interest in research, medical education, clinical outcomes and medical leadership. He obtained an MBA from Warwick Business School and is a Founding Fellow of the Faculty of Medical Leadership and Management.

Matthew has held a number of management and leadership roles, including Clinical Director for outcomes and effectiveness, Chief Clinical Information Officer and Associate Medical Director for patient support services. He is currently the Caldicott Guardian and the Responsible Officer for the Trust.

Mr Garry Marsh – Executive Director of Nursing & Clinical Governance

Garry joined the Trust in February 2015 from United Lincolnshire NHS Trust, where he had been Deputy Chief Nurse for four years.

Beginning his nursing career as a healthcare assistant in an orthopaedic hospital, Garry continued to undertake his nurse training, qualifying in 1997.

Since qualifying he has gained a wide range of experience in a variety of both clinical and operational roles. Garry holds an MSc in Healthcare Management & Policy.

His portfolio responsibilities include Nursing, Clinical Governance, Controlled Drug Accountable Officer, Safeguarding & Director of Infection Prevention & Control.

He is Executive Lead for the Quality & Safety Committee.

Marie Peplow – Executive Chief Operating Officer

Marie Peplow was appointed as Chief Operating Officer in September 2019. She is keen to continue to transform services whilst keeping the highest quality patient care at the heart of everything she does. Marie started her NHS career over 25 years ago as a Radiographer in Birmingham. Having developed her clinical and academic career in a range of acute Hospital settings in Leicestershire, she then moved into various leadership roles managing Radiology services across Birmingham and Solihull and gained a Masters in Organisational Development. Marie has an impressive track record for achieving national performance targets and driving excellence. Marie started working at ROH in April 2018 as the Deputy Chief Operating Officer (COO), and quickly 'fell in the love with the place.' In her role as Deputy COO Marie drove forward improvement projects such as redeveloping the Pre-operative assessment Centre (POAC) pathway, Theatre expansion, & Improving referral to treatment times (RTT). Now as the Executive Chief Operating Officer Marie has pledged to deliver a number of key objectives in her role, however her passion for keeping patients & staff at the heart of everything she does is the most prominent. Marie will be working with our partners to listen to patients and staff to build on the relationships she has fostered over the last 18 months to improve the services we offer further and to continue working with the ROH family to do great things together.

Prof Phil Begg – Executive Director of Strategy & Delivery

Phil has been in the Trust since 2014 he provides executive leadership at Board level on strategy, estates, facilities, communications, research, education, innovation and development. His role is to lead on the implementation of the five-year strategy and all strategic developments. Phil is also the Trusts Accountable Emergency Officer (AEO), where he is accountable for leading on major emergency incidents and the implementation of the Trust's Major Incident response. He is also holds academic and research Chairs at the Universities of Birmingham, Kentucky, USA and Brunel. He has a significant history of senior management positions, which sit alongside a successful clinical career.

Mr Stephen Washbourne – Interim Executive Director of Finance and Performance

Steve joined the Trust on secondment from University Hospitals Birmingham NHSFT (UHB) in October 2017, where he was the trust lead for strategy and planning, as part of a broader package of support through the local Birmingham and Solihull Sustainability and Transformation Partnership.

Steve was an NHS National Financial Management Trainee, qualifying as an accountant in 2000. Since then he has gained significant financial management experience working in a number of acute hospitals, as well as 10-year spell in commissioning specialised services, becoming Regional Head of Specialised Commissioning for the West Midlands in 2013, before re-joining UHB in 2014.

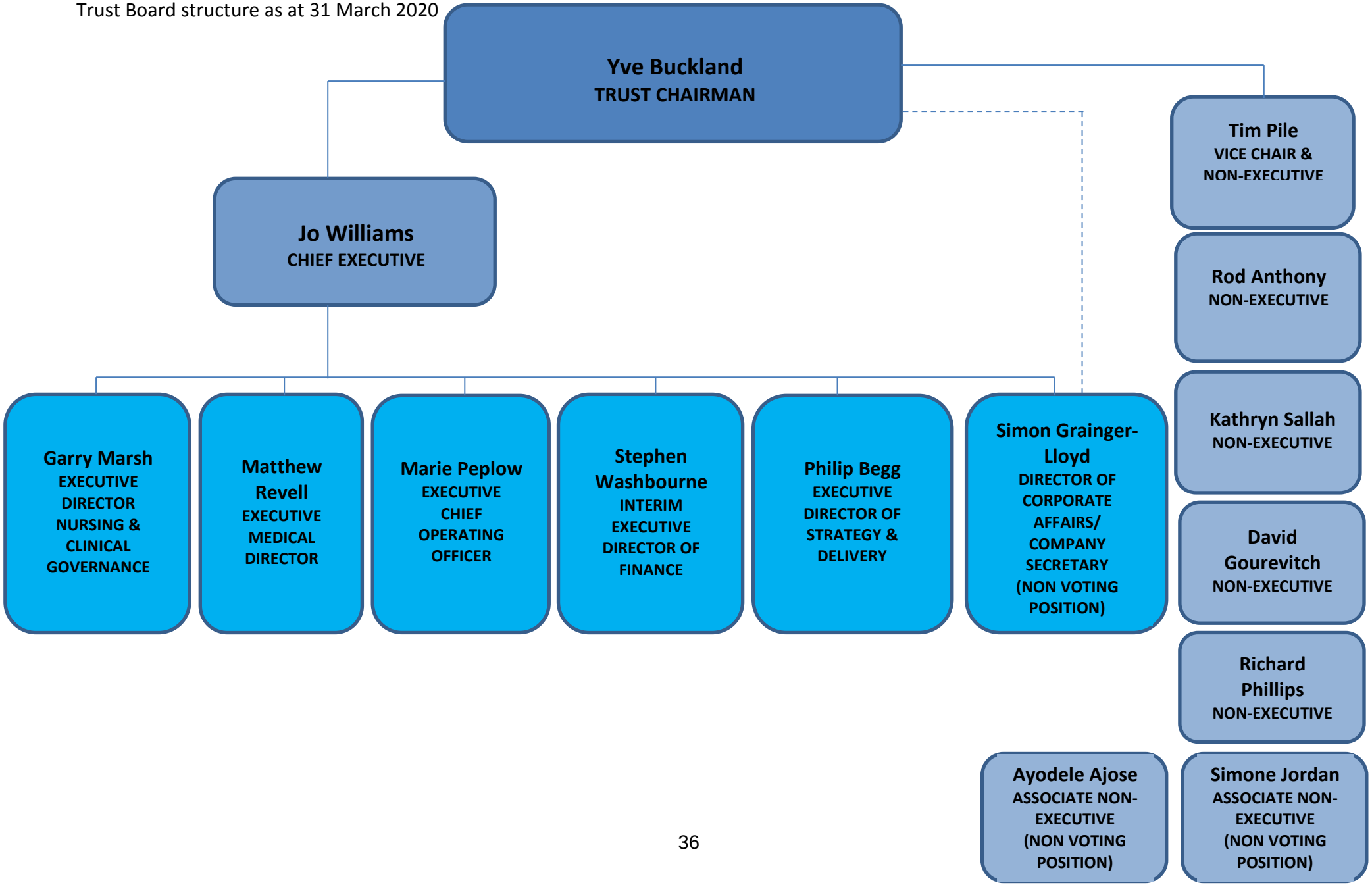
Steve grew up and went to school in Northfield, and still lives locally.

Mr Simon Grainger-Lloyd – Director of Corporate Affairs & Company Secretary (Non-Voting)

Simon was appointed in August 2015, following a number of years as Trust Secretary of a large acute provider trust and Board Secretary of the Forensic Science Service prior to this. He has an Honours degree in Biology and has extensive experience of project and programme management, risk management and Board support.

Simon is the ROH's Data Protection Officer. His other portfolio responsibilities include risk management, claims & litigation, Freedom to Speak Up, Freedom of Information and membership.

Trust Board structure as at 31 March 2020



1.1 Directors' interests and independence

The Trust's Register of Directors' interests is open to the public and can be accessed by writing to:

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

The Board considers 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 purpose of the Trust's Board is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands. The Board of Directors is made up of Non-Executive and Executive Directors.

As at 31 March 2020, the Trust has two Non-Executives on its Board with a clinical background; two Non-Executives with financial expertise: one of whom is a qualified Accountant, a Non-Executive with a clear commercial focus, and an Associate Non-Executive with skills and experience in workforce and innovation & improvement and another Associate Non-Executive with a legal background. The Chairman has a wide range of experience as both a Non-Executive and Board Chairman 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

Under law each year the Directors are obliged to prepare financial statements and present these to the Trust's Council of Governors and members at its Annual General Meeting.

The Directors are responsible for the adoption of suitable accounting policies and their consistent use in the financial statements, supported where necessary by reasonable and prudent judgements.

The Directors confirm the above requirements have been complied with in the financial statements. The Directors are also 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.

The Directors also confirm the Board has conducted a review of the effectiveness of its system of internal controls as set out in the Annual Governance Statement.

1.4 Meetings of the Non-Executive Directors

In accordance with the Foundation Trust Code of Governance during the year, as and when required, the Chairman held meetings with the Non-Executive Directors without the executives being present. In addition, the Chairman systematically held regular meetings prior to formal Board meetings with Non-Executive Directors without Executive Directors being present. On some occasions, the Chief Executive attended these meetings by invitation to discuss a particular item of interest.

1.5 Significant Commitments of the Trust Chairman

Dame Yve Buckland, Trust Chairman was appointed as Pro-Chancellor of Aston University in 2017, a position she still holds. Dame Yve, from May 2019, is also Interim Chair of Dudley Group of Hospitals NHS Foundation Trust.

1.6 Appointment of Chairman and Non-Executive Directors and process for appointing Non-Executive Directors

During 2019/20 the Non-Executive cadre of the Board comprised five Non-Executive Directors, two Associate Non Executive, plus the Chairman.

The Council of Governors has the power to appoint and remove the Chair and Non-Executive Directors of the Trust. The Council of Governors' is supported by a joint Nominations and Remuneration Committee, however during this year the decisions around appointments and extensions has been taken by the Council as a whole.

In accordance with the Trust's constitution, Non-Executives and the Trust Chairman are appointed for an initial term of three years, with the possibility of reappointment for a further term once this has expired. Extension beyond this is subject to agreement by the Council of Governors that the individuals remain independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement.

During the year, the Council of Governors was asked to support the extension of Richard Phillips and David Gourevitch for a further term of three years, which was agreed. The terms of office for Tim Pile and Simone Jordan were also extended by a further year on the agreement of the Council of Governors on the basis that the Trust was currently experiencing a period of significant change given the system-wide plans and the embedding of the new Chief Executive. Finally, the Council of Governors supported the appointment of an additional Associate Non Executive Director, Ayodele Ajose, who would support the Board with her legal background.

1.7 Removal of the Chair or Non-Executive Director

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 Statement of operation of the Board of Directors and Council of Governors

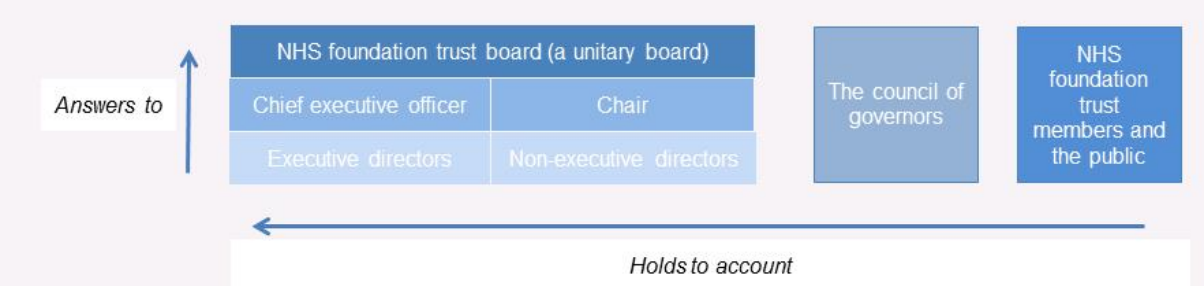
The Board of Directors comprises Executive Directors and Non-Executive Directors. The Executive Directors are employees, led by the Chief Executive Officer and they are responsible for the day-to-day management of the Trust.

The Non-Executive Directors are not employees and bring an independent perspective to Board meetings. They have a particular duty to challenge decisions and proposals made by Executive Directors. The Board is led by the Chairman who is also a Non-Executive Director. There is a Deputy Chair who is also the Senior Independent Director (SID). Tim Pile fulfils this responsibility at the Trust, this position being approved by the Council of Governors, the last time being when Tim's term of office was renewed.

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 Trust. To achieve this, the Board receives regular reports on all aspects of its business to enable appropriate decisions to be taken.

The Board has a schedule of reserved decisions, which lists out decisions which only the Board can make and a scheme of delegation which details areas of responsibility delegated to committees and individual Directors/Manager.

The Trust's "chain of accountability" – including the position of the Council of Governors - is shown below:



The Chairman of the Board of Directors is also the Chairman of the Council of Governors and she is responsible for ensuring the Board and Council work effectively together.

A key role 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 overriding role of the Council of Governors is to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors and to represent the interest of the Trust's members and the public. Notwithstanding this, the Board of Directors and Council of Governors at the Royal Orthopaedic Hospital NHS Foundation Trust view their interaction as primarily one of constructive partnership with both the Board and Council seeking to work effectively together in their respective roles.

The Governors are responsible for appointing and removing the Chairman and the Non-Executive Directors and set their terms of office. The Trust's auditors are appointed by the Governors and the 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 each director individually, is to act with a view to promoting the success of the organisation to maximise the benefits for members of the Trust as a whole and the public.

The Board of Directors:

- provides entrepreneurial leadership within a framework of prudent and effective controls, which enables risk to be assessed and managed;
- is responsible for ensuring the Trust complies with its licence, 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 the necessary financial and human resources are in place for the Trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance;
- is responsible for ensuring the quality and safety of healthcare 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 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 which benefits the Trust and the services it provides. The Senior Independent Director and Chairman encourage informal communication on behalf of the Board of Directors. This includes discussions between individual 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.

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

- Specific requests by the Council of Governors are 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 take place between the Council of Governors and the Board of Directors as and when necessary.

1.9 Working with Governors and Members

The Royal Orthopaedic Hospital NHS Foundation Trust is a membership organisation with a membership which consists of two constituencies of staff members and two constituencies of the general public. Members in each constituency vote to elect governors and can also stand for election themselves.

The Trust is locally accountable and it is the Council of Governors who collectively bind the Trust to its patients, service users, staff and stakeholders. The Council of Governors consists of elected members and appointed individuals who represent both members and other stakeholder organisations and the Governors act as a link between patients, the public and the Board of Directors.

Members of the Board and, in particular, the Non-Executive Directors, develop an understanding of the views of Governors and Members about the Trust through a number of ways including:

- Attendance at Council of Governors meetings by the Non-Executive Directors, the Chief Executive and Executive Team colleagues who brief the Governors on the Trust's strategy and current developments and answer questions to ascertain their views.
- At meetings, Non-Executive Directors report on their role on the Board and their Committee responsibilities. At meetings a question and answer session is held. Non-Executive Directors also account to the Governors for key Board decisions.
- Governors are invited to attend public Board meetings and attend some of the key committees and the Trust's working groups as observers and report back on the work of those groups.
- Non Executives and Governors are invited to participate in multi-disciplinary quality assurance walkabouts.

1.10 Evaluation of the Trust Board

Each Board Committee prepares an annual work plan and evaluates its performance against this by way of an annual report which is presented to the Trust Board. In addition, each Board and Committee agenda includes an item for some reflection on the effectiveness of the meeting. During 2019/20 there was a continued drive for improvement and refinement in the operation of the Board committees, with an emphasis on strengthened upward reporting on matters of positive assurance or concerns requiring Board attention.

Within the year there was a workshop held which allowed the Board some time to focus on its approach to risk appetite and also provided space to consider the new five year strategic plan, described earlier in this report.

The Board also commissioned an external well led assessment, the details of which are described in detail in Section 1.15.

Executive Directors are set objectives which are evaluated by the Chief Executive. The Chief Executive's own performance is evaluated by the Chairman. The Non-Executive Directors' objectives are set by the Chairman; their evaluation is carried out by the Chairman, informed by feedback from a 360 degree appraisal exercise. The results are shared with the Council of Governors. The Chairman's appraisal is carried out by the Senior Independent Director, facilitated by the Director of Corporate Affairs & Company Secretary, with input from the Lead Governor. The results are shared with the Council of Governors.

1.11 Board and Committee Membership

The Board continually reviews the structure of its Board Committees with a view to improving upward reporting and the escalation of issues. The future operation of the Trust Board and its committees will be informed by the recommendations of the well led assessment described previously.

It should be noted that the structure, content and operation of the Board and its committees was impacted in the final month of 2019/20 by the global Coronavirus pandemic, when an interim set of governance arrangements was implemented that scaled back the scope of the Board and committee meetings to allow sufficient time to focus on the response to the pandemic. Agendas and membership were reduced to essential items and members only and meetings were held virtually using video conference facilities. The arrangements were implemented for an initial period of three months, with a review after this time.

Trust Board

The Royal Orthopaedic Hospital's Trust Board is a unitary board which means that within the Board of Directors the Non-Executive directors and the Executive Directors share the same liability. All directors, Executive and Non-Executive, have responsibility to constructively challenge the decisions of the Board and help develop proposals on priorities, risk mitigation, values, standards and strategy. The Non-Executive Directors have a particular duty to ensure appropriate challenge is made and have to satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented.

A key strength of the unitary board is the opportunity to exchange views between Executive and Non-Executive Directors, drawing on and pooling their experience and capabilities with all Board members sharing corporate responsibility for formulating strategy, ensuring accountability and shaping culture.

Board meetings are held on a regular basis and are chaired by the Trust Chair. There were 11 meetings of the Trust Board, including one workshop during the year and one special meeting to approve the annual report and accounts.

Although the Board exercises all the powers of the Trust some powers may be delegated to a Committee of Directors or to an Executive Director.

Attendance at the Trust Board during the year was as follows:

MEMBER	MEETING DATE										TOTAL
	3/4/2019	1/5/2019	5/6/2019	3/7/2019	4/9/2019	2/10/2019	6/11/2019	4/12/2019	5/2/2020	04/3/2020	
Yve Buckland (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Tim Pile	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	**9/10**
Kathryn Sallah	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	**9/10**
Rod Anthony	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Richard Phillips	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	**9/10**
David Gourevitch	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	**9/10**
Ayodele Ajose							✓	A	✓	✓	**3/4**
Paul Athey[#1]	✓	✓									**2/2**
Jo Williams[#2]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Garry Marsh	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	**9/10**
Phil Begg	✓	✓	A[#3]	✓	✓	✓	✓	✓	✓	✓	**9/10**
Marie Peplow			✓	✓	✓	✓	✓	✓	✓	✓	**8/8**
Stephen Washbourne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		
#1	Acting Chief Executive until 6 May 2019	#2	Chief Executive from 6 May 2019
#3	Planned absence – ROH work commitment		

Board Committees

During 2019/20 the Board was supported by the following committees as detailed below.

Audit Committee

The Audit Committee is chaired by a Non-Executive of the Trust, Rod Anthony, who is a finance professional. During 2019/20 the Committee met five times. The Director of Finance is the lead executive for the Committee, supported by the Director of Corporate Services & Company Secretary. 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 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 Committee provides assurance to the Board that the controls and systems in place are robust, reliable and fit for purpose.

MEMBER	MEETING DATE					TOTAL
	26/04/19	24/05/19	19/07/19	17/10/19	24/01/20	
Rod Anthony (Ch)	✓	✓	✓	✓	✓	**5/5**
Tim Pile	✓	✓	✓	✓	✓	**5/5**
David Gourevitch	A	A	✓	✓	A	**2/5**
Executive Directors in attendance						
Steve Washbourne	✓	✓	✓	✓	✓	**5/5**
Garry Marsh	✓	✓	A	✓	A	**3/5**

KEY:

✓	Attended	A	Apologies tendered

During 2019/20, in line with its approved internal audit plan, the Trust commissioned a number of internal audit reviews. The internal auditors issued eight reports, three of which gave positive assurance (all reasonable assurance opinion) and two provided partial assurance. The remaining three reports were either advisory or agreed upon procedures which did not result in a formal assurance opinion. A summary of the opinions from the internal audit report is below:

Review	Assurance provided
Operating theatres utilisation review	Advisory
Temporary staff usage	Reasonable
IT disaster recovery planning	Partial
Focussed follow up – NICE guidelines	Reasonable
Key financial systems	Reasonable
Data Security and Protection Toolkit	Agreed upon procedures
Estates – works and maintenance contracts	Advisory
Effective recruitment	Partial

During 2019/20 the 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 coordination, 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 and report recommendations across the Trust; and
- 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 meeting and an assurance report is provided by the Chair of the Audit Committee to the following Trust Board meeting. The Committee has an annual work plan that ensures it embraces the necessary range of activities, including those relating to internal and external audit activities.

Where work which is not of an audit nature is undertaken by auditors, this is separately commissioned against a clear brief and is undertaken by someone not engaged in independently auditing the Trust. Where possible, this is scheduled into the work plan and is included in the information presented to the Council of Governors. The Chairman of the Audit Committee is available to update the Council on any matters of interest.

Discharge of Responsibilities

During 2019/20 the Audit Committee reported assurance to the Trust Board with a particular focus on:

- Ensuring the financial statements for the year end reflected a true and fair position that there were no significant issues within the External Auditors' report that needed to be reported to the Trust Board;

- Ensuring the Annual Governance Statement reflected the Committee's knowledge of the Trust and no further disclosures were required. The Committee considered in detail the annual Head of Internal Audit Opinion and other sources of assurance;
- Following-up on audit work completed in the previous year, the Committee continued to receive regular reports from executive managers;
- During the year the Committee continued to strengthen a supportive working relationship with the Quality & Safety Committee (QSC). A Non Executive member of the Quality & Safety Committee is a member of the Audit Committee which provides the link between Audit Committee and the work of the Quality & Safety Committee and its sub-committees. The Executive Director of Nursing and Clinical Governance or his deputy is also a regular attendee at the meeting;
- The Audit Committee reviews arrangements that allow staff of the Trust and other individuals where relevant to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters;
- The Committee monitored closely matters of compliance with specific clinical policies and procedures, as noted in the Annual Governance Statement and worked with the Quality & Safety Committee to strengthen controls and compliance in this area;
- The Trust's internal audit function is provided by RSM UK and the Trust works closely with a Partner and Senior Manager to ensure independent, objective assurance is provided 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 has been developed in line with the Trust's key strategic risks and objectives and the Committee monitors delivery against this plan at each meeting.
- To strengthen the role of the Audit Committee in holding the Executive to account, a slot was included on the agenda of each meeting to allow the relevant Executive leads to join the meeting to update the Committee on the work undertaken to address the recommendations arising from the internal audit reviews.

In 2019/20, the Committee considered a review of its effectiveness. Members and regular attendees of the Audit Committee were issued with a questionnaire over summer 2019, asking them to provide a view of the strength of the Committee's arrangements in respect of a number of measures covering seven domains:

- Creating an effective Audit Committee
- Running an effective Audit Committee
- Professional Development
- Overseeing financial reporting
- Overseeing risk management and internal control
- Overseeing external audit
- Overseeing internal audit

The methodology and questionnaire used were based on approach set out in the Audit Committee Institute Audit Committee Handbook 2014.

Although the review provided a positive picture of effectiveness, in a number of cases, there was some variance between the actual and ideal position. These areas can be summarised in broad terms as:

- Improvements needed to the induction arrangements for new members and regular attendees to the committee and a lack of provision for members to keep up to date through formal and informal training courses once appointed.

- Succession planning for existing members, particularly given the expiry of the terms of office of the current chair and one of the other Non Executive members in 2020.

- The balance of discussion around risk at the meetings, with some commenting that the meetings can be 'finance heavy' on occasions. It was suggested that the responsibilities of the Audit Committee in providing assurance to the Board on reviewing risk management arrangements, risk appetite and the risk profile of the organisation could also be improved.

As a result a number of improvement actions were agreed, the majority of which were to be discharged by the Director of Corporate Affairs and Company Secretary which will be delivered over 2020/21.

Quality & Safety Committee

The Quality & Safety Committee has designated responsibility for oversight of clinical risk management and is chaired by Kathryn Sallah, a Non-Executive Director of the Trust with a clinical background. The Director of Nursing and Clinical Governance is the lead Executive. A member of the Council of Governors has a standing invitation to attend meetings. The Trust Chairman, although not a member of the Committee joined a number of the meetings. The Quality & Safety Committee meets most months and regularly reviews clinical risks through consideration of an extract 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 Quality & Safety Committee provides upward assurance to the Board on the activities undertaken by its subgroups covering particular aspects of quality, for example drugs and therapeutics, safeguarding, research & development, health & safety and infection control. Much work has been undertaken during the year to strengthen the quality and content of the upward reports from the subgroups into the Quality & Safety Committee and a new simpler prescribed 'quadrant' format has been embedded during the year which subgroup chairs use when they attend by rotation to present to the Committee.

MEMBER	MEETING DATE											TOTAL
	24/4/19	29/5/19	26/6/19	31/7/19*	28/08/19	25/09/19	30/10/19	27/11/19	29/01/20	26/02/20	25/03/20**	
Kathryn Sallah (Ch)	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	**10/11**
David Gourevitch	✓	✓	✓	✓	A	✓	A	✓	✓	✓	✓	**9/11**
Simone Jordan	✓	A	✓	A	✓	✓	✓	✓	✓	✓	✓	**9/11**
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/11**
Paul Athey	A											**0/1**
Matthew Revell	✓	✓	A	A	✓	✓	✓	✓	✓	✓		**8/10**
Jo Williams	✓	✓	✓	✓	✓	✓	✓	A	✓	✓		**9/10**
Marie Peplow		✓	✓	A	A	✓	A	✓	✓	✓		**6/9**

KEY: ✓	Attended	A	Apologies tendered
	Not in post/not required	*	The July meeting was an assurance briefing
		**	Slimmed attendance under Covid interim governance arrangements

Finance and Performance Committee

The Committee is chaired by Tim Pile, the Vice Chair, and the Director of Finance and Performance is the lead Executive for this committee. The Trust Chairman and other members of the Board, although not formal members, attended the committee meetings from time to time during the year. The Committee meets monthly (apart from December) and regularly reviews finance and performance-related risks through consideration of an extract of the Corporate Risk Register, which also includes risks of a sufficient severity and/or impact as to warrant inclusion on the Board Assurance Framework.

A key area of focus for the Committee during the year was on continued improvements in financial and performance recovery however. The Committee also continued to receive upward reports from the IM&T Programme Board, the Estates Strategy & Delivery Group and the Information Governance Group. In June, the Committee also received and supported a plan to create a 'Perfecting Pathways' Programme Board which would act as the primary body through which project and continuous improvement work would be reported. This would report upwards to the Finance and Performance Committee on a regular basis. The Committee received a report progress with the plans to improve the productivity of the private patient unit and to develop capability in respect of marketing and GP liaison. Others areas considered by the Committee during the year included a business case for a manage service in theatres and the impact and potential solutions to the pensions tax liability issue which impacted on the Trust's ability to deliver the activity levels in the Trust's operational plan.

MEMBER	MEETING DATE											TOTAL
	26/4/19	4/6/19	26/6/19	23/7/19	15/8/19*	24/9/19	22/10/19	26/11/19	24/1/20	28/2/20	24/3/20**	
Tim Pile (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	**10/11**
Rod Anthony	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		**10/10**
Richard Phillips	✓	✓	✓	A	✓	A	A	✓	✓	A		**6/10**
Ayodele Ajose								✓	✓	✓		**3/3**
Paul Athey	✓											**1/1**
Stephen Washbourne	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	**10/11**
Jo Williams	✓	✓	✓	✓	✓	✓	✓	A	✓	✓		**9/10**
Phil Begg	✓	✓	A	✓	A	✓	✓	✓	✓	✓		**8/10**
Marie Peplow		✓	✓	A	✓	✓	✓	✓	✓	✓	✓	**9/10**

KEY:

✓	Attended	A	Apologies tendered
*	Special Briefing Meeting		Not in post/not required to attend
**	Slimmed attendance under Covid interim governance arrangements		

Staff Experience and Organisational Development (OD) Committee

The Staff Experience & OD Committee was established to provide enhanced oversight of the Trust's workforce agenda. The Committee is chaired by a Non Executive, Richard Phillips, and the Chief Executive is the executive lead. The Associate Director of Workforce, HR & OD is the key operational lead for the Committee.

The focus for the Committee is to provide the Board with assurance concerning the arrangements and progress with performance against key workforce targets and delivery of key activities in support of the Trust's workforce strategies. As with the Quality and Safety Committee and the Finance & Performance Committee, the Staff Experience & OD Committee regularly reviews workforce performance and related risks through consideration of a workforce dashboard and a Risk Register, which also includes risks of a sufficient severity and/or impact as to warrant inclusion on the Board Assurance Framework. The Committee also receives at each meeting a presentation from a member of staff or team outlining their experience of working at the ROH and have the opportunity to make suggestions for ways in which the life of staff working at the Trust might be improved.

MEMBER	MEEETING DATE										TOTAL
	3/4/19	1/5/19	5/6/19	3/7/19	25/9/19	30/10/19	27/11/19	29/1/20	25/2/20	24/3/20*	
Richard Phillips (Ch)	✓	A	✓	✓	A	✓	✓	✓	✓	✓	**8/10**
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	A		**8/9**
Kathryn Sallah	✓	✓	✓	A	✓	✓	✓	✓	✓		**8/9**
Paul Athey	✓	✓									**2/2**
Phil Begg	✓	✓	A	✓	✓	✓	✓	✓	✓		**8/9**
Jo Williams	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	**9/10**
Garry Marsh	A	✓	✓	✓	✓	✓	✓	✓	A		**7/9**
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓		**9/9**
Marie Peplow				✓	✓	A	✓	✓	✓		**5/6**

KEY:

✓	Attended	A	Apologies tendered
	Not in post/not required to attend		
*	Slimmed attendance under Covid interim governance arrangements		

Also in attendance at this meeting are the Associate Director of Workforce, & Organisational Development, Head of HR Operations, Head of OD & Inclusion and Head of Education & Training.

Charitable Funds Committee

The Trust Board is the corporate trustee for the charitable funds of the Trust. Charitable funds are examined separately from exchequer funds and the Trustees discharge their responsibilities independently from the Foundation Trust itself. The Committee usually meets four times per year however during 2019/20 it met twice, with the meeting in the year being cancelled and business conducted virtually in line with the revised interim governance arrangements associated with the response to the Coronavirus pandemic.

Membership comprises all voting members of the Trust Board, a governor representative, a patient representative and a patient facing staff member.

During the year, the Committee considered a number of requests for funding, an update on the financial health of the charity and the annual report and accounts, which was considered and approved at the November 2019 meeting. The Committee also considered a draft of the Charity policy.

DIRECTOR	MEETING DATE		TOTAL
	26/6/19	27/11/19	
David Gourevitch (Ch)	✓	✓	**2/2**
Rod Anthony	A	✓	**1/2**
Simone Jordan	✓	✓	**2/2**
Kathryn Sallah	A	✓	**1/2**
Richard Phillips	✓	A	**1/2**
Yve Buckland	A	A	**0/2**
Tim Pile	A	A	**0/2**
Garry Marsh	✓	✓	**2/2**
Stephen Washbourne	✓	✓	**2/2**
Phil Begg	A	✓	**1/2**
Jo Williams	✓	A	**1/2**
Matt Revell	A	A	**0/2**
Marie Peplow	A	A	**0/2**

KEY:

✓	Attended	A	Apologies tendered

Nominations and Remuneration Committee (Executive Directors)

The Nominations and Remuneration Committee is chaired by the Trust Chairman and comprises all the Non-Executive Directors. The Chief Executive is a member but, in the case of matters relating to the Chief Executive themselves, they must withdraw from the Committee. It meets as required to consider any matters relating to the continuation in office of any Executive Director, including the supervision or termination of service of an individual or an employee of the Trust. During the year, the Committee met five times.

The Committee serves a dual purpose:

- To review the structure, size and composition of the Board (including skills, knowledge and experience) required of the Board and make recommendations to the Board or Council of Governors where appropriate with regard to any changes. It also gives full consideration to succession planning. 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.
- The Remuneration Committee has delegated responsibility for setting the remuneration for all Executive Directors, including pension rights and any compensation payments. The Committee also recommends and monitors 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.

MEMBERS	MEETING DATE					TOTAL
	4/4/2019*	5/6/2019	7/8/2019**	4/9/2019	5/2/2020	
Yve Buckland (Chair)	✓	✓	A	✓	✓	4/5
Tim Pile	✓	✓		✓	✓	4/4
Kathryn Sallah	✓	✓		✓	✓	4/4
Rod Anthony		✓		✓	✓	3/3
Richard Phillips		✓		✓	✓	3/3
David Gourevitch		✓		✓	✓	3/3
Simone Jordan	✓	✓	✓	✓	✓	5/5
Ayodele Ajose					✓	1/1
Jo Williams		✓	✓	✓	✓	4/4

KEY:

✓	Attended	A	Apologies tendered
*	Panel for the appointment of the Chief Executive	**	Panel for the appointment of the Chief Operating Officer

1.12 Cost allocation and charging guidance

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

1.13 Political Donations

There were no political donations during the financial year.

1.14 Better Payment Practice

The Trust paid 51.5% of non-NHS invoices (43.2% by value) within 30 days against the target of 95%. Of the remaining balance, 48.5% of invoices were paid late and 7.2% were paid late due to a dispute on the invoice. The Trust did not incur any late payment penalties during 2019/20 under the Late Payment of Commercial Debts (Interest) Act 1998.

1.15 NHS Improvement's well-led framework

The Board commissioned an external well led assessment undertaken by the consultancy arm of Grant Thornton UK LLP. This was the first developmental review of leadership and governance using the NHS Improvement well led framework that the Trust had undertaken. The review and assessment was far reaching and involved Board and Committee observations, board member, stakeholder and focus group interviews and analysis of the effectiveness of the risk and control environment from ward through the divisions and up to Board. Through 2020/21, the action plan developed in response to the recommendations made by the review will be delivered and create a strengthened leadership and governance model for the Trust.

1.16 How the Foundation Trust has had regard to NHS Improvement'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

Quality governance is discussed in more detail in the Annual Governance Statement (Section 8); this section gives a brief overview of the arrangements in place to govern service quality.

The Board receives assurance on quality governance through the Board Assurance Framework, performance against a wide range of indicators in the monthly Finance and Performance Overview, through assurance provided by the Quality and Safety Committee, which considers in detail a comprehensive report on Quality and Patient Safety and by the performance against a range of workforce indicators considered by the Staff Experience & OD Committee.

The Quality and Safety Committee provides upward assurance to the Board on the activities undertaken by its subgroups covering particular aspects of quality. Much work has been undertaken during the year to strengthen the reporting lines and quality of information provided to the Quality and Safety Committee.

Work has continued throughout the year to develop enhanced approaches to data reporting through the continuous refinement of the Finance and Performance Overview, Quality and Patient Safety report and Workforce overview to enable greater and more informed scrutiny. In 2020/21 there are plans to introduce an integrated performance dashboard which will be presented to each of the main Board committees to allow better triangulation of data.

There is a process of escalation of risk related to quality throughout the Trust; much work has been undertaken during the year to strengthen existing risk registers, with further work planned during 2020/21, particularly around better use of the electronic risk management solution and to deliver training on risk management more systematically.

Board members carry out informal walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients and staff and others. A formal programme of Quality Assurance walkabouts is in place led by a senior nurse in conjunction with the Chair of the Quality & Safety Committee. There are plans to strengthen the reporting of the outcome and action plans from these visits to the Quality & Safety Committee when the usual cycle of the business resumes in the restoration and recovery phases of the Covid-19 response.

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 had continued to deliver the action plan developed in response to the inspections by the CQC in 2018 and 2019. There now remain a small number of open actions with a robust plan to address these. Exception reports on the delivery of the plan are considered by the Quality and Safety Committee and Trust Board as part of their routine cycle of business.

1.17 Patient Care

The Trust has demonstrated significant progress in delivering its Quality Priorities for 2019/20, which included success in implementing Multi-Disciplinary ward rounds, learning from serious incidents and complaints, reductions in Outpatient waiting times and a reduction in theatre cancellations.

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 six improvement priorities for 2019/20, 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 Clinical Quality Group where a regular progress report will be presented. Any concerns will be escalated to the Quality & Safety Committee.

The Commissioning for Quality and Innovation (CQUIN) system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in

quality and innovation in specified areas of patient care. This means that a proportion of our income depends on achieving quality improvement and innovation goals, agreed between the Trust and its Commissioners. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients, a principle fully supported at all levels of the hospital. The Trust agreed CQUINs for 2019/20.

The overall CQUIN value relates to a percentage of the overall contract value; 1.25% of the main CCG contract and 0.75% of the main NHSE contract. During 2019/20 the total amount of CQUIN awarded from both the CCG and NHSE was maximum value £746,345.

The provision of Patient Experience services has continued to be monitored during the year; the transition of all Patient Experience data to the PALS and Complaints department has proved to be successful from a number of perspectives. Firstly, it has enabled triangulation of all data to ensure that any concerns are identified and acted upon promptly. It has also ensured that good practice is identified and shared.

The Trust continues to perform strongly in the National Inpatient Survey and resulted in official recognition last year for the level of improvement seen. The Trust remains in the top 20% of Trusts for overall patient experience of our services.

The Trust has received just over 6,000 individual pieces of feedback from the Friends and Family Test in 2019/20, across all areas and departments. All data is collected via the 'iwantgreatcare' system; all feedback is read on receipt by the Patient Experience Team and action is taken immediately where necessary. Compliments from these are also now recorded and shared with individuals and teams. The Trust has maintained a 96.1% positive score meaning that over 6420 patients have indicated that they are happy with and would recommend the care that they have received here in the last twelve months.

The PALS department has handled over 770 contacts in 2019/20, which has decreased as planned by the removal of the PALS telephone number from all letters and correspondence and the appropriate contact information being provided. This has resulted in better support being provided for patients that require assistance, as PALS staff are not being overwhelmed with redirecting calls to the appropriate place.

The Complaints Department continues to function effectively in line with the policy developed in 2018. Divisional Managers now receive complaint report writing and investigation training to further improve the quality of responses.

All of the key performance indicators for the year have been met and greater scrutiny of actions taken as a result of complaints is happening within the Divisional meetings.

The Executive Team receive weekly updates on the status of all complaints and there have been no issues highlighted with the management of complaints during the year.

The team has continued to work closely with operational and nursing colleagues to ensure that patient experience remains at the heart of decision making in the Trust. In particular, the Trust has developed a Patient Involvement, Engagement and Volunteer Strategy involving patients,

carers and Healthwatch Birmingham. The strategy will inform the work being undertaken by the Patient and Carer Forum and the Patient Engagement and Experience Group.

1.18 Stakeholder Relations

During the year, the Trust has continued to develop its place and contribution within the refreshed Birmingham and Solihull Sustainability and Transformation Partnership (STP). Alongside this, there have been discussions with neighbouring trusts, University Hospital Birmingham NHSFT and Birmingham and Women's NHSFT to create a closer working relationship through the Birmingham Hospitals Alliance (BHA).

The decision to cease paediatric surgery in 2017 necessitated a widescale public engagement process, both communicating the decision and the potential impact where understood, as well as listening to concerns from the relatives and carers of our paediatric patients. Discussions with stakeholder partners, including commissioners, the CQC and Birmingham Women's and Children's NHSFT was also an essential part of working through the transition plan in readiness for the service to move from 30 June 2019, a key change for the services of the ROH during the year.

The Trust has continued to work with Stryker Performance Solutions during the year, to develop and embed the JointCare pathway, this being based on a 'wellness' model that is enjoying success in the USA and in other places. The Trust has also continued to use the robotic technology from Stryker to assist with joint replacement surgery. The JointCare reunion events have provided a sound opportunity for engaging with a large cohort of our patients and the feedback on their experience has been useful in shaping the future service offerings.

Throughout the year there have been approaches from commercial companies seeking to understand what opportunities for partnership with the ROH might be feasible and beneficial for patients. The Trust Board over 2020/21 will consider these more fully and pursue those that might be of most value to the Trust and its service users.

The Trust has an active Patient and Carers' Forum in place, which has met regularly during 2019/20 and has reported on its work to the Council of Governors. The Forum is a great source of patient feedback and its focus on developing fit for purpose patient information has continued to be particularly valuable this year. Further work has also been undertaken during the year to establish a Patient Engagement and Experience Group (PEEG), which will focus on more strategic issues impacting on patients and will cement some of the processes already in place to seek the views of our service users

The focus of public and patient activity this year has continued to be on creating regular and one-off opportunities for engagement directly with the Trust. Engagement also continues to be through our Council of Governors, both through their routine meetings and through informal communications that have been issued throughout the year on key topics. To strengthen this opportunity for engagement using the governors as the key link, the Trust uses a series of drop

in sessions to allow visiting patients, relatives and the Trust's own staff to give feedback to the governors or to find out information about the happenings at the Trust that can be disseminated back into the community. The outcome of these sessions is conveyed to a member of the Executive Team who then takes responsibility for feeding this back to the wider management team and implementing any action needed as a result.

There are further plans moving into 2020/21, when the impact of the Coronavirus pandemic has been managed, to reinstate the development of the processes to engage members of our patient and public community, while working through some of the limitations offered by the new social distancing measures that are to be adopted in the longer term.

To conclude this chapter, two specific statements need to be made as to the consistency of the annual report with other corporate documents and a statement to the auditors that the Directors of the organisation have taken all reasonable steps to disclose information to the auditors and to take all steps necessary to identify information of which they are aware which needs to be disclosed.

1.19 Material inconsistencies

There are no material inconsistencies between:

- the Annual Governance Statement;
- annual Board declarations;
- the Corporate Governance Statement submitted with the annual plan;
- the 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.

1.20 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.

Section 2:

Remuneration Report

1.0 Annual statement on Remuneration

During the year the Nominations and Remuneration Committee met on four occasions and made decisions concerning executive pay in relation to determining whether to implement the national guidance on the cost of living salary increase for staff on a Very Senior Manager payscale, which at the Trust is only Executive Directors and the Director of Corporate Affairs & Company Secretary. The guidance proposed an uplift of 1.32% on a consolidated basis, with a further 0.77% non-consolidated cash lump sum, backdated to April 2019. For individuals paid above the upper quartile for their role, according to NHS Improvement's published pay ranges, then payments were to be made on a non-consolidated basis. The Nominations & Remuneration Committee supported the implementation of this guidance at its meeting in February 2020.

The Committee did not seek the advice or services of any director or third party in assisting the Committee with its decision-making at this meeting.

2.0 Senior managers' remuneration policy

2.1 Future policy table: Executive Directors

	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	None	Not Applicable	Not Applicable	NHS Pension Scheme membership	Basic pay for consultant role (Medical Director only) Allowance for the Acting Chief Executive paid as a short term recruitment and retention premium (until his departure on 2 June 2019)
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 This enables continuity of service and leadership until a

	Salary and fees	Taxable Benefits	Annual Performance -related bonuses	Long-term Performance-related bonuses	Pension-related benefits	Other Remuneration
						substantive CEO is appointed
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 Nominations & 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 framework used to assess performance	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable

Accompanying notes

There were no new core 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.

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.

. **2.2 Future policy table: Non-Executive Directors**

	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**
Description	Fee for the Chair , Committee Chairs and other Non-Executive Directors	Not applicable	Expenses incurred in the course of their duties such as public transport, mileage and subsistence as determined by Trust policy.
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 Non-Executive Directors must be competitive in order to recruit and retain talented individuals	Not applicable	To ensure Non-Executive Directors are appropriately compensated for those journeys they have undertaken on behalf of the Trust. The policy for Non-Executive Director expenses is the same as that applying to other staff
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 Non-Executive Directors are set by the Council of Governors.

	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
The maximum that could be paid in respect of that component	The rate of remuneration payable to the Chairman of the Trust is £36,417.50 pa for up to two days a week. The Chair of the Audit Committee and the Senior Independent Director are remunerated at a rate of £14,567.03 pa. The current rate of remuneration payable to other Non-Executives is £11,445.52 pa for approximately three days a month.	Not applicable	Not applicable
Where applicable, a description of the framework used to assess performance	Performance of Non-Executive Directors is assessed by the Chairman annually, and for the Chairman, by the Lead Governor and Senior Independent Director	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 Non-Executive Directors, they are usually employed for a fixed-term basis and the Trust acts to ensure a permanently employed appropriate replacement 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.

During the year there have been no payments made to senior managers for loss of office.

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.

The Trust has in place, in addition to the professional indemnity cover provided under the Trust's arrangements with the NHS Litigation Authority, an additional directors & officers liability policy.

2.6 Trade Union Facility Time

Table 1

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
5	963.44

Table 2

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	*Number of employees*
0%	3
1-50%	1
51%-99%	1
100%	0

Table 3

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£20,559
Provide the total pay bill	£56,723,000

	Figures
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.03%

Table 4

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: 10.19% *(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100*

2.7 Senior managers paid in excess of £150,000[#1]

One director whose remuneration exceeded £150,000 was in post prior to 1 April 2020. The remuneration for this post holder was assessed and benchmarked against comparable Trusts, utilising published independent market salary information and was considered appropriate.

[#1]£150k is the threshold used in Civil Service for approval by the Chief secretary to the Treasury, as set out in guidance issued by the Cabinet Office. The Cabinet Office approvals process does not apply to NHS foundation trusts but this is considered a suitable benchmark above which NHS foundations trusts should make this disclosure.

2.8 Payments to past senior managers

During the year there have not been any payments made to past senior managers.

3.0 Annual Report on Remuneration

3.1 Service contracts

Name and title	Date of service contract	Unexpired term	Notice period
Dame Yve Buckland **Chairman**	1 May 2014	Until 30 April 2023	Note 1
Mr Timothy Pile **Non-Executive Director and Vice Chairman**	1 January 2016	Until 31 Dec 2020	Note 1
Mrs Jo Williams **Chief Executive**	6 May 2019	Not applicable	6 months
Mr Matthew Revell **Executive Medical Director**	18 February 2019	Not applicable	6 months
Mr Garry Marsh **Executive Director of Nursing & Clinical Governance**	1 September 2015	Not applicable	6 months
Mrs Marie Peplow **Executive Chief Operating Officer**	1 September 2019	Not applicable	6 months
Prof Philip Begg **Executive Director of Strategy & Delivery**	1 November 2014	Not applicable	6 months
Mr Stephen Washbourne **Interim Executive Director of Finance**	On secondment from University Hospital Birmingham NHS Foundation Trust from October 2017		
Mr Simon Grainger-Lloyd **Director of Corporate Affairs & Company Secretary**	4 August 2015	Not applicable	6 months
Mr Rod Anthony **Non-Executive Director**	1 June 2014	Until 30 November 2020	Note 1
Mrs Kathryn Sallah **Non-Executive Director**	1 April 2015	Until 31 March 2021	Note 1
Mr Richard Phillips **Non-Executive Director**	1 February 2017	Until 31 January 2023	Note 1
Prof David Gourevitch **Non-Executive Director**	1 February 2017	Until 31 January 2023	Note 1
Ms Simone Jordan[#2] **Associate Non-Executive Director**	1 July 2017	30 June 2020	Note 1
Ms Ayodele Ajose[#3] **Associate Non-Executive Director**	1 November 2019	31 October 2020	Note 1

Notes:

#1 Non-Executive Directors may resign by giving one month's notice in writing

#2 One year fixed term appointment initially extended by a further year to 2019 and then to 2020

#3 Rolling one year fixed term appointment, initially to 2020

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).

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 report subject to audit

4.1 Remuneration of the Board directors for 2019/20

Name and Title	2019-20 (12 months to 31st March 2020)					
	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
Mrs Joanne Williams Chief Executive Officer	130-135	0	0	0	122.5-125	0
Mr Garry Marsh Executive Director of Nursing & Clinical Governance	110-115	0	0	0	27.5-30	0
Mr Matthew Revell Executive Medical Director	160-165 (note 1)	0	0	0	27.5-30	0
Professor Philip Begg Director of Strategy and Delivery	105-110	100	0	0	(135-132.5)	0
Mr Stephen Washbourne Interim Executive Director of Finance	120-125	0	0	0	47.5-50	0
Mrs Marie Peplow Chief Operating Officer	95-100	0	0	0	305-307.5	0
Dame Yve Buckland, Chairman	35-40	0	0	0	0	0
Mr Tim Pile Vice Chair and Non Executive Director	10-15	0	0	0	0	0
Mr. Rod Anthony Non Executive Director	10-15	0	0	0	0	0
Mrs. Kathryn Sallah Non Executive Director	10-15	0	0	0	0	0
Prof. David Gourevitch Non Executive Director	10-15	0	0	0	0	0
Mr. Richard Phillips Non Executive Director	10-15	0	0	0	0	0

Note

1. As Executive Medical Director, Mr. Revell's salary is comprised of month medical and management fees. The medical fees are in the band £50k-£55k.

4.2 Remuneration of the Board directors for 2018/19

Name and Title	2018-19 (12 months to 31st March 2019)					
	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 Paul Athey Acting Chief Executive Officer	140-145	0	0	0	(127.5-130)	0
Mr Garry Marsh Executive Director of Nursing & Clinical Governance	110-115	0	0	0	(17.5-20)	0
Mr Andrew Pearson Executive Medical Director **Note 1**	125-130	0	0	0	(102.5-105)	0
Mr Matthew Revell Executive Medical Director **Note 1**	10-15	0	0	0	Note 1	0
Professor Philip Begg Director of Strategy and Delivery	105-110	100	0	0	110-112.5	0
Mr Stephen Washbourne Interim Executive Director of Finance	115-120	0	0	0	Note 2	0
Mrs Joanne Williams Interim Chief Operating Officer	115-120	0	0	0	Note 3	0
Dame Yve Buckland, Chairman	35-40	300	0	0	0	0
Mr Tim Pile Vice Chair and Non Executive Director	10-15	0	0	0	0	0
Mr. Rod Anthony Non Executive Director	10-15	0	0	0	0	0
Mrs. Kathryn Sallah Non Executive Director	10-15	200	0	0	0	0
Prof. David Gourevitch Non Executive Director	10-15	0	0	0	0	0
Mr. Richard Phillips Non Executive Director	10-15	0	0	0	0	0

Note

1. Mr Andrew Pearson stepped down as the Trust's Medical Director on the 18th February. On the same date Mr Matthew Revell took up the position of Medical Director. The above information has been pro-rated accordingly. Part of the remuneration received by the Medical Director is in relation to their clinical role. Mr Pearson earned £38k and Mr Revell earned £5k as clinical pay during their time as Medical Director.
2. Mr S Washbourne has been Interim Director of Finance from October 2017, the Trust does not hold the pension information for 2017/18 to allow accurate calculation of the pension figures for the table above.
3. Mrs J Williams joined the Trust part way through 2017/18, the Trust does not hold the pension information for 2017/18 to allow accurate calculation of the pension figures for the table above.

4.3 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 2019/20 was £160-£165k (2018/19: £140-145k). This was 6.2 times (2018/19: 4.8 times) the median remuneration of the workforce, which was £26k (2018/19: £29k). The median remuneration is calculated by grossing up the payment to be the equivalent of a full-time member of staff on an annualised basis. 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 2019/20, 4 employees (2018/19: 11) received remuneration in excess of the highest-paid director. Annualised remuneration ranged from £8k to £169k (2018/19: £4k to £164k), 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.

5.0 Salary and Pension Entitlements of Senior Managers

a) Pension Benefits* 2019-20

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 2019 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Real Increase/ (decrease) in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Mrs Joanne Williams – Chief Executive Officer	12.5-15	100-105	552	443	98	0
Mr. G. Marsh – Director of Nursing & Clinical Governance	(2.5-0)	110-115	597	558	25	0
Mr. Stephen Washbourne – Interim Director of Finance and Performance	0-2.5	120-125	636	581	41	0
Mrs Marie Peplow - Chief Operating Officer	47.5-50	150-155	896	572	310	0
Mr. Matthew Revell – Medical Director	(2.5-0)	125-130	732	685	30	0
Professor. P. Begg – Director of Strategy and Delivery	(22.5-20)	50-55	126	563	(451)	0

*This element of the annual report has not been audited

b) Pension benefits* 2018-19

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 2018 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real Increase/ (decrease) in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Mr. P. Athey –Acting Chief Executive Officer	(20-22.5)	80-85	339	355	(27)	0
Mr. G. Marsh – Director of Nursing & Clinical Governance	(2.5-5)	100-105	480	421	47	0
Mr. Stephen Washbourne – Interim Director of Finance and Performance	**Note 1**	**Note 1**	**Note 1**	**Note 1**	**Note 1**	0
Mrs Joanne Williams Interim Chief Operating Officer **Note 2**	**Note 2**	**Note 2**	**Note 2**	**Note 2**	**Note 2**	0
Mr. A. Pearson – Medical Director **Note 3**	(17.5-20)	180-185	1050	1027	(7)	0
Mr. Matthew Revell – Medical Director **Note 3**	**Note 3**	**Note 3**	**Note 3**	**Note 3**	**Note 3**	0
Professor. P. Begg – Director of Strategy and Delivery	17.5-20	65-70	475	418	44	0

*This element of the annual report has not been audited

Note 1 Mr S Washbourne has been Interim Director of Finance from October 2017, the Trust does not hold the pension information for 2017/18 to allow accurate calculation of the pension figures for the table above.

Note 2 Mrs J Williams joined the Trust part way through 2017/18, the Trust does not hold the pension information for 2017/18 to allow accurate calculation of the pension figures for the table above.

Note 3 Mr A Pearson stepped down as Medical Director in February 2019, his pension figures in the table above have been pro-rated. Mr M Revell replaced Mr A Pearson in the role. Due to the timing not all of the pension information was available for this report.

5.1 Total Pension Entitlement

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

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

The CETV figures, and from 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 is subject to audit

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

	2019-20	2018-19
Number of Directors in office*	12*	12*
Number of Directors with expense claims	4	6
Financial value of expense claims made by Directors (£)	£3,225	£3,667
Number of Governors in office	16	18
Number of Governors with expense claims	0	1
Financial value of expense claims made by Governors (£)	0	530

*excludes interim Board members and the Associate Non Executive Director. Includes the former Chief Executive.

Mrs Jo Williams
Chief Executive
19 June 2020

Section 3:

1.0 Staff Report

1.1 Analysis of Average Staff Numbers

During the course of the year, the Trust employed an average of **1,091** staff equating to **963.44** whole time equivalents representing an increase of 57 more people (just over 79 whole time equivalents) employed in the Trust in comparison to the 2018/19 financial year.

The Trust has recruited 232 new starters of which 74 have been Registered Nurses to fill a combination of both vacant and new posts and when including recruitment to the staff bank, this increases to 349 new starters in total.

Recruitment through open day events has continued to be successful in attracting people to The Royal Orthopaedic Hospital and has significantly supported recruitment to the Theatre Expansion programme.

In relation to medical staff, the Trust has successfully appointed seven substantive consultants in Oncology, Radiography, Therapy Services, Large Joints and Spinal in the 19/20 financial year.

The Trust is also embracing new roles in the form of Nursing Associates and Theatre Assistant Practitioners: staff in these roles will play an important role in future years.

1.2 Employee expenses and numbers – Trust only

	2019/20			2018/19		
	Total	Permanently Employed	Agency	Total	Permanently Employed	Agency
	£000	£000	£000	£000	£000	£000
Salaries and wages	41,737	41,737	0	39,677	39,677	0
Social security Costs	4,128	4,128	0	3,963	3,963	0
Apprenticeship levy	188	188	0	178	178	0
Employer's contributions to NHS Pensions	4,637	4,637	0	4,235	4,235	0
Employer contributions paid by NHSE on provider's behalf (6.3%)	2,006	2,006	0	0	0	0
Agency staff	4,013	0	4,013	5,543	0	5,543
TOTAL EMPLOYEE EXPENSES	**56,709**	**52,696**	**4,013**	**53,596**	**48,053**	**5,543**

1.3 Employee expenses

The total Employer Pension contribution payable for the period to 31 March 2019 is £4,637,031 (31 March 2018 £4,059,684).

1.4 Average number of persons employed

	2019/20			2018/19		
	Total	Permanently Employed	Agency	Total	Permanently Employed	Agency
	Number	Number	Number	Number	Number	Number
Medical and dental	128	107	21	130	105	25
Administration and estates	414	370	44	397	349	48
Healthcare assistants and other support staff	161	137	24	149	122	27
Nursing, midwifery and health visiting staff	282	235	47	270	210	60
Scientific, therapeutic and technical staff	122	108	14	128	109	19
TOTAL PERSONS EMPLOYED	**1,107**	957	150	**1,074**	895	179

Note: the information above relates to Trust employees only as the associated charity which has been consolidated into these accounts does not employ any staff.

1.5 Breakdown of staff by type of employment contract

Average number of Staff in Post (1 April 2019 - 31 March 2020) Staff Group	Fixed Term Temp	Locum	Permanent
Additional Prof Scientific and Technical	1	0	43
Additional Clinical Services	6	0	154
Administrative and Clerical	18	0	292
Allied Health Professionals	2	0	74
Estates and Ancillary	1	0	110
Healthcare Scientists	0	0	0
Medical and Dental	31	6	78
Nursing and Midwifery Registered	9	0	263
Students	0	0	3
Grand Total	**68**	**6**	**1,017**

In addition, as at 31st March 2020 the Trust had access to the following bank workers:

Staff Group	Bank and substantive	Bank Only
Additional Prof Scientific and Technical	23	15
Additional Clinical Services	146	83
Administrative and Clerical	192	58
Allied Health Professionals	53	22
Estates and Ancillary	29	42
Medical and Dental	20	20
Nursing and Midwifery Registered	257	83
Students	3	0
Grand Total	**723**	**323**

In this table, the 'bank only' column refers to people who are available to the Trust on an ad-hoc basis, while the 'bank and substantive' column reflects the fact that many of our existing staff are available for additional hours via a separate registration agreement, in addition to their existing contracts of employment.

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

1.6 Breakdown of staff at year end by gender

In terms of gender composition, the Trust's substantive workforce as at 31 March 2020 was as follows:

	Male	Female	Total
Directors[#1]	7	4	11
Senior Managers	10	20	30
Employees	319	792	1111

[#1]This figure is Voting Directors (including Non Executive Directors) but not interim Board members

1.7 Sickness Absence

At the end of March 2020, the Trust's average sickness absence figure for the financial year was 4.48% (in comparison to 4.45% in March 2019) showing that sickness absence has remained fairly similar.

The Trusts ambition would be to see this figure reduce further over the coming year given the investment made in staff Health and Wellbeing and more supportive approaches to managing sickness absence in the 2019/20 financial year however the Trust is realistic about the impact of COVID-19 on staff sickness absence and will be taking all necessary measures to support staff wellbeing as we move through Recovery and Restoration.

Stress related illness and musculo-skeletal issues have remained as the top two reasons for both short- and long-term sickness absence. There has been significant investment in Mental Health First Aid training for staff to be able to support colleagues as well as streamlined referral processes for access to mental health support such as counselling. Further work is required to support employees with musculo-skeletal issues however early referral to Occupational Health and early identification of risk factors which may be contributing to this have been implemented.

1.8 Policies and Actions applied during the financial year

1.8.1 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 those with a disability who are shortlisted for interview to enable them to perform their best during the selection process. This policy is supported by the Trusts inclusion Policy which reinforces key expectations around equality of opportunity for all in all aspects of employment.

Additionally, the Trust is proud in achieving 'Disability Confident Committed' status through the Governments Disability Confident Scheme and will be working towards to Disability Confident Employer Level' Status in the 20/21 financial year. This endorses the Trusts recognition that those with long term health conditions have the opportunities to fulfil their potential and realise their aspirations.

1.8.2 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.

In addition, the Trust has a Stress Management Policy which endeavours to support employees to address any stress related issues both within the home and the workplace and provides guidance around how to undertake stress risk assessments in order for appropriate actions to be taken.

1.8.3 Policies applied during the financial year for the training, career development and promotion of disabled employees

The Trust's policies are open to all of our staff, irrespective of protected characteristics including disability.

1.8.4 Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees

The Trust has a variety of robust communication channels in order to provide employees with relevant information in a timely manner. These include regular daily composite e-mails via e-bulletins, a weekly e-mail update from the Chief Executive, a monthly team brief, and staff intranet, in addition to other specific briefing sessions as issues have arisen in year, for instance in relation to the potential transfer of paediatric services.

The Trust also promotes and values staff feedback received through the Annual Staff Survey and in the last financial year has seen a positive increase in the response rate. Staff are informed of the actions taken in response to their feedback via the usual communication channels.

1.8.5 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 and to encourage the involvement of employees in the Trust's performance

The monthly Team Brief has regularly contained detail around the Trust's financial performance which is cascaded throughout the Trust by managers and also available on the intranet and an open invitation to all staff every month.

The Trust Consultative Committee and Joint Negotiating Committees provide the formal structure for staff to have a voice about matters of important to them and both forums are attended by the Executive Team. During the COVID 19 pandemic, the Trust has implemented weekly virtual staff side meetings attended by the relevant unions and professional bodies with Senior Management including the CEO to proactively address any employee concerns and to feedback on the actions being taken by the Trust to support staff during these unprecedented times.

1.9 Occupational Health and Health and Safety Performance

The Health & Safety Executive (HSE) has agreements with regulatory health bodies i.e. the CQC/GMC/NMC, which set out roles and responsibilities and clarifies which regulator is likely to act in the event of a patient suffering serious harm/death.

These health bodies have important roles to play ensuring professional standards are maintained and are likely better placed than the HSE to secure justice, improve standards and prevent a recurrence.

The HSE will **not**, in general, investigate or take action against NHS organisations in the event of:

a. Incidents affecting patients arising due to poor clinical judgements;
b. Incidents affecting patients associated with poor quality care, such as failing to meet hydration and nutritional needs.
c. Incidents involved with standards of care, such as the effectiveness of diagnostic equipment; or the numbers and experience of clinicians;
d. Incidents arising from disease or illness for which the patient was admitted (whether or not that disease was properly diagnosed or treated) - unless the prime cause was inadequate maintenance of, or training in the use of equipment needed to treat the disease or illness.

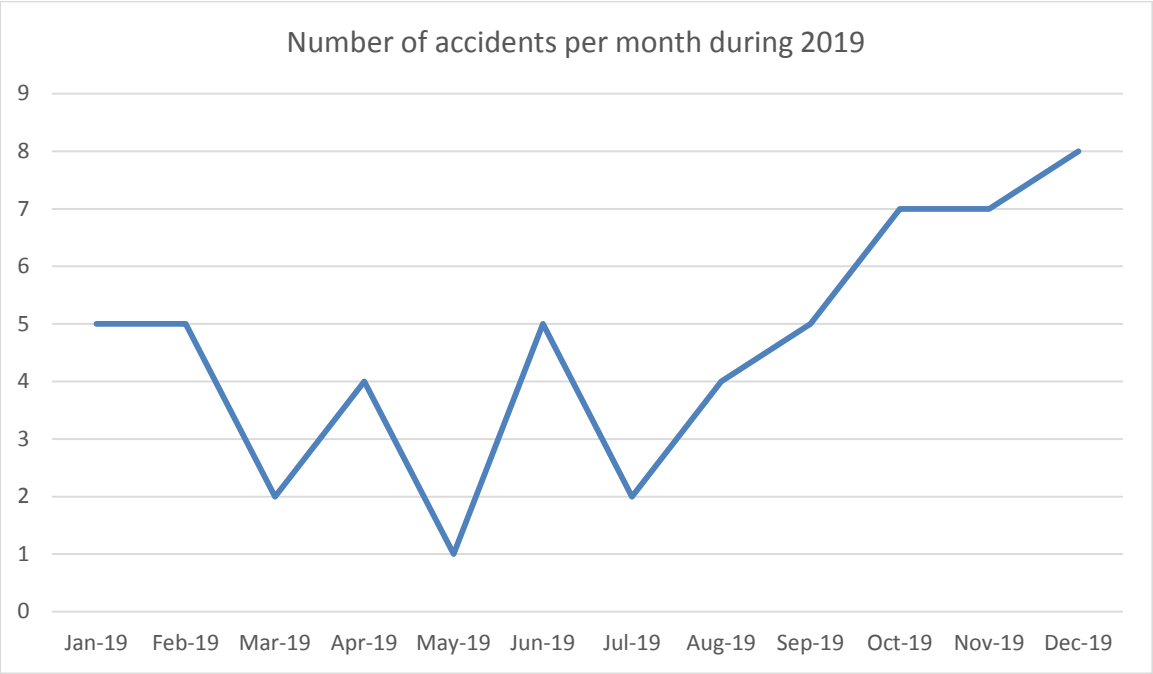
The HSE **will** investigate a systemic failure of management systems, which may include:

a. A systemic failure to implement 'established standards' - i.e. H&S statutory law.
b. The absence of or wholly inadequate arrangements for assessing risks to health and safety.
c. Lack of suitable controls and inadequate monitoring and maintenance of the procedures or equipment needed to control the risks, resulting in serious harm or death.

The HSE **may**, dependant on the circumstances, investigate the following incidents:

a. Inadequate maintenance of, or training in the use of work equipment needed to diagnose or treat disease or illness.
b. RIDDOR reportable incidents (burns and scolds from hot water, patients falling from windows resulting in fractures, unconsciousness and fatalities, serious slip trip and fall injuries, serious injuries or fatalities after gaining access to hazardous substances).
c. Failing to implement Safety Alerts, or similar warnings that are widely known across the sector - i.e. a failure to implement Estates & Facilities Alerts/Medical Device Alerts leading to serious harm or death.
d. Failure to uphold the duty holders own internal guidance, or well-established external guidance from others.
e. In general, 'established standards' will **not**, in general, include those that cover drugs and quality of care issues i.e. hydration and nutrition.

Number of Accidents per Month:



Number of Accidents by Category. 1 Jan 2019 - 31 Dec 2019

Accident Category	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
Manual Handling Injuries	1	0	0	1	0	0	1	1	0	2	1	0
Burns / Scalds	0	0	0	0	0	0	0	0	0	0	0	0
Contact with hazardous substances (COSHH)	0	2	0	0	0	1	0	0	0	1	0	1
Road traffic accident/ incident	0	0	1	0	0	0	0	0	0	0	1	1
Sharps injuries	1	0	1	0	0	2	0	2	2	1	0	2
Slips, trips and falls (staff, visitors & contractors)	2	1	0	1	0	1	1	0	2 inc 1 visitor	2 inc 1 visitor	3	3
Impact Injury (with static or moving object)	1	2	0	2	1	1	0	1	1	1	2	1
Total figure for each month	=5	=5	=2	=4	=1	=5	=2	=4	=5	=7	=7	=8

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Reporting

It is a statutory legal requirement to report specified injuries, diseases, deaths and dangerous occurrences. During 2019 the following RIDDOR report were submitted to the HSE:

- Impact injury resulting in a fracture. Caused by carry case containing medical device falling onto foot.
- Sharps injury in Theatres from a patient infected with Hepatitis B. Reportable as a 'dangerous occurrence'.
- Trip and fall resulting in fractured ankle.
- Severe back pain after a road traffic accident on trust premises during official business. Reportable as an over 7-day ill health sickness absence.

Health and Safety staff training

A total of 47 H&S training courses were delivered during 2019. This included:

- Mandatory training
- COSHH training
- Volunteers training
- Care certificate training
- Stress awareness Training

Central Alerting System (CAS) Alerts

From the period 1 Jan-31 Dec 2019 a total of 74 Alerts were received and subsequently disseminated throughout the Trust for action. All Alerts have been completed with none outstanding.

1.10 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 reactive support.

1.11 Off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2020	0
Of which…	
No. that have existed for less than one year at time of reporting	0
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.

Off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2019	0
Of which…	
No. that have existed for less than one year at time of reporting	0
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 2019 and 31 March 2020, for more than £245 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 2019 and 31 March 2020,	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 regards to the use of off-payroll contractors to reflect the evolution in guidance as it is received from HMRC.

New off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 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 2018 and 31 March 2019,	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 regards to the use of off-payroll contractors to reflect the evolution in guidance as it is received from HMRC.

1.12 Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

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.	15

1.13 Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

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.	14

1.14 Off-payroll engagements: Trust policy

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 these are in place. The Trust monitors engagements which are more than £245 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.

1.15 Exit packages

Exit package cost band (including any special payment element)	2019/20 Number of compulsory redundancies Number	2019/20 Number of other departures agreed Number	2019/20 Total number of exit packages by cost band Number	2018/19 Number of compulsory redundancies Number	2018/19 Number of other departures agreed Number	2018/19 Total number of exit packages by cost band Number
<£10,000	**0**	**0**	**0**	0	0	0
£10,001 - £25,000	**0**	**0**	**0**	0	0	0
£25,001 - 50,000	**0**	**0**	**0**	0	0	0
£50,001 - £100,000	**0**	**0**	**0**	0	0	0
£100,001 - £150,000	**0**	**0**	**0**	0	0	0
£150,001 - £200,000	**0**	**0**	**0**	0	0	0
>£200,001	**0**	**0**	**0**	0	0	0
Total number of exit packages by type	**0**	**0**	**0**	0	0	0
Total resource expense (£000s)	**0**	**0**	**0**	0	0	0

This note relates to the Trust only as the Charity does not have any employees.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme except for three employees who left the Trust via the Mutually Agreed Resignation Scheme. This disclosure reports the number and value of exit packages taken by staff leaving in the year and the expense associated with these departures may have been recognised in part or full in a previous period.

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1.16 Retirements due to ill health

During the year to 31 March 2020 there were no early retirements from the Trust agreed on the grounds of ill-health (31 March 2019, nil).

1.17 Gender pay gap reporting

The Trust's information on gender pay reporting can be accessed on the hospital's internet site at: https://www.roh.nhs.uk/about-us/publications/corporate-documents

National information and guidance about gender pay reporting can also be accessed on the Cabinet Office website at: https://gender-pay-gap.service.gov.uk

2.0 Staff Survey Results

2.1 Commentary

The Trust is required to participate in the National Staff Survey (NSS) each year. All permanent or fixed term contract (FTC) staff are requested to complete a survey either online (via an email link) or paper based between October and November each year. In 2019, the Trust response rate was 51% which was higher than 2018 at 41%. The average response rate across trusts nationally was 48% (46% in 2018) and across Acute Specialist Trusts (ASTs) the median was 58%. The survey is administered on behalf of the Trust by Capita People Solutions.

Overall the results for 2019 have been very positive with particular progress in feedback for Health and Wellbeing, Safety Culture and Appraisals.

Comparing ROH results from 2018, there has been an improvement in 46 questions across the different themes. There has been a negative change in 32 questions and work will be completed during the year to understand how these scores can be improved.

Some of the areas where we have seen most improvement are:

- I know who the senior managers are here
- Senior managers act on staff feedback
- Communication between senior management and staff is effective
- Senior managers here try to involve staff in important decisions
- There are enough staff at this organisation for me to do my job properly
- When errors, near misses or incidents are reported, my organisation takes action to ensure they don't happen again
- Does your organisation take positive action on health and wellbeing
- Have you had any training, learning or development in the last 12 months
- I am confident that my organisation would address my concern
- I would recommend my organisation as a place to work
- The values of my organisation were discussed in my appraisal

The ROH Engagement score has increased to 7.6 from 7.4 against a national score across the NHS of 7.0. Across Acute Specialist Trusts, the average is lower at 7.4%.

Overall Engagement score is significantly driven by 'recommend as place to work'. This has improved since 2018 to 77% from 72%.

2.2 Summary performance - NHS Staff Survey

Details of the key findings from the latest NHS Staff Survey.

The response rate to the 2019 survey among trust staff was 51% (2018: 41%). Scores (out of 10) for each indicator together with that of the survey benchmarking group (Specialist Acute Trusts) are presented below:

	2019/20		2018/19		2017/18	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.2	9.2	9.2	9.3	9.2	9.3
Health and wellbeing	6.3	6.3	6.3	6.3	6.2	6.3
Immediate managers	7.2	7.1	7.3	7.0	6.9	6.9
Morale*	6.4	6.4	6.4	6.3	n/a	n/a
Quality of appraisals	6.2	5.8	5.9	5.7	5.5	5.5
Quality of care	7.8	7.9	7.9	7.8	7.8	7.7
Safe environment – bullying & harassment	8.3	8.3	8.1	8.2	8.1	8.4
Safe environment - violence	9.9	9.8	9.8	9.7	9.7	9.7
Safety culture	7.3	7.0	6.9	6.9	6.6	6.9
Staff engagement	7.5	7.5	7.4	7.4	7.1	7.4
Team working	6.9	6.9	6.9	6.9	6.7	6.8

*Questions in this section are new in the survey, therefore only data for 2018/19 is available.

2.3 Commentary on the Key Findings

The Trust continues to experience a significant period of change. However, the results show a significant improvement in feedback from staff members which may be linked to:

- The Trust has focused on promoting Health and Wellbeing to all staff members
- There has been significant investment in the facilities at the Trust including new

Theatres and Wards

- The Trust had increased its focus on performance management across all teams.
- Senior Leaders have continued to engage with staff using different formats
- The Trust was successful in being shortlisted for an HSJ award
- The Trust has developed a stronger inclusion culture across the Trust with support from the Exec team and Equality and Diversity network

2.4 Key priorities to improve staff feedback

The Trust understands there is a direct link between staff engagement and patient outcomes and will continue to put in place actions that will enable staff members to give feedback and be heard. The Trust will focus on three key areas as a response to staff feedback in the survey. These are **Promoting Health and Wellbeing**, **Improving Performance** and **Tackling Bullying and Harassment, Enhancing further Development opportunities and Managing Stress**. The Trust also intends to take the following action to improve the response to the annual staff survey engagement score (and other surveys):

- Continue to embed a coaching and inclusive style of leadership and management supported by a programme of manager and staff members using different mediums.
- Establish an employer brand and further develop attraction, recruitment and selection processes closing the gap between establishment and filled posts.
- Further improve staff communication with improvements to enhance the staff voice across all departments and disciplines
- Further develop the staff wellbeing agenda using the 5 ways to wellbeing
- Develop and implement local staff engagement plans informed by local staff survey analysis.
- Further embed staff survey results in local business planning activities

2.5 Plans and mechanisms to monitor performance

Trust Board will receive assurance and monitoring of performance through the Staff Experience and OD Committee which is kept informed by reports from the internal People Committee.

The Trust will also ensure that:

- All departments focus on actions to support an improvement in staff engagement.
- All staff have the appropriate time and access to complete the staff survey to ensure everyone has the opportunity to have their say.
- All departments have clear action plans to address some of the issues noted in the survey results. These actions will be reviewed regularly for progress with bi-annual updates to the Trust Board.

2.6 Schwartz Rounds

Schwartz Rounds have been running at the ROH since September 2017 as a means of supporting staff and engaging with them on the social and emotional impact of working in healthcare. They have been extremely well received, with over 350 attendees to date and 91% rating Schwartz Rounds as either 'Excellent' or 'Exceptional'.

Background

In 1994 a health attorney in the U.S. called Ken Schwartz was diagnosed with terminal lung cancer. During his treatment, he found that what mattered to him most as a patient were the simple acts of kindness from his caregivers, which he said made "the unbearable bearable." Before his death, he left a legacy for the establishment of the Schwartz Center in Boston, to help to foster compassion in healthcare.

Rounds are implemented by The Point of Care Foundation and are CPD certified. We were very proud to have introduced Schwartz Rounds here at The Royal Orthopaedic Hospital NHS Foundation Trust. The topics so far have included:

- The patient I will never forget
- The day I made a difference
- Responding to a crisis: rallying together
- Going above and beyond
- When communication breaks down
- Dealing with angry families
- Fear of getting it wrong
- Pushing beyond the stereotypes
- Communicating with teenagers and young adults
- Openness with Mental Health

- How our Values make a difference
- Safeguarding
- Supporting each other through the Transgender Lens
- Trading Places – The impact of being a patient

Detailed below is a sample of feedback from staff relating to the Rounds:

- Amazing how far the Trust has come with mental health! Amazing, refreshing, positive
- Great to have such openness and respect in the room
- This is my first Schwartz round and I will definitely attend future rounds. The open and honest (and confidential) space was refreshing
- Great to see our values displayed and lived by our amazing leaders. Thank you
- As a new member of staff, I found this first meeting very inspiring and it made me feel like the ROH is one team, working together. I will definitely be attending these in future.
- I think today was amazing, both were brave and really open and honest. It is lovely to know I work with such kind people around the Trust.
- Very inspirational, open and honest

Attendees consistently rate that the 'Rounds would help them to work better with their colleagues' and 'the group discussion was helpful to them'.

All staff who have participated in multiple Schwartz Rounds sessions have reported increased insight into the social and emotional aspects of patient care, improved teamwork, interdisciplinary communication, appreciation for the roles and contributions of colleagues from different disciplines, decreased feelings of stress and isolation and more openness to giving and receiving support.

There is a group of two trained facilitators who support each panellist in preparation for the Schwartz Round. They also provide facilitation on the day of the Schwartz Round. In addition, a Steering Group is made up of colleagues from across the Trust with the Deputy Director of Nursing as the Clinical Lead. The Steering Group are responsible for deciding on the direction and planning of future Rounds.

2.6 Expenditure on consultancy

Consultant spend for the year was £114,000 (2018/19, £166k) which included spend on governance in respect of mandated external well led assessment, fire protection and site maintenance.

Section 4:

1.0 The work of the Council of Governors 2019/20

Structure and Members

As a Foundation Trust, the Royal Orthopaedic Hospital has a Council of Governors which helps ensure its key stakeholders - patients, members of the public, staff and partner organisations - all have a say in shaping our local health services. Our Governors act as a direct link between the Trust, local communities and staff and engage with our members to gather feedback and views to ensure their voice is heard.

The Governors play an important role in making the Royal Orthopaedic Hospital publicly accountable for the services it provides and bring valuable perspectives and contributions to our activities. In addition, they help set the strategic direction of the Trust.

Key aspects of the Governors' role include:

- Appointing (or removing) the Trust's Chairman and Non-Executive Directors
- Approving the appointment of the Trust's Chief Executive
- Appointing the Trust's external auditors
- Agreeing salaries of Non-Executive Directors and the Chairman
- Receiving the annual report and accounts
- Advising the Board and representing members' views about the strategic direction
- Helping the Trust to recruit members
- Contributing thoughts, views and opinions at Council of Governors meetings
- Holding the Non-Executive Directors to account for the performance of the Trust Board.

At the Royal Orthopaedic Hospital, The Council of Governors comprises eighteen members, nine of which are elected to represent public constituencies, four members are elected as staff representatives, and five members are appointed from key local stakeholders and partners.

Governors are elected or appointed by constituency members to represent their interests. In accordance with the Constitution, all the Trust's Public and Staff Governors are elected through a formal election process and appointed Governors are nominated by their respective organisations.

Brian Toner is the Royal Orthopaedic Hospital's Lead Governor (but during the year neither had no cause to exercise the role in regard to dialogue with NHS Improvement regarding the performance of the Non-Executive Directors).

1.1 Doing its job – as a whole Council

During the year, the Council of Governors continued to work with the Board to provide input to some of the Trust's key strategic decisions, including the movement of paediatric services and the plans for growth involving the new modular theatre set up. As the next piece of work to refresh the Trust's overall strategy progresses over 2020/21 the Board will consult the governors for their views and feedback on the plans.

1.2 Governor Representation on Trust Committees/Groups/walkabouts

The Council nominates members to attend Trust advisory groups and committees as observers. They are then able to report back directly to the Council on work being carried out by the Trust.

During the year, members of the Council attended as observers at the following groups:

- Quality and Safety Committee
- Charitable Funds Committee
- Patient and Carers' Forum
- Estates Strategy & Delivery Group

The governors are also invited to join the quality assurance walkabouts which are scheduled monthly.

In this way the Council actively engages in the work of the Trust, assesses the work of the Board and observes the work of the Chairman in a context other than as Chairman of the Council of Governors. The governors are also formally invited to join the public Board meetings twice yearly and the Lead Governor has a standing invite to each session of the Board.

1.3 Council of Governors Nominations and Remuneration Committee

The Nominations and Remuneration Committee comprises four governors and is chaired by the Trust Chairman. The Committee decides the remuneration, allowances and other terms and conditions for the Chair and Non-Executive Directors. The Director of Corporate Affairs & Company Secretary provides support to the Committee.

The Nominations and Remuneration Committee of the Council of Governors did not have cause to meet during the year. Agreement to a one-year extension to the terms of office for Tim Pile and Simone Jordan were agreed by the whole Council of Governors as part of routine meetings. The whole Council was also asked at their meeting in January 2020 to approve a proposed additional term of office for the Richard Phillips and David Gourevitch, which was agreed.

1.4 Contacting the Governors

The Governors can be contacted through the Director of Corporate Affairs & Company Secretary, the Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

2.0 Governor Constituencies

Members of the public who are members of the Trust are automatically placed into a constituency based on their postcode. Members are able to put themselves forward to become a Governor or vote for a Governor in their registered constituency.

Staff membership is open to those with a permanent or twelve-month fixed term employment contract with the Trust. Staff members are able stand as a Governor or vote for a Governor in their registered class. At the Royal Orthopaedic Hospital there are two classes of staff governor: clinical and non-clinical.

2.1 Public Members

At the Royal Orthopaedic Hospital, public members of the Trust are drawn from two identified constituencies across England and Wales.

During 2019/20 the Trust had two public constituencies within its public membership:

- Birmingham and Solihull (five seats)
- Rest of England & Wales (four seats)

Eligibility for membership is restricted to those living within the relevant boundary and over sixteen years of age. All election boundaries for public members (including patients) are coterminous with local authority boundaries.

2.2 Staff Members

The Trust has two constituencies within its staff membership:

- Clinical (two seats)
- Non-clinical (two seats)

2.3 Appointed Governors

The Trust's Appointed Governors, represent local stakeholder organisations. They provide key insight into the health needs of the communities the Trust serves and put forward the views of their organisations at Council of Governors' meetings. The following organisations make nominations to the Council of Governors:

- Birmingham City Council

- Bournville Village Trust
- Member of Parliament from the parliamentary constituency in which the ROH is located
- Birmingham City University
- University of Birmingham

During 2019/20 there were no new nominations to accommodate.

At the January 2020 meeting, a proposal was presented to the Council to make a number of changes to Trust's Constitution. The majority were minor in nature, however a more substantial changes related to the plan to replace the appointed governor membership with a member of the local community, rather than the local Member of Parliament. This proposal was supported by the Council of Governors and agreed by the Trust Board and ensured that the membership was in line with practice in other organisations.

2.4 Governor Elections 2019/2020

During the year, the Trust conducted Governor Elections to fill seats that had become vacant and used an external company, Electoral Reform Services, to oversee the election process with both sets of elections being conducted using the single transferable electoral system.

At the start of the process an invitation letter, from the Chairman, was sent to all relevant members (where a Governor seat was open for election) to inform them that the election process was starting. The invitation letter included the contact details of the external company facilitating the election process. Ballot papers were then sent to members who in turn voted for the candidate(s) that they wished to be elected to our Council of Governors.

2.4.1 Result: Birmingham and Solihull

A Governor election was called during the Summer of 2019 to fill **one** vacancy in the Public Constituency for Birmingham & Solihull:

Electorate	3,132
Total number of votes cast (by post: 410 and online: 22)	432
Turnout	13.8%
Invalid votes cast	5
Total valid votes	427

The election was run by an external provider, Electoral Reform Services and the successful candidate was Lindsey Hughes. Lindsey was re-elected for a second term of office of three years which will finish on 28 May 2022.

2.4.2 Result: Rest of England and Wales

Concurrently with the above election, an election took place in the Summer of 2019 to fill **two** seats for the Rest of England and Wales.

This election was also overseen by Electoral Reform Services. The deadline for nominations for the above election was 5:00 pm on 11 April 2019. Further to this deadline, the constituency for the Rest of England and Wales was uncontested. Brian Toner was elected unopposed and one vacancy remains in this area.

2.4.3 Staff Elections and Results

During 2019/20 there were no vacancies for either clinical staff or non-clinical staff governors and therefore no elections took place.

2.4.4 Elections during 2020/2021

A planned election will be undertaken during the autumn of 2020 when the term of office for Governors in the following constituencies will be complete:

Birmingham and Solihull	2 seats
Rest of England and Wales	1 seat
Non-Clinical Staff Governor	1 seat

In addition, the terms of office for two of the stakeholder governors will end and therefore there are plans to ask the respective organisations to confirm that they are content for the two current representatives to serve a further three-year term or to nominate another individual.

2.4.5 Process for removal of a governor

The Trust's constitution makes provision for the removal and disqualification of members of the Council of Governors. Governors shall cease to be a member of the Council if:

- They resign in writing to the Company Secretary;
- They fail to attend at least half of the meetings of the Council of Governors in any financial year, unless the majority of the Council of Governors consider the reasons for the absence to be reasonable;
- They, during their tenure, fail to meet the criteria for being a member of the Council of Governors set out in Annex 6 of the Constitution – 'Additional provisions – Council of Governors'; or
- They fail to undertake training without good reason.

A member of the Council of Governors may be removed from the Council by a resolution approved by not less than two-thirds of the remaining members present and voting at a general meeting of the Council of Governors that they have committed a serious breach of the Trust principles set out in the Constitution; acted in a manner detrimental to the interests of the

Trust; and the Council considers that it is not in the best interests of the Trust for them to continue as a member of the Council of Governors.

2.5 Governor Profiles

Profiles for each governor, together with their term of office, who served on the Council of Governors during the period 1 April 2019 to 31 March 2020 are provided below:

Public Governors

- **Brian Toner, Lead Governor** - Brian belongs to the Rest of England and Wales constituency. He considers the Trust's paramount goal is to deliver high quality health care, whilst responding to today's economic demand. Having twice been a patient at the Hospital, he had been hugely impressed by the professionalism of the staff and care he received and was happy to become a member and later a Governor, and give something back. Brian believes that quality services are delivered by committed staff, supported by a strong governance foundation, including feedback from service users. Equally, strategic direction needs to be developed through genuine stakeholder engagement and his experience as a patient, his health service background**,** work with charities and his involvement with the Care Quality Commission will enable him to make a positive contribution as a Governor to the Trust's success and ongoing development. Brian continues his role as Lead Governor until 4 October 2020. Prior to his role as lead governor, Brian's first term of office was due to end on 12 May 2019 and following election to the Council of Governors, at the close of nominations on 5 April 2019, Brian was elected unopposed.

Birmingham and Solihull (five seats):

- **Lindsey Hughes** - Having spent over 38 years in the NHS, including several as a Head of Nursing and Clinical Governance Lead, Lindsey became a volunteer at the Royal Orthopaedic Hospital. Lindsey is passionate about the best care for patients and wishes to ensure high standards of care are maintained. Lindsey has participated in two PLACE assessments and enjoys obtaining feedback from patients on their care. Lindsey is an experienced risk assessor and problem solver; constructive and tenacious. Lindsey's first term of office ended in May 2019 and she was elected to serve a second term of office which will end on 28 May 2022.

- **Marion Betteridge** - Marion was re-elected in 2018. Marion has lived in Northfield for the last fifty years and has been a volunteer at the Royal Orthopaedic Hospital for a number of years doing a range of jobs to 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 second term of office ended on 31 July 2018 and she was elected to serve a third and final term ending on 31 July 2021.

- **Sue Arnott** - Sue has been a patient at the Hospital for 30 years and has received many joint replacements and much physiotherapy at the Hospital. 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 represents the Council of Governors on the Trust's Quality and Safety Committee as an observer. Sue was re-elected for a second term of office which will end on 9 December 2020.

- **Petro Nicolaides** - Petro has been a patient with ongoing treatment since January 2010. He is extremely grateful to the hospital for all it has done and continues to do for him. Petro 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 is currently serving his second term office which is due to end on 31 July 2021.

- **Kennedy Iroanusi** - Kennedy was elected as Governor in December 2017 for a first term of office of three years. Kennedy is currently an Electrical and Electronics Engineering Lecturer at Dudley College. He formerly worked at the Trust as a Theatre Assistant, whilst studying at the University of Birmingham. As a former employee, and his personal experience of a family member using the NHS service regularly, he would like to give something back to the community for the greater good of others in need of health and social wellbeing. Kennedy's first term of office is due to come to an end on 9 December 2020.

Rest of England and Wales (four seats including Lead Governor as above)

- **Robert Talboys** - Rob became a patient of the Hospital 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. In May 2016, Rob was successfully elected to a third term of office which ended on 12 May 2019.

- **Carol Cullimore** – Carol was elected as a Governor in July 2015 and her first term of office ended on 31 July 2018; she was successfully elected to serve a second three year term, which will end on 31 July 2021. Carol retired from nursing after 45 years and has also been a patient of the Hospital for over 20 years. She brings her expertise as both a nurse and as a patient to the role of Governor and

recognises the challenges faced by the Trust and to give something back to help make a difference.

- **Arthur Hughes** - Arthur was elected as Governor in July 2018 for a first term of office of three years. Arthur's national and international business life has given him experience of listening to both sides of discussions in helping/guiding with solutions. Arthur has lived/worked in Africa, Europe, North America and China working alongside management boards of companies, government departments/ organisations and professional bodies (including the World Health Organisation). Arthur is a former patient of the hospital and also a member of Patient and Carers Forum. He wishes to work with the Trust in his Governor role to help the hospital continue its successful progress. Arthur's first term office will come to an end on 31 July 2021.

Stakeholder Governors

- **Bournville Village Trust** - David Robinson is the Director of Financial Resources at Bournville Village Trust who own the freehold of Hospital as the Cadbury family donated the building and land to the people of Birmingham for health purposes. David joined BVT in May 2017 and covers all aspects of Finance and IT for them and its associated managed societies. David's professional membership includes Fellow of the Royal Society of Arts (FRSA) and through his fellowship he contributes to several groups and forums on public policy and supports the Society in their aims to contribute to building a better society. He is also a member of the Charity Finance Group and Charity Group as well as a Member of the Voluntary Organisations Disabilities Group – Finance Director Group. David's first term of office will come to an end on 30 April 2021.

- **Member of Parliament -** Richard Burden 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 many years. 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. In January 2020 Richard's role as MP for Birmingham Northfield came to an end. As discussed earlier in this section, the agreed change to the constitution saw the membership of the Council of Governors replace the local Member of Parliament with a member of the local community.

- **Birmingham City Council** - Liz Clements is a Councillor on Birmingham City Council and was elected on 3 May 2018 to represent the Bournville and Cotteridge Ward. On the Council she is Chair of the Sustainability and Transport

Overview & Scrutiny Committee. Her Committee Membership from 2018 to 2019 consisted of Co-ordinating the Overview & Scrutiny Committee, Sustainability and Transport Overview & Scrutiny Committee and WMCA Overview & Scrutiny Committee. Liz's first term of office as Governor with the Trust will come to an end on 31 July 2021.

- **University of Birmingham** - Dr Dagmar Scheel-Toellner represents the University of Birmingham on the Council of Governors. Dagmar is currently leading a research team at the University of Birmingham that investigates the basic mechanism of joint inflammation in patients with rheumatoid arthritis. Dagmar initially trained as a pharmacist, and the translation of her research on autoimmunity into therapeutic strategies is still an important long-term aim in her work. She closely collaborates with her clinical colleagues within the Rheumatology Research Group in their investigation of the early stages of the development of rheumatoid arthritis. Dagmar's first term of office will come to an end on 31 July 2020.

- **Birmingham City University** - Hannah Abbott represents Birmingham City University (BCU) on the Council of Governors. Hannah's current role at BCU is an Associate Professor and Acting Head of School for the School of Health Sciences. Hannah is passionate about the development of the future healthcare workforce and being part of ROH allows her to better understand the issues affecting the hospital. Hannah's professional background is in theatres as an Operating Department Practitioner, and therefore has a keen interest in surgery and particularly patient safety. Hannah's first term of office will end on 31 August 2020.

Clinical Staff Representatives (two seats)

- **Adrian Gardner** – Adrian was elected as Clinical Staff Governor on 17 August 2018. Adrian has been involved with the Trust, firstly as a trainee and then became a consultant since 2002. He acknowledges in the future the ROH faces even more change with the loss of paediatrics and the inevitable reorganisation of some services with UHB at the Queen Elizabeth Hospital.

  Adrian feels that colleagues should all be able to say "I would bring my mother to the ROH for her surgery" knowing it would be the best. He did exactly that several years ago and stands by that decision. He is of the opinion that this is the level where we as a hospital should be and can be. Adrian's first term of office will end on 18 August 2021.

- **Karen Hughes** - Karen has been a registered nurse since 1989 and has a background in surgical nursing. Karen has worked at the Hospital as clinical nurse tutor since 2010 and during the year was appointed as one of the two Heads of Nursing in the Trust. She is undertaking a Master's Degree in Advanced Healthcare Practice. Karen is passionate about high quality standards of care and the good stewardship of valuable NHS resources. Karen was re-elected to serve a third term which will end on 9 September 2021.

Non-Clinical Staff Representative (two seats)

- **David Richardson** - David has worked at the hospital for 8 years, and currently works as the Head of Education and Training. His interest in being a governor is twofold: firstly, he is passionate about the Trust, and wants it to be successful and he feels that his experience in both the public sector and private sector would enable him to be of value during this significant period of change. His role touches on all departments and staff within the Trust, and spreads externally through schools, colleges, higher education institutes and other NHS organisations. This breadth of contact enables David to understand the views and experiences of a much wider audience. David's first term of office will end on 14 September 2020.

- **Gavin Newman** – Gavin joined the hospital in 2014 and was appointed as Staff Governor on 8 September 2018. Gavin currently works as a Project Manager in the Strategy team and previously in the IT Department as Service Desk Manager. Gavin has strived to make a difference in any way he can, be it service related or via support for and to his colleagues.

  As a governor, Gavin wishes to continue to embrace the changes required to provide the best possible outcome for the ROH and its patients and continue to build on the CQC "good" evaluation.

  Gavin is very proud to be a Governor of an organisation that strives to provide excellent care for every patient it serves and having been born and bred within a mile of the ROH he appreciates value to the community. Gavin's first term of office will come to an end on 9 September 2021.

2.6 Attendance by Governors at Council of Governor Meetings 2019/20

During the period 1 April 2019 to 31 March 2020 the Council of Governors formally met on four occasions. There was a special meeting held on 4 April 2019 to discuss a recommendation that the Council of Governors received from the Nomination and Remuneration Committee of the Trust Board that Jo Williams be appointed as the substantive Chief Executive.

A record of the number of attendances by each Governor at these formal meetings is included in the table below:

GOVERNOR/CHAIRMAN	MEETING DATE				TOTAL
	04/04/19	22/05/19	10/10/19	15/01/20	
Yve Buckland (Ch)	✓	✓	✓	✓	**4/4**
Brian Toner	✓	✓	✓	✓	**4/4**
Rob Talboys					**0/0**
Arthur Hughes	✓	✓	✓	✓	**4/4**
Sue Arnott	A	A	✓	✓	**2/4**
Carol Cullimore	A	✓	✓	✓	**3/4**
Petro Nicolaides	A	✓	✓	✓	**3/4**
Marion Betteridge	✓	✓	✓	✓	**4/4**
Lindsey Hughes	A	✓	✓	✓	**3/4**
Kennedy Iroanusi	A	✓	-	-	**1/4**
Richard Burden	A	A	✓		**0/1**
Liz Clements		A	A	✓	**1/3**
David Robinson	✓	A	✓	A	**2/4**
Dagmar Scheel-Toellner	✓	✓	A	✓	**3/4**
Hannah Abbott	A	✓	A	✓	**2/4**
Adrian Gardner		A	✓	A	**1/3**
Karen Hughes	✓	✓	A	✓	**3/4**
David Richardson	✓	✓	✓	A	**3/4**
Gavin Newman		✓	✓	✓	**3/3**

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		

A record of attendance by Board members at Council of Governor Meetings during 2019/20 is provided in the table below:

BOARD MEMBERS		MEETING DATE		
	04/04/19	22/05/19	10/10/19	15/01/20
Tim Pile				✓
Kathryn Sallah		✓	✓	
Rod Anthony		✓	✓	✓
David Gourevitch				✓
Simone Jordan			✓	✓
Ayodele Ajose				✓
Jo Williams		✓	✓	✓
Paul Athey				
Phil Begg				✓

The Annual General Meeting was held on 10 October 2019, at which over 50 members (including governors) attended.

2.7 Council of Governor Meetings

There were four Council of Governor meetings held during the year. Topics covered at meetings included:

- A review of the draft version of the Annual Report (including Quality Account) and Accounts 2018/19.
- Developing the Trust's Strategy
- CQC Inspection update
- External well led assessment plans
- Chair and Chief Executive's updates
- Paediatrics services update
- Updates and information on the work of the STP and Birmingham Hospitals Alliance, including STP key messages
- Modular theatres update and plans for car parking
- Proposed amendments to the Constitution
- Staff survey results
- Chair and Non Executive appraisals
- Annual complaints report
- Fit & Proper Persons Test update

- Patient and Carers' Forum update from Stella Noon, Chair of the forum.
- Update on the plans for membership engagement and development

Executive Directors of the Trust attended meetings to provide updates as follows:

- The Chief Executive attended each Council of Governors meeting during the year to provide updates on key areas, including paediatric transition and Birmingham Hospitals Alliance.

- The Executive Director of Strategy & Delivery attended the January 2020 meeting to provide an update on the Modular theatres and plans for car parking.

- The Interim Director of Finance joined the May meeting to present an overview of the annual accounts

As the overriding role of the Council of Governors is to hold the Chairman and Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors, Non-Executive Directors of the Trust regularly attended meetings and provided updates to the Council of Governors on the following areas during the year:

- Kathryn Sallah attended the May 2019 meeting to present the outcome of the staff survey results. She reported good improvement in the staff survey results and the governors were reminded that a few years ago, the Trust had been criticised for the low senior management visibility, a position which had been reversed. There was an evident step change since this time and there was also move in terms of positing relative to other organisations, placing the Trust in a much better position relative to other organisations. It was recognised that there remains more work to do but overall the results were very encouraging.

- At the May 2019 meeting, Rod Anthony gave an overview of the work of the Audit Committee which had met regularly and had tested the robustness of control environment in the Trust through the internal audit programme. He reported there were to be some areas of partial assurance but these were being addressed. The external auditors were pleased at the engagement with the finance team but had highlighted the need to improve handling of stock. The process for handling NICE guidelines was an area of improvement noted.

  The key annual audit documents had been reviewed and the quality of the first draft of the documents was seen to be of high. Those responsible were thanked. The Audit Committee meeting scheduled for the end of the week would be expected to

recommend to the Board the adoption and approval of the annual accounts and report.

It was noted that the Chairman had received good feedback on the quality of the chairmanship of the Audit Committee.

- Kathryn Sallah at the October 2019 presented the latest version of the annual complaints report and reported that there had been a 7% decrease in the number of complaints from the previous year. There were two complaints with the Parliamentary and Health Service Ombudsman (PHSO) awaiting a response. It was recognised that concerns were being handled robustly before they moved into being a formal complaint. In terms of learning, it was suggested that there should be an audit to identify if any changes had resulted in change.

  The satisfaction with the complaints service was noted to be high and a questionnaire with Healthwatch was being developed to garner additional feedback on the complaints process. The governors challenged that they did not see an overview of complaints on a regular basis, nor did they see any benchmarking information to be able to form a judgement as to how the Trust was performing compared to other organisations. It was therefore agreed that a routine summary would be presented to the Council in future.

- At the October meeting, the governors highlighted that they had not access to David Gourevitch, Non Executive and therefore they had not been able to hold him to account for his work, as they were required to do. The Director of Corporate Affairs was asked to ensure that David joined the next meeting, which he did and provided an update on his work as a Board member and as a member of the Quality & Safety Committee.

- The governors challenged at the October meeting that they felt that the Trust's Fit and Proper Persons Test should be widened to cover the Council of Governors. It was agreed that the self-certification process would be extended to cover the governors when it was next undertaken in May 2020.

- Ayodele Ajose as a new Associate Non Executive Director was asked to describe her experience so far as a member of the ROH Board. She reported that her experience had been positive to date and she provided an overview of her skills as a barrister and with commercial law.

The governors at the January 2020 meeting expressed a view that it was critical that the paediatric oncology service should remain in the Midlands as a matter of principle.

2.8 Governor Training and Induction

The Trust continually reviews delivery of Governor training and continues to develop in-house Trust-specific training.

At the May 2019 meeting of the Council, the governors were given an overview of the process to develop the Trust's new strategy and sought any comments that they may have to build into the final document.

Acknowledging that there is more that can be done to train our governors, work will be undertaken in 2020/21 to develop additional training sessions, including creating a forum for sharing best practice between our peer organisations.

As there were no new governors during the year there had not been a need to conduct an induction process. The current induction process includes a welcome meeting with the Chair, Chief Executive and Director of Corporate Affairs & Company Secretary, a site tour and an induction booklet setting out the statutory duties of a member of the Council of Governors. The Director of Corporate Affairs & Company Secretary acts as the primary first point of contact for the governors and their training needs.

During February 2020, Brian Toner (Lead Governor) and Gavin Newman (Staff Governor) attended a Governor Regional Workshop which was held in Birmingham and facilitated by NHS Providers.

2.9 Effectiveness of the Council of Governors

During the year has not been a formal effectiveness review of the Council of Governors organised, the last review being presented at the October 2018 meeting. Questionnaires were issued to all governors seeking views on the effectiveness of the body across a range of areas. Overall, the review presented a positive view of the arrangements, particularly around:

- Skill mix of the governors
- Quality and discussion and debate
- The Council being able to identify performance issues

There were a number of areas where there was an opportunity to strengthen the processes and understanding however, particularly in relation to the induction of new governors. Some of the feedback identified some training needs and this will continue to be picked up in the workplan for the governors over the coming year.

At the end of each meeting, there is an opportunity to discuss the effectiveness of the Council of Governor meeting and a pre-meet of the governors that started in 2019 has continued

throughout the year which allows the governors to talk about matters that may not lend themselves to discussion in the formal confined of a meeting.

2.10 The Council of Governors' Register of Interests

The Register 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 they are entitled to claim expenses at an agreed rate.

3.0 Engaging Our Membership

In October 2019 it was agreed that all member communication will not be electronic due to the costs associated with member news materials. This has drove an increase of members to submit their email address in order to actively hear from us.

Through active promotion of changing over to online communication only we also gained over 50 email addresses.

Monthly member mailouts are now sent out via email to those individuals who have given their email address. These include:

- General trust information
- Governor drop in session dates and election dates
- NHS discounts promotion
- Charity Promotion
- Any positive news stories.

Member Events

Annual General Meeting (AGM)

Due to the success of the previous year, we decided to arrange a market place along with refreshments, displaying all the work done over the last year. The displays included the improvement projects completed by the hospital, fundraising and charity events throughout the year as well, as information around our governor drop-in sessions.

We had over 50 individuals attend which included a good turnout from public members.

In a bid to make the AGM more inclusive, we asked for the help of one of our members on how best to make our events more easily accessible by those not able to attend. From this conversation we opted to use Facebook live, whereby individuals could log on and listen to the AGM at any time or place. From this being uploaded to Facebook, we received 600 unique views and reached 1232 individuals.

Member Recruitment

Although the strategy in place for this year focussed on specifically on engagement rather than recruitment, there have been some small steps taken in order to actively recruit new members. In order to support the Hospital, the Trust needs to continue to recruit a broad range of members from a variety of backgrounds, including hard-to-reach areas.

Below are some of the actions taken over the last year:

- A social media campaign is undertaken once a quarter to advertise the benefits in this way; and
- A membership presence is at all the Harrison Lectures, as well as junior doctors induction and Simulated patients day.
- A membership session at the yearly work experience sessions, and encourage all individuals to sign up or consider signing up.
- All staff leavers were sent information regarding foundation trust membership and how to apply.
- All charity donors were sent information regarding foundation trust membership and how to apply.

3.1 Membership Strategy

The membership engagement strategy and action plan owned by the membership officer and Council of Governors focusses on retention, recruitment and engagement. It aims to give our public, patients and families the opportunity to share their voice in a proactive way. Quarterly updates with the Membership officer and the Trust's Associate Director of Governance & Company Secretary are held to ensure all actions are met appropriately.

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

3.2 Membership size and movements

The trust has two membership constituencies as follows:

- Public constituency
- Staff constituency

Public members are drawn from those individuals who are aged 16 or over and:

- Who live in one of the trust's public constituencies or
- Who live in the Rest of England constituency

	2019-20	Next year (estimated)
Public constituency		
At year start (April 1)	4,966	4793
New members	30	300
Members leaving	203	100
At year end (March 31)	4,793	4,993
Staff constituency		
At year start (April 1)	1,061	1,150
New members	232	256
Members leaving	86	95
At year end (31 March)	1,152	

* Leavers on flat turnover rate of 10.29%

** New starters increase of 10.14%

3.3 Analysis of current membership

The analysis of information we hold is below. Further work is planned over coming months to target key areas of the public, including hard to reach communities to improve the diversity of our membership.

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	1	324,525
17-21	56	102,709
22+	4,515	943,782
Socio-economic groupings*:		
AB	1,188	107,482
C1	1,356	160,373
C2	1,031	97,019
DE	1,162	163,997
Gender analysis		
Male	1,838	677,513
Female	2,875	693,502

3.4 Volunteers

Some members of the Trust are also volunteers and they play an important role at the Royal Orthopaedic Hospital.

Our volunteers are part of a dedicated team of over 120 people who support our staff and enhance patient experience through a variety of roles.

Our volunteers demonstrate and promote the Trust's values. Visitors and our surveys regularly mention how much patients value having volunteers around the hospital.

Their commitment of time, skills and experience is greatly valued and appreciated by all.

There are a variety of roles that the volunteers carry out from ward visiting, gardening and administration to welcoming visitors to our Outpatient Department. Currently we are specifically looking for administration, gardeners, simulated patient and Day Case Unit Volunteers.

Section 5:

1.0 Code of Governance and Foundation Trust 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, last updated 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, with which the Trust is compliant 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 as to 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 (1.8): 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 (1.1): 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 (2.5): Council of Governors Report)
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 (2.6): 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 (1.0): 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 (1.0): Directors Report
n/a	The annual report should include a brief description of the length of appointments of the Non-Executive Directors, and how they may be terminated.	Detail included in the Accountability Report (Section 1 (3.1): 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 (1.11): 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 Non-Executive Director.	Not applicable
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.	Accountability Report (Section 1 (1.5): 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.	Accountability Report (Section 4 (1.2): Council of Governors Report)
n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151(8) of the Health & 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 2019/2020
B.6.1	The Board of Directors should state in the annual report how performance evaluation of the Board, its Committees and its Directors, including the Chairperson, has been conducted.	Accountability Report (Section 1 (1.10): 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.	Accountability Report (Section 1 (1.15): Directors Report)

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.	Accountability Report (Section 4 (2.9): Council of Governors Report)
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).	Accountability Report (Section 1 (1.3): Directors Report and Section 8: 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.	Accountability Report (Section 8: 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.	Accountability Report (Section 1 (1.11): Directors Report and Section 8: Annual Governance Statement)
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	Accountability Report (Section 1 (1.11): Directors Report)

	If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	
D.1.3	Where an NHS foundation trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
E.1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability Report (Section 1 (1.9): Directors Report and Section 4 (2.7): 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.	Accountability Report (Section 4 (3.0): 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.	Accountability Report (Section 4 (1.4): Council of Governors Report)
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.	Accountability Report (Section 4 (2.0): 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	Alternative disclosure Accountability Report (Section 1 (1.1): Directors Report)

	members of the public can gain access to the registers instead of listing all the interests in the annual report.	

2.0 Comply or explain requirements

The Trust believes 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
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 Council of Governors included nine public governors, across two constituencies: Birmingham & Solihull and the rest of England, whose responsibility it is to represent the views of the population and local community served by the Trust. The Patient & Carer's Council and the Patient Experience & Engagement Group (PEEG) includes representatives from the Council of Governors and the Chair of the Patient and Carers Forum joins the Council of Governors on a regular basis to report on the work of the group. Further work is planned to strengthen the representation of the Council of Governors on trustwide corporate committees or groups.

Jo Williams
Chief Executive

19 June 2020

Section 6:

Regulatory Ratings Report

1.0 NHS Single Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

2.0 Segmentation

The breach of licence identified in the 2018/19 Annual Report was removed in 2019 and confirmation was received that the Trust was moved from Segment 3 to Segment 2 as a result of this. The segmentation information is the Trust's position as at June 2020. Current segmentation information from NHS trusts and foundation trusts is published on the NHS Improvement website.

3.0 Use of Resources

The Use of Resources Rating measures the Trust against five key financial indicators which include both short-term financial performance and longer-term financial resilience. A score of 1 is the highest score than can be received, whilst a score of 4 is the lowest.

NHSI Use of Resources Rating (UOR)			
	Plan	**Actual**	**2018/19**
Capital Service Cover	2	4	4
Liquidity	3	4	4
I&E Margin	2	4	4
I&E Margin – Variance against plan		4	1
Agency metric	2	3	4
Overall UOR		4	3

Given the Trust is still managing a deficit position and is in receipt of a revenue support loan, it receives the lowest rating across the first three metrics which relate to the cash / surplus generated by operational activities. Moreover, as the Trust did not meet it's planned deficit for the year, it also recorded a 4 for this metric. However, whilst the Agency Cap was not met, agency expenditure reduced significantly in year compared to 2018/19, hence a score of 3 is an improvement on this metric from 2018/19.

In overall terms, the Trust's Use of Resources Rating is 4.

Jo Williams
Chief Executive

19 June 2020

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.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which 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 those Directions. 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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, 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;
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a Going Concern basis and disclose any material uncertainties over Going Concern.

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.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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.

Jo Williams
Chief Executive
19 June 2020

Section 8:

Annual Governance Statement

1.0 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.

2.0 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 2020 and up to the date of approval of the annual report and accounts.

3.0 Capacity to handle risk

3.1 How leadership is given to the risk management process

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

At an operational level, the Director of Corporate Affairs & Company Secretary, oversees the risk management framework within the Trust.

The Trust Board has four primary committees to oversee risk management: the Quality & Safety Committee, the Finance & Performance Committee, the Audit Committee and the Staff Experience & Organisational Development Committee. Figure 1 sets out the reporting Board & Committee framework within the Trust.

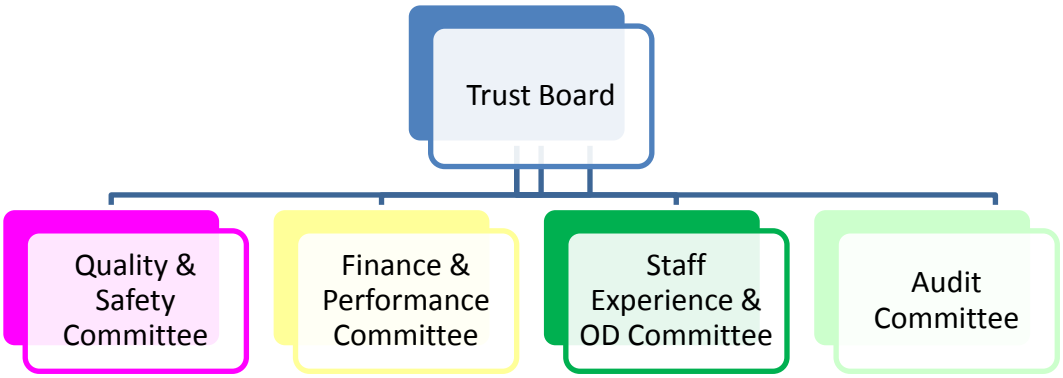


Figure 1: Trust Board & Committee structure

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 Executive Director of Nursing & Clinical Governance is the lead executive for this committee. The Committee meets monthly (apart from July and December when an assurance briefing is held) and regularly reviews clinical risks through consideration of a Quality & Patient Safety overview. 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 has a designated responsibility for the oversight of the performance of the organisation from a financial and operational perspective and is chaired by the Vice Chair of the Trust. The Interim Director of Finance is the lead executive for this committee. The Committee meets monthly (apart from August and December) and regularly reviews risks associated with the financial position & operational performance through a comprehensive finance and performance overview report.

Staff Experience & OD Committee: The Staff Experience & OD Committee has designated responsibility for the oversight of workforce-related matters, including HR performance metrics, delivery of workforce strategies and organisational development. It is chaired by a Non Executive. The Chief Executive is the lead executive for this committee, supported by the Associate Director of Workforce, HR & OD. The Committee meets monthly (apart from August and December) and regularly reviews risks associated with the Trust's workforce and its

development through a workforce overview which is considered on alternate months. The overview includes a focus on different professional groups on a rotational basis.

The Quality & Safety, Finance & Performance and the Staff Experience & OD Committees all consider an extract of the Corporate Risk Register, which also includes risks pertinent to the remit of the Committee that are of sufficient severity and/or impact as to warrant inclusion on the Board Assurance Framework.

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

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, positive assurances and decisions taken, together with any key action that has been taken.

The Chief Executive chairs a weekly business meeting of the **Executive Team** which comprises the Executive Directors, the Director of Corporate Affairs & Company Secretary and the Associate Director of Workforce, HR & OD. The agenda for the Executive Team covers operational delivery, clinical governance, risk management and policy approval as standard items, together with a range of ad hoc matters which require decision or discussion by the entire Executive Team. The Executive Team business meeting provides a forum for the Chief Executive to hold colleagues to account and offers assurance 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 by the Executive Team in the Chief Executive's update at the public sessions of the Trust Board meetings.

Finally, the Trust Board considers its Board Assurance Framework (BAF) at each of its public and private sessions. The BAF has been realigned during the year to the Trust's strategy, structuring it into the 'Five Ps' (People, Process, Performance, Partnerships and Patients) and so an extract is considered at the start of each section of the Board agenda to which it relates.

The Trust has an electronic risk register system (Ulysses) that facilitates management of both local and corporate risk registers and the Board Assurance Framework and further work is planned through 2020/21 to develop the functionality of this system further and better align its structure to that of the organisation.

3.2 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 policy. 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 part of the governance section of the mandatory training programme. The Corporate Governance Manager/Assistant Company Secretary also attends key operational management meetings to present the risk register and offers support to those wishing to raise a risk or strengthen their knowledge of risk management. There is further work planned over 2020/21 to devise a formal risk management training programme, which will be structured around the Risk Management policy and incorporate best practice guidance.

3.3 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 trustwide learning events for staff. Extensive work has continued this year on developing processes for learning lessons from incidents, Root Cause Analyses and complaints.

4.0 The risk and control framework

4.1 The key elements of the risk management framework

To ensure a consistent 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.

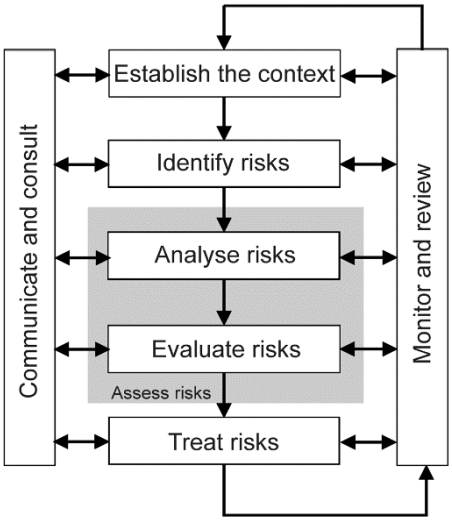


Figure 2: Risk management process

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 misses and incidents
- Investigation of serious incidents and root cause analyses
- 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

During the year, there has been further work undertaken to cleanse the content of existing risk registers and the Ulysses system to ensure that only relevant risks remain captured. The divisional risk registers and risk registers of some of the key governance committees have also undergone an overhaul during the year to ensure that the information is current and that risks are framed appropriately.

4.2 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 Trust Board interprets “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 or area
- 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

A Board session was held in October 2019 to discuss the concept of risk appetite and to demonstrate how this is applicable in practice at the ROH. Further work is planned during 2020/21 to further embed an understanding of risk appetite and to develop a fit for purpose risk appetite statement for the Trust.

4.3 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 Care Quality Commission (CQC) registration requirements

The Board receives assurance on the quality of care through the Board Assurance Framework and monitors performance against a wide range of indicators in the monthly Finance & Performance Overview, the Quality & Patient Safety report and Workforce overview.

The Quality & Safety Committee provides upward assurance to the Board on the activities undertaken by its subgroups covering particular aspects of quality, for example drugs and therapeutics, safeguarding, health & safety, research & development and infection control. More work has been undertaken during the year to strengthen the quality and content of the upward reports from the subgroups into the Quality & Safety Committee and a prescribed 'quadrant' format has been introduced which subgroup chairs use when they attend by rotation to present to the Committee.

Quality information is also scrutinised by the Clinical Quality Group, one of the bodies upwardly reporting into Quality & Safety Committee, this being chaired by the Deputy Director of Nursing & Clinical Governance.

The clinical outcomes data is reviewed by the Clinical Audit & Effectiveness Committee, a further subgroup of the Quality & Safety Committee with a remit that is complementary to the agenda of the Clinical Quality Group.

Some Board members during the year have carried out informal walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients and staff and others. A formal programme of Quality Assurance walkabouts is also in place, led by the Clinical Governance Team which involves Non Executives, patient representatives and members of the Council of Governors, together with operational managers.

The Chief Executive has held monthly briefings with senior managers for dissemination of key messages to teams and to receive feedback from the organisation. She has also arranged special briefings on significant matters of interest to the wider organisation.

During the year, the CQC published its findings following its unannounced inspection in October 2019 on three of the Trust's core services: surgery, medicine and critical care and then a planned review against the Well Led framework. The Trust's overall rating remained at 'Good', with a 'Good' rating being awarded across each of the CQC domains.

During 2019/20 there has been good progress with delivery of our CQC action plan, following the inspection with now only a small number of longer term strategic or minor operational actions outstanding.

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

standards. During the year, there has been further work undertaken to design and implement a HealthAssure system which will provide the capability to assess the Trust's position against the CQC Key Lines of Enquiry (KLoE), both at a divisional and department level and at an organisational level.

4.4 How risks to data security are being managed and controlled

The Head of Digital holds the IT Security role and is responsible for managing the technical/cyber security aspect of data. The Information Governance Manager supports the awareness and communications part of this work. Data Security and associated risks are monitored via the Information Governance (IG) Group which maintains a Risk Register and an action plan which addresses issues which are reviewed and actioned quarterly. Lessons learned are fed into training and awareness.

The Data Security & Protection (DSP) Toolkit is used as one of the controls for implementing data security and the action plan to achieve this toolkit is monitored by the IG Group. The Audit Committee has oversight of progress towards meeting the toolkit requirements and has also discussed throughout the year the plans to safeguard the Trust against cybercrime.

The network infrastructure has in-built data security control features and security threats are monitored. Controls also include software patching and anti-virus mechanisms. Encrypted datasticks are not permitted and all portable devices are protected by encryption and Trust-owned tablets/smartphones are monitored via Mobile Device Management (MDM) software. No personal devices can operate on the Trust network. Remote access to data is protected by two factor authentication.

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. The Trust has almost removed faxing and encourages the use of secure email. Information assets (IT systems and paper records) 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 to ensure up to date knowledge about the importance cyber security and the confidentiality and security of information.

4.5 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 2019/20.

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
FINANCE			
The Trust does not currently have a clear financial and operational plan that describes how the organisation will deliver sustainability over the medium to long term.	The Trust is delivering a deficit position and requires cash to continue day to day operations. The Trust's long-term sustainability, credibility within the local system and Going Concern status are placed in jeopardy	F	Mitigation/Controls: • Refreshed Trust five-year strategy to become the first choice for orthopaedic care • Restoration and recovery plans following the immediate impact of Covid-19 • Modular theatres plans • 'Perfecting Pathways' programme • Discussions within the STP to agree and develop a region-wide orthopaedics pathway • Reviewing blue print of other NHS organisations with similar ambitions and models to harness learning Outcome Assessment: • Agreement reached with local partners and the STP about the role of the ROH in future plans • Trust meets its financial and operational obligations on an ongoing basis • Trust remains free from regulatory undertakings which have been lifted during 2019/20
Loss of income as a result of the inability to deliver the activity levels	The Trust's inability to meet its financial control total for 2019/20,	IY/F	Mitigation/Controls:

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
anticipated in the operational plan as a result of the in-year pensions tax liability position	which may in turn call into question the organisation's future sustainability as a standalone organisation Inability to attract the full Financial Recovery Funding available for organisations meeting their control total		• Plans to create a separate vehicle for contracting medical staff • Additional recruitment of consultant staff • New approach to the pensions annual allowance taper • Ongoing discussions with regulators to update them on the impact of the situation on the ability to meet the control total • System discussions to establish what flexibility there may be to support the ROH's position Outcome Assessment: • Improved financial and operational performance during the final quarter of 2019/20 • Improvement in the performance against constitutional targets • The improving trajectory of performance was overtaken by the impact of the Covid-19 pandemic on NHS organisations and the change in case mix and funding arrangements
There is a large and increasing growth in the number and	The Trust is vulnerable to a cyberattack,	IY/F	• Cyber Operational Readiness Support (CORS) has been

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
type of malicious attempts to disrupt IT systems and hold organisations to ransom.	thereby compromising the Trust's ability to operate its range of systems and processes to support safe clinical care and there is a risk of patient confidentiality being compromised		secured and a remediation plan has been developed • Process implemented to patch corporate windows servers monthly. Further work planned to extend the type of patches installed and the range of operating systems patched. • Cyber security Board level champion appointed and is creating networking opportunities with other organisations with a view to strengthening advice & support • Additional investment to be made on a risk-based process into strengthening the Trust's cyber security framework • Internal audits into Trust's IT disaster recovery and protection from cyber crime Outcome Assessment: • A risk of escalating severity and likelihood as a result of the distractions and vulnerability caused by the Covid-19 pandemic • The Trust is continuing to work through the mitigations to ensure that the Trust's systems are as protected as possible

OPERATIONAL PERFORMANCE			
Failure to meet the national 18 weeks RTT target trajectory agreed with regulators	• Patients wait excessively long time before treatment • Regulatory oversight regime invoked, including failure to improve segmental rating	IY/F	• Trajectories developed at a sub speciality level • Oversight by Finance & Performance Committee through the finance and performance overview • Routine operational meetings to review RTT position and review on an ongoing basis the capacity and demand position to identify any gaps in service capacity to meet plans developed. • Recruitment of additional consultant capacity. Outcome Assessment: • Month on month improved performance against the 18 weeks RTT target, until the capacity and resource issues associated with the pensions tax liability issue took effect • A deterioration in the performance against the 18 weeks RTT target as a result of the national mandate to pause elective waiting lists as a consequence of the impact of the Covid-19 pandemic as described in the performance section earlier in this document
Inability to replace equipment beyond its useful life due to limited capital funding	Poor patient flow and inability to meet performance targets	IY/F	Mitigation/Controls: • Capital plan 2019/20 • Theatre close down over Easter 2019 for routine maintenance

			• Phase 1 of the modular theatres set up becoming operational during the final quarter of 2019/20 Outcome Assessment: • Increased theatre utilisation • Reduction in hospital-instigated cancellations • Consideration of Phase 2 of the modular theatres plan as part of the system-wide response to restoration and recovery as a result of the Covid-19 pandemic
The Trust may experience supply chain disruption and experience an adverse impact on areas which are dependent on overseas staffing in the event of a "no-deal" Brexit	Operations cancelled and long lead times for securing overseas staff	IY	Mitigation/Controls: • Brexit Steering Group • National and regional situation reports • Business continuity and resilience exercises • Linkages with neighbouring organisations Outcome Assessment: • The risk reduced significantly when it was agreed that there would be a period of transition following the UK's planned departure from the European Union on 31 January 2020
PATIENT SAFETY			
The suspension of the paediatric oncology service at Birmingham Children's Hospital NHSFT (BCH)	Poor patient experience, adverse clinical outcomes and low staff morale	IY/F	Mitigation/Controls: • Paediatric transition/transfer programme • Harm review process

creates long delays for patients requiring surgery, leading to poor patient experience, clinical outcomes and disenfranchisement of the oncology consultants			• Stakeholder Oversight group • Monthly report to Trust Board in public • Divert in place to ensure that patients needing treatment undergo surgery at the Royal National Orthopaedic Hospital NHS Trust (RNOH) Outcome assessment: • Plans were developed to resume surgery in April 2020, however the operational distraction caused by the Covid-19 pandemic has created a further delay to the resumption of services at BCH • Patients continue to receive surgery at the RNOH
WORKFORCE			
The Trust fails to attract and retain the skills and number of staff to secure financial sustainability and to maintain a high quality service and environment for our patients	Poor patient experience, high costs associated with recruitment and use of temporary staffing	IY	Mitigation/Controls: • Recruitment open days • Repositioning job advertisements to provide clarity on the ROH's unique offering • Development of new models of staffing - Nursing Associates, Theatre Assistant Practitioners, Mid Level Medical Staffing • Health and Wellbeing programme • Introduction of 100 days onboarding process Outcome assessment:

			• Successful recruitment campaign and positive retention position, driven in part by the attraction associated with the new modular theatres build but also the improved positioning of career opportunities at the Trust

Although these were the risks discussed by the Board for the majority of 2019/20, it should be highlighted that during March 2020, the Trust experienced a new set of risks with a more immediate focus, as a result of the impact of the global Coronavirus pandemic. A standalone risk register was established to monitor the impact of these risks, capture key mitigations and this was reviewed by Board members on a weekly basis as the primary risk management tool during this exceptional period.

A number of risks on the Covid risk register related to the impact of accepting a new caseload, including trauma patients into an elective setting and the workforce implications of the virus, including sickness absence and the effect of the government's guidelines on isolation and social distancing.

4.6 The principal risks to compliance with the NHS foundation trust condition FT4 (FT governance)

There has been a continued improvement in the arrangements and governance framework in the organisation that provides confidence in the Trust's ability to comply with the conditions of its licence. The CQC report highlighted that there is clarity regarding reporting lines and accountabilities between the Board and its committees and within the year there have been examples of topics remitted to other committees, which are then reported back to the originating committee.

The CQC report also highlighted that there was a strong risk management framework in place in the Trust, with clear escalation and comprehensive coverage of risks across the organisation.

In terms of achievement of the constitutional standards, as at the end of March 2020, there are no patients waiting in excess of 52 weeks for treatment. Reasonable progress was being made with the improvement trajectory to achieve the 18 weeks Referral to Treatment Time target, however the impact of the Covid-19 pandemic which took effect during March 2020 is likely to see a deterioration against this target and the 52 weeks standard, as the elective activity that accounted for the majority of the Trust's work was paused.

4.7 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 Staff Experience & OD Committee in providing assurance regarding Corporate Governance has been described earlier in this Statement.

Each year a Board paper is created with input of the whole of the Executive Team summarising evidence for the validity of each element of the Corporate Governance Statement which is available for Board members to interrogate if needed. This is presented to the Trust Board with a recommendation that the Trust declare compliance or otherwise.

4.8 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.

The Corporate Governance Manager/Assistant Company Secretary provides dedicated support to improving the quality of risk registers across the organisation, most notably at division level, but also at Trustwide committee level.

Divisions receive localised risk register reports which are discussed as part of monthly Divisional Governance Board meetings and specific risk registers have been developed for some of the key operational and clinical fora, such as Clinical Quality Group, Drugs and Therapeutics Committee, Safeguarding Board, Infection Prevention and Control Committee and Operational Management Board.

The Executive Team considers on a regular basis a Corporate Risk Register report which shows progress with delivery of key mitigating actions to address the organisation's key risks. This is shared with the Trust Board twice per year in full as part of the Board's workplan.

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 continues to be updated to develop detailed reports in order to provide Divisions and wards with better information on risk. The Serious Incident policy which is published in the Trust standardises the process and ensures effective and accurate reporting of incidents. Incidents are reviewed on a daily basis by the Clinical Governance Team to ensure timely escalation of any patient safety queries that may arise as well as to quality check the data inputted.

A weekly meeting of the Executive Triumvirate (the Medical Director, Director of Nursing & Clinical Governance and Chief Operating Officer) is held to review incidents and complaints and to distil any learning from investigations into these which may be shared across the organisation.

Information on all incidents requiring an investigation and any clinical negligence claims is shared with key staff and through the Divisional Management routes.

The Executive considers a monthly report on complaints, including those that have been reopened or referred to the Parliamentary Health Service Ombudsman. 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.

4.9 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 England/Improvement, CQC, Commissioners, Subcontractors, Voluntary Groups, the Trust's membership, Patient and Carers' Forum, patients and the local community. A Patient Engagement and Experience Group is also in place which provides a more strategic focus for discussion around matters affecting public and patients.

4.10 Ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective. Compliance with the 'Developing Workforce Safeguards' recommendations

The Board of Directors and Board subcommittees, namely Staff Engagement & OD, Finance & Performance and Quality & Safety committees receive regular reports detailing staffing arrangements in place and provide assurance in respect of staffing being safe, effective and sustainable as outlined in the 'Developing Workforce Safeguards' recommendations. The

reports detail areas of risk and mitigation in relation to workforce. Assurance is also provided in respect to key workforce metrics such as establishment data, sickness absence, turnover and statutory and mandatory training as well as data relating to workforce costs, thereby enabling effective triangulation.

The Trust has also outlined its ambition with regards to workforce within its 'Five Year People Plan' which has key objectives to create a sustainable workforce, embed new roles and continue to develop our workforce infrastructure so that we continue to deliver outstanding care and become an employer of choice across the Birmingham and Solihull STP region. Talent management and succession planning are also a key feature of the Trust's People Plan and this will enable us to focus our attention on more strategic workforce planning in addition to the operational elements. The Trust has the ambition to become a national leader in Health and Wellbeing and this workstream is sponsored by the Chief Executive. It is envisaged that this will positively impact on workforce sustainability through improved morale, attendance and retention. The People Plan is monitored through the Staff Engagement & OD subcommittee of the Board. In addition, the committee receives gap analysis data around nursing vacancies and establishment. Prior to the unprecedented position we find ourselves in relation to Covid-19, the Trust was actively engaged with work to develop the STP workforce plan and this work will be re-established through the STP People Board in addition to other joint priorities around workforce across the region.

The Trust's workforce plans are developed in conjunction with the Annual Business Planning cycle and this is revisited through triangulation meetings in divisional meeting structures such as the Clinical Workforce Development Group and Divisional Board meetings. Risks and issues are highlighted through the Trust's governance structures. In addition, the Trust has invested in technological workforce solutions such as Allocate to support e-rostering and e-job planning and there are plans to roll this out to Allied Health Professionals in addition to Nursing and Medical staff groups.

4.11 The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The outcome of the Trust's unannounced inspection and planned assessment against the Well Led Framework are described in Section 4.3. The Trust retained its 'Good' rating overall but most notably improved its rating in Critical Care from 'Requires Improvement' to 'Good'. This leaves the only 'Requires Improvement' rating in the CQC ratings matrix as Well Led in Outpatients, an area that the CQC did not inspect this year.

The inspection report did not list any 'Must Do' measures for the Trust to address.

The action plan to address any weaknesses identified by the inspection is considered by the Quality & Safety Committee as part of its routine workplan.

4.12 Managing Conflicts of interest guidance

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

4.13 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 Pens ion Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

4.14 Equality and Diversity and sustainability

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 has a sustainable development management plan in place which takes account of UK Climate projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5.0 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 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 two principal divisions: Patient Services & Access and Patient Support services. These are supported by a number of corporate departments. This arrangement provides a robust structure of accountability for the key elements of the Trust's business. Until the changes arising from the response to the Covid-19 pandemic took effect, the division met monthly for a management board, the agenda for which is divided into a section to review performance and 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 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. More work is planned in 2020/21 to improve

the effectiveness of the arrangements to monitor divisional performance and develop strengthened lines of accountability to the Executive Team.

The Trust has developed, within its Finance Overview, a set of infographics which monitor both national and local targets together with efficiency indicators which are reported on a monthly basis. This is considered and challenged on a monthly basis by the Finance and Performance Committee and also by the Trust Board when it meets in public.

A component of the Trust's financial planning is the implementation and delivery of a Cost Improvement Programme (CIP). Financial delivery against the Trust's CIP is monitored on a divisional basis through the divisional management boards and the formal executive divisional reviews, with Trust-wide performance monitored and challenged monthly as part of the Finance Overview to the Finance & Performance Committee. The quality impact of the schemes is reviewed through Quality & Safety Committee.

The Trust has been at the forefront of the National Costing Transformation Programme, working closely with NHS Improvement to develop national costing standards that have now been implemented across the NHS. Pilot National Cost Collections have been running since 2016-17 and the Trust has participated in all voluntary returns and will again be using the Patient-Level Information and Costing System (PLICS) to generate the compulsory collection. In addition, the Trust continues to be a member of NHS Improvement's Technical Focus Group that influences the improvement to costing standards and direction of travel.

Service Line reporting is now being reported on a monthly basis across all specialities and reported at Consultant level using the PLICS data. This is now used to benchmark consultant performance and highlight any areas where efficiencies can be gained, such as change in prosthesis type. The PLICS is also being used to maximise income generated through the national Payment by Results system, highlighting any areas where income is being 'lost' due to quality and recording inefficiencies. The Trust is also using the system to develop business cases for change in service using the underlying data to evidence the potential gains.

The Trust along with other National Orthopedic Alliance members, has been successful in influencing NHS Improvement and NHS England in view of the specialist nature of the activity that stand alone Orthopaedic Hospitals are undertaking and will continue to develop this relationship going forward to ensure continued support to specialist organisations.

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 oversees, 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 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 Quality & Patient Safety report, Workforce Overview and Finance Overview.

For further information on financial and operational performance for the year, please refer to the Performance section (1.6) earlier in this document.

6.0 Information Governance

During the year, the Trust reported 22 incidents relating to information governance and data security. None of these met the threshold for reporting to the Information Commissioner and/or the Department of Health and Social Care. The Information Governance Group received an update on these incidents which are in turn reported in overview up to the Finance and Performance Committee.

For the remaining incidents common themes are carelessness such as sending documentation for other patients in with correspondence, dropping handover sheets or leaving documentation in insecure places.

Managers deal with incidents at a local level supported by the Trust's Information Governance Manager where needed who then reviews all incidents to identify themes and learning. This is monitored by the Information Governance Group and messages cascaded to staff via training and awareness. Where required, letters of apology and explanation are sent to affected patients.

7.0 Data quality and governance

Across the Trust we have a number of operational systems that collect and store data about the patients treated. This data provides a valuable source of information that is critical the running of the Trust. From delivering effective and timely care to patients through to making future business decisions.

When data is of excellent quality, it can be easily processed and analysed, leading to insights that help the trust make better decisions. High quality data is essential to aid business intelligence reporting and other types of data analytics, as well as lead to better operational efficiency.

With this in mind the following are examples of some systems in place at the Trust to ensure that we secure and maintain high quality data:

- The business intelligence team uses over 75 automated data quality checks on the Trust's data. These checks are used to create regular reports which are shared internally and with stakeholders, highlighting and resolving data quality issues.

- A data quality group is established which is chaired by the Executive Chief Operating Officer. The group includes key stakeholders members from the business intelligence, operations, education and training teams.
- In 2020/21, there are plans to recruit a data quality and systems trainer to provide further support for the training of staff using operation systems.
- During the year clinical coders spent a week in theatres working with consultants to help improve the depth of coding of describing the specialist work we do. This will now be repeated regularly throughout the year.

8.0 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 Account 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 2019/20, 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 that out of the eight assurance reports issued, three provided positive (either substantial, reasonable or some progress) assurance opinions, two negative (partial) assurance opinions and three advisory reports. The report states that in the view of the Head of Internal Audit, there were no specific issues identified during the year that needed to be raised as significant control issues within this Annual Governance Statement.

The Effective Recruitment Audit identified 12 low and medium priority actions and no high priority actions. Since receipt of the report, nine of these actions have been addressed and the remaining 3 require engagement and consultation with wider stakeholders across the Trust and will be addressed by the deadlines agreed and reported to the Staff Experience & OD Committee for assurance/approval. In summary, the key actions are:

- A communique is being drafted to remind line managers to notify HR of leavers at the point of them being notified and to ensure that leaver notification forms are sent to HR prior to an individual's leaving date
- The recruitment team is ensuring that they are dating job descriptions and person specifications which are published to NHS Jobs and saved to new starter files

- The recruitment team is printing adverts from NHS Jobs which include the closing date and saving these to new starter files as opposed to documents received by the recruiting manger
- The recruitment standard operating procedures are being reviewed to ensure that conditional offers are sent to successful candidates within a day of receiving the form from recruiting managers where possible.
- The new starter form has been reviewed and rebranded as an Appointee Form and any areas of duplication for HR removed.
- The recruitment team is now signing and dating all evidence documents on the date reviewed and retaining these in the new starter file.
- Reference approvals from recruiting managers are being saved to new starter files.
- New starters are being reminded to sign and date a copy of their contract of employment and return this to HR by a deadline. The recruitment team are keeping the recruitment 'open' until a signed, dated copy of the contract from the employee is placed on the file
- HR Managers are now signing off all new starter files.

In terms of the IT disaster recovery audit, the key actions agreed, the completion of which is planned for 2020/21, include:

- Implementation of a schedule for testing the disaster recovery plans periodically
- Review management information from third party managed services to ensure that backup information is included.
- Full system restoration testing from back up media in accordance with an agreed schedule
- Complete and seek approval of the draft IT disaster recovery documentation
- Ensure that the responsibility for the IT disaster recovery is formally assigned and documented
- Ensure that the identification and prioritisation of key IT services is completed and approved by management
- Consider implementing a door card access system across both the Admissions and Day Case Unit and Disaster Recovery server rooms

The effectiveness of our systems has also been considered during 2019/20 through an unannounced CQC visit, visits by our commissioning partners and professional bodies and by an external well led assessment.

Other steps taken during 2019/20 to maintain and improve 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 of 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 Board Committee structure has been further enhanced during the year to provide better oversight of workforce matters through the embedding of the Staff Experience & OD Committee.
- the terms of reference for all Board Committees have been reviewed and refreshed during the year.
- the annual work plans for the Board and its committees have been revised and made more comprehensive.
- a refreshed series of Quality Assurance walkabouts has been implemented and a programme of staff experience walkabouts has been conducted to complement the clinical assurance process.
- Clinical Audit sessions continue to share good practice, learn from experience and improve 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.
- Weekly Executive triumvirate meetings are now held to review complaints, incidents and operational issues.
- The operational management structure has embedded, supported by a strong governance framework to ensure that there are clear lines of accountability and risk management and clinical governance discussions are given significant focus. This has been enhanced during the year by the decision to split the deputy Chief Operating Officer role into two separate roles, each for the management of the two principal divisions.
- The Executive Management Team includes an Associate Director of Workforce, HR and OD to provide leadership to the workforce agenda. Together with the Head of HR Operations, the HR processes in the Trust have been improved, with the development of a business partner approach.
- During the year, the terms of office of three of the Non Executives was extended, including that of the Audit Committee chair to provide continuity over the Covid-19 period. The Board was also joined by a new Associated Non Executive who has a legal background.
- The substantive Freedom to Speak Up Guardian returned to work after a period of maternity leave and began a structure series of walkabouts across the Trust to encourage staff to raise concerns. An ‘app’ has been developed to allow staff to register concerns from their mobile devices if they wish.
- A routine Quality bulletin is issued to communicate lessons learned and any key developments on quality and safety matters that need to be shared with staff.
- The Board Development plan was refreshed and further work is planned in 2020/2021 to create a more strategic focus on board development activities.

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

- There have been three Never Events reported: one wrong site surgery, one wrong side block and a retained foreign object post procedure. A robust process is in place for investigating and harnessing the learning from these Never Events, with some of the key points being:
    - Implementation of marking for all spinal patients to be completed as it is with other groups of patients undergoing surgery
    - Revision to the Safe Surgery policy to clarify the practice for surgical site marking to avoid any room for misinterpretation in future
    - Tightening the WHO checklist process and include radiographers in all cases when Imaging is to be included as part of the procedure
    - Imaging requests must include detail of the side/level of Imaging required
    - Mandate that the 'Stop Before You Block' check is completed immediately prior to needle insertion by the anaesthetist or allocated team member
    - Strengthening the process for swab counting and escalation in the eventuality of any irregularities

9.0 Conclusion

Whilst acknowledging the Never Events described in the section above represent significant specific weaknesses in internal control, 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 2020/21 to the continued development of our governance and control system building on the progress and learning undertaken in 2019/20.

Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust

Date: 19 June 2020

The Royal Orthopaedic Hospital NHS Foundation Trust

Consolidated Accounts for the year ended 31 March 2020

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Report on the audit of the financial statements

1. Qualified opinion

In our opinion, except for the possible effects of the matter described in the basis for qualified opinion section of our report, the financial statements of The Royal Orthopaedic Hospital NHS Foundation group

(the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2020 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the group and foundation statements of financial position;
- the group and foundation trust statements of changes in taxpayers' equity;
- the group and foundation trust statements of cash flows;
- the statement of accounting policies; and
- the related notes 1 to 25.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

2. Basis for qualified opinion

At the time of the physical counting of inventories, attendance was impracticable due to safety threats imposed by the Covid-19 pandemic. We were unable to satisfy ourselves by using other audit procedures concerning the inventory quantities held at 19 April 2020, which were rolled back to the year end. Inventory is included in the balance sheet at £6.7m. Consequently we were unable to determine whether any adjustment to this amount, or related balances such as operating expenses, was necessary.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

3. Material uncertainty relating to going concern

We draw attention to note 1, Accounting Policies, which states there is a material uncertainty that may cast significant doubt over the entity's ability to continue as a going concern. The group incurred a net deficit of £10.2m (2018/19: £4.5m) during the year ended 31 March 2020, and is projecting a further substantial deficit of £8.4m for 2020/21 before impairments and revaluations.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement (NHSI) announced reforms to the NHS cash regime for the 2020/21 financial year. This post balance sheet event results in existing DHSC interim revenue and capital loans as at 31 March 2020 being extinguished during 2020/21 and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans of £19.8m are therefore classified as current liabilities within these financial statements and this results in net current liabilities of £16.9m (2018/19: £2.7m net current assets).

There is lower reliance on borrowings in the immediate future due to the loans being extinguished, however if further funding was required, any agreement to further financing will not be agreed until the month prior to requirement of cash. This information is not currently available and due to the uncertainty in the future duration of the block contract arrangements and additional Financial Recovery Fund (FRF) funding.

The foundation trust has identified additional funding is required before the end of 2020/21 to support the foundation trust in meetings its liabilities which is yet to be formally agreed. Without additional funding, the group will have insufficient working capital to meet its liabilities as they fall due.

In response to this, we:

- We obtained an understanding and evaluated the relevant key controls in place around management's assessment and monitoring of the group's financial sustainability;
- reviewed the group's financial performance in 2019/20 including its achievement of planned cost improvements in the year;
- held discussions with management to understand the current status of the impact of the block contract regime and whether this would result in the planned break even position with additional up front Covid-19 and FRF funding;
- reviewed the group's cash flow forecasts and the group's pre-Covid-19 financial plan submitted to NHS Improvement;
- challenged the key assumptions used in the cash flow forecasts by reference to NHSI guidance and by benchmarking information for other acute providers; and
- assessed the consistency and historical accuracy of the budgeting process used by the group.

As stated in note 1, Accounting Policies, these events or conditions, indicate that a material uncertainty exists that may cast significant doubt on the group's and the foundation trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

4. Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • Recognition of NHS Clinical Revenue • Property Valuation • Valuation of Stock • Financial Performance and Sustainability • Limitation of scope in respect of inventory (see basis for qualified opinion section) • Going concern (see material uncertainty relating to going concern section) Within this report, key audit matters are identified as follows: Newly identified Increased level of risk Similar level of risk Decreased level of risk
Materiality	The materiality that we used for the group financial statements was £1.8m which was determined on the basis of 2% of revenue.
Scoping	The focus of audit work was on the foundation trust, with work performed directly by the audit engagement team, led by the audit partner. Our audit covered all of the entities within the group, including the Foundation Trust's

	subsidiary, The Royal Orthopaedic NHS Foundation Trust Charitable Fund, which account for 100% of the group's net assets, total revenue and deficit.
Significant changes in our approach	Our key audit matters relating to going concern and inventory each have a revised scope in comparison to the prior year. This is because management have identified a material uncertainty related to going concern in the current year and the limitation of scope identified in the current year over the existence of stock. Property valuation is also included as a key audit matter in the current year due to a full revaluation performed by the valuers and material uncertainty clause declared within their report.

5. Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

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.

Further, to the matter described in the material uncertainty relating to going concern section and the matters described in the basis for the qualified opinion section, we have determined the matters described below to be the key audit matters to be communicated in our report.

5.1. Recognition of NHS Clinical Revenue

Key audit matter description	As described in note 1.5, Accounting Policies, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: • the complexity of the Payment by Results regime, in particular in determining the level of overperformance and revenue to recognise; and • the judgemental nature of accounting for disputes, including in respect of outstanding overperformance income for quarters 3 and 4. Details of the group's income, including £79.9m (2018/19: £76.9m) of Commissioner Requested Services are shown in note 3 to the financial statements. NHS receivables are shown in note 12 to the financial statements.
How the scope of our audit responded to the key audit matter	We obtained an understanding of and evaluated the relevant controls around revenue recognition. 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.
Key observations	Based on the audit evidence obtained, we conclude that NHS revenue is appropriately recognised.

5.2. Property valuation

Key audit matter description	The group holds property assets (Land, Buildings and Dwellings) within Property, Plant and Equipment at a modern equivalent use valuation of £36.8m (2018/19: £38.6m), per note 9. 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 detailed in note 1.3, in applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by Covid-19, and therefore properties which are priced on their trading potential, including healthcare establishments, may experience a greater impact on pricing in comparison to other asset classes.
How the scope of our audit responded to the key audit matter	We obtained an understanding of relevant controls over property valuations, and tested the accuracy and completeness of data provided by the group to the valuer. We worked with Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the group's properties. We have reviewed the disclosures in notes 1.3 and 9 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation. We considered the impact of uncertainties relating to the UK's exit from the EU and the Covid-19 pandemic upon property valuations in evaluating the property valuations and related disclosures including the adequacy of the disclosure of the material valuation uncertainty. 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 Income Statement or in Other Comprehensive Income.
Key observations	While we note the increased estimation uncertainty in relation to the property valuation as a result of Covid-19, and as disclosed in note 1.3 and 9, we consider that the key judgements are within the acceptable range.

5.3. Valuation of Stock

Key audit matter description	The group holds stock which consists of pharmacy and theatre items, of which implants make up the majority of the value; these are held at cost, as described in note 1.13. Stock has decreased in value at 31 March 2020 to £6.7m in comparison to £6.8m at 31 March 2019 as per Note 11. Management is responsible for maintaining records regarding the physical stock and recording its value in the financial statements. Management's stock count procedures identified that there were a number of items owned by the foundation trust but for which there is no assigned value. We therefore identified a key audit matter relating to the risk that stock is understated, due to unassigned values to a number of stock items. This is a re-occurring issue from the prior year due to insufficient record keeping of some stock items. Furthermore, due to the restrictions imposed by Covid-19 we were unable to attend the stock count, which therefore resulted in a Limitation of scope (see basis for qualified opinion section).

How the scope of our audit responded to the key audit matter	We obtained an understanding of and evaluated relevant controls around stock valuation. On a sample basis, we have agreed the stock items on the stock listing to invoices to assess whether the appropriate cost is being used to value stock. We further evaluated management's explanations regarding items for which the foundation trust did not have an assigned value, including consideration of the nature of these items, and assessed the potential impact on the financial statements.
Key observations	Based on the audit evidence obtained, we conclude that the value of stock items sampled was appropriate. Although some progress has been made with assigning all items with values, and record keeping from the prior year, further enhancement is required and management are in the process of reviewing the arrangements in place.

5.4. Financial Performance and Sustainability

Key audit matter description	We are required to consider whether the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources. Our work takes account of: • The Accountable Officer's statement in the Annual Governance Statement; and • The results of work of relevant regulators, including the Care Quality Commission (CQC) and NHSI. At 31 March 2020 the foundation trust is reporting a deficit of £10.2m (2018/19: £4.5m), and did not receive their allocation of Provider Sustainability Fund (PSF) and (FRF). This represents an underachievement of plan by £4.9m. The foundation trust had a Cost Improvement Plan (CIP) target of £1.6m for the year to 31 March 2020 and has achieved savings of £1.5m, which was all achieved on a recurrent basis. The foundation trust's cash position at 31 March 2020 is £0.7m (2018/19: £2.7m). The foundation trust currently has a Use of Resources Rating (UOR) of 4, which is adverse to plan.
How the scope of our audit responded to the key audit matter	We have monitored the performance of the foundation trust throughout the year, including the arrangements in place at the foundation trust to monitor the position and the arrangements in place for financial planning and agreeing a plan for the forthcoming year. We have reviewed procedures and controls for financial planning, held high level interviews with management and benchmarked the foundation trust's performance against plan – including delivery of CIPs and working with NHSI for monthly performance.
Key observations	We noted that the foundation trust's breach of license was lifted in July 2019. The foundation trust has delivered £1.5m CIPs from the planned £1.6m, all on a recurrent basis. While the foundation trust did not meet its control total for 2019/20 it is noted that plans continue to progress to return to a breakeven position in future years. Management have concluded and we concur that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its

use of resources.

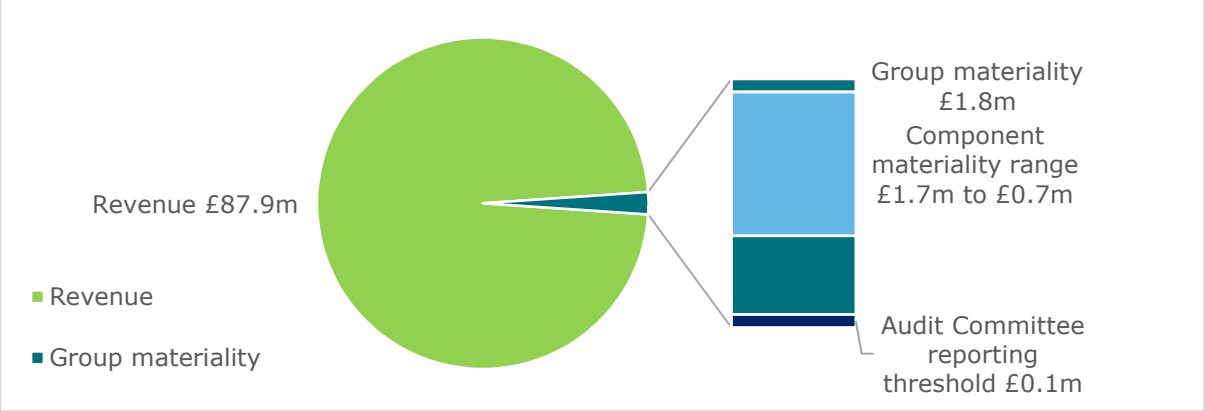
6. Our application of materiality

6.1. 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.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation Trust financial statements
Materiality	£1.8m (2018/19: £1.8m)	£1.7m (2018/19: £1.7m)
Basis for determining materiality	2% of revenue (2018/19: 2% of revenue)	2% of revenue (2018/19: 2% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the group is a non-profit organisation, and revenue is a key measure of financial performance for users of the group's financial statements.	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the foundation trust's financial statements.



6.2. Performance materiality

We set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality for the financial statements as a whole. Group performance materiality was set at 75% of group materiality for the 2020 audit (2019: 75%). In determining performance materiality, we considered the following factors:

a. the state of the control environment;
b. the low volume of corrected and uncorrected misstatements identified in the previous audit; and
c. the stable finance team during the current and prior period.

6.3. Error reporting threshold

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £87k (2018/19: £87k), 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.

7. 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 foundation trust, with work performed directly by the audit engagement team, led by the engagement lead.

We performed specified audit procedures in relation to the foundation trust's subsidiary, The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund, where the extent of our testing was based on our assessment of the risks of material misstatement and the component materiality specific for the subsidiary.

Our audit covered all of the entities within the group, which account for 100% of the group's net assets, total revenue and deficit with no component auditors involved in the audit.

Deloitte Real Estate and IT Specialist were involved for bringing specific skills and experience in property valuations and Information Technology systems.

8. Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the inventory quantities of £6.7m counted as at 19 April 2020 and rolled back to 31 March 2020. We have concluded that where the other information refers to the inventory balance or related balances such as operating expenses, it may be materially misstated for the same reason.

9. Responsibilities of accounting officer

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, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the foundation trust or to cease operations, or has no realistic alternative but to do so.

10. Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

11. Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have 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.

12. Matters on which we are required to report by exception

12.1. 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 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 are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

12.2. Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

13. 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.

14. Use of our report

This report is made solely to the Board 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 foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Ian Howse, CPFA, CPA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
Cardiff, United Kingdom
23 June 2020

FOREWORD TO THE ACCOUNTS

The accounts for the year ended 31 March 2020 have been prepared by The Royal Orthopaedic Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Mrs. Joanne Williams

Accountable Officer

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2020

		Consolidated	
		Year Ended 31 March 2020	Year Ended 31 March 2019
	Notes	£000	£000
Income from patient care activities	**3.1**	82,561	80,000
Other operating income (excluding PSF and STF)	**3.1**	5,376	4,996
Provider Sustainability Fund (PSF) and Sustainability and Transformation Funding (STF)	**3.1**	0	2,464
Operating expenses	**4**	(97,167)	(90,089)
Net valuation gain/(loss) on land and buildings	**9.3**	(602)	(783)
Operating Deficit		**(9,832)**	**(3,412)**
Finance Expenses			
Finance income	**6**	61	49
Finance expense - financial liabilities	**6**	(232)	(119)
Finance (expense)/income - unwinding of discount on provisions	**16**	(12)	120
PDC dividends payable	**1.21**	(839)	(1,152)
Net Finance Expenses		**(1,022)**	**(1,102)**
DEFICIT FOR THE YEAR		**(10,854)**	**(4,514)**
Other comprehensive (expense)/income			
Will not be reclassified to income and expenditure:			
Impairment loss on land and buildings	**9.3**	(1,025)	(1,126)
Other reserves movements		0	5
May be reclassified to income and expenditure when certain conditions are met:			
Fair value losses on investment	**10**	(105)	(2)
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(11,984)**	**(5,637)**

All income and expenditure is derived from continuing operations. There is no deficit for the year attributable to minority interests.

The notes on pages 163 to 204 form part of these accounts.

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2020

		Consolidated		Trust only	
		31 March 2020	31 March 2019	31 March 2020	31 March 2019
Non-current assets	**Notes**	**£000**	**£000**	**£000**	**£000**
Intangible assets	8	1,326	1,389	1,326	1,389
Property, plant and equipment	9	43,980	46,129	43,980	46,129
Investments	10	796	755	0	0
Total non-current assets		**46,102**	**48,273**	**45,306**	**47,518**
Current assets					
Inventories	11	6,690	6,752	6,690	6,752
Trade and other receivables	12	10,070	8,740	10,058	8,739
Short term investments and deposits	13.1	8	123	0	0
Cash and cash equivalents	14	1,471	3,763	663	2,655
Total current assets		**18,239**	**19,378**	**17,411**	**18,146**
Current liabilities					
Trade and other payables	15	(13,979)	(15,629)	(13,967)	(15,487)
Borrowings	15.2	(20,525)	(726)	(20,525)	(726)
Provisions	16	(406)	(84)	(406)	(84)
Other liabilities	15.1	(250)	(210)	(250)	(210)
Total current liabilities		**(35,160)**	**(16,649)**	**(35,148)**	**(16,507)**
Total assets less current liabilities		**29,181**	**51,002**	**27,569**	**49,157**
Non-current liabilities					
Borrowings	15.2	(721)	(10,891)	(721)	(10,891)
Provisions	16	(526)	(215)	(526)	(215)
Total non-current liabilities		**(1,247)**	**(11,106)**	**(1,247)**	**(11,106)**
Total assets employed		**27,934**	**39,896**	**26,322**	**38,051**
Financed by taxpayers' equity					
Public Dividend Capital		37,136	37,114	37,136	37,114
Revaluation reserve		2,569	3,594	2,569	3,594
Charitable fund reserve		1,612	1,845	0	0
Income and expenditure reserve		(13,383)	(2,657)	(13,383)	(2,657)
Total taxpayers' equity		**27,934**	**39,896**	**26,322**	**38,051**

The financial statements were approved by the Audit Committee and authorised for issue on behalf of the Board of Directors on 19 June 2020 and are signed on its behalf by:

Mrs. Joanne Williams – Chief Executive Officer

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2020

	Consolidated					Trust only				
	Total	Public Dividend Capital	Revaluation Reserve	Charitable Fund Reserve	Income and Expenditure Reserve	Total	Public Dividend Capital	Revaluation Reserve	Charitable Fund Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2018	**45,439**	36,976	4,720	2,225	1,518	**43,201**	36,976	4,720	1,505	
Deficit for the year	**(4,514)**	0	0	(351)	(4,163)	**(4,163)**	0	0	(4,163)	
Valuation loss on property, plant and equipment	**(1,126)**	0	(1,126)	0	0	**(1,126)**	0	(1,126)	0	
Public dividend capital received	**138**	138	0	0	0	**138**	138	0	0	
Fair value gains/(loses) on investments	**(2)**	0	0	(2)	0	**0**	0	0	0	
Other reserve movements	**(39)**	0	0	(27)	(12)	**1**	0	0	1	
Taxpayers' Equity at 31 March 2019	**39,896**	37,114	3,594	1,845	(2,657)	**38,051**	37,114	3,594	(2,657)	

	Total	Public Dividend Capital	Revaluation Reserve	Charitable Fund Reserve	Income and Expenditure Reserve	Total	Public Dividend Capital	Revaluation Reserve	Charitable Fund Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2019	**39,896**	37,114	3,594	1,845	(2,657)	**38,051**	37,114	3,594	(2,657)	
Deficit for the year	**(10,854)**	0	0	(128)	(10,726)	**(10,726)**	0	0	(10,726)	
Valuation loss on property, plant and equipment	**(1,025)**	0	(1,025)	0	0	**(1,025)**	0	(1,025)	0	
Public dividend capital received	**22**	22	0	0	0	**22**	22	0	0	
Fair value gains/(loses) on investments	**(105)**	0	0	(105)	0	**0**	0	0	0	
Taxpayers' Equity at 31 March 2020	**27,934**	37,136	2,569	1,612	(13,383)	**26,322**	37,136	2,569	(13,383)	

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
CONSOLIDATED AND TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2020

		Consolidated		Trust only	
		Year Ended 31 March 2020	Year Ended 31 March 2019	Year Ended 31 March 2020	Year Ended 31 March 2019
	Notes	£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit		(9,832)	(3,412)	(9,672)	(3,029)
Non-cash income and expense					
Depreciation and amortisation	**4**	2,694	2,065	2,694	2,065
Donated assets		0	0	(204)	(334)
Impairments	**9**	1,619	783	1,619	783
Reversal of impairments	**9**	(1,017)	0	(1,017)	0
Increase in Trade and other receivables	**12**	(1,431)	(2,603)	(1,431)	(2,525)
Decrease/(Increase) in Inventories	**11**	62	(1,895)	62	(1,895)
(Decrease)/Increase in Trade and other payables	**15**	(1,544)	1,834	(1,544)	1,834
Increase in Other Liabilities	**15**	40	3	40	3
Increase/(Decrease) in Provisions	**16**	621	(108)	621	(108)
Movement in Charitable fund working capital		(140)	140	0	0
Other movements in operating cash flows		0	(18)	0	19
NET CASH USED IN OPERATING ACTIVITIES		**(8,928)**	**(3,211)**	**(8,832)**	**(3,187)**
Cash flows from investing activities					
Interest received		30	16	30	16
Proceeds from sales of property, plant and equipment		0	2	0	2
Purchase of intangible assets	**8**	(67)	(920)	(67)	(920)
Purchase of Property, Plant and Equipment		(2,018)	(1,777)	(1,814)	(1,443)
NET CASH GENERATED FROM INVESTING ACTIVITIES		**(2,055)**	**(2,679)**	**(1,851)**	**(2,345)**
Cash flows from financing activities					
Interest element of finance lease		(7)	(7)	(7)	(7)
Capital element of finance lease rental payments		(114)	(135)	(114)	(135)
Interest element of loans		(224)	(112)	(224)	(112)
Movements on loans from the Department of Health and Social Care	**15.2**	10,341	5,398	10,341	5,398
Movements on other loans	**15.2**	(599)	366	(599)	366
PDC received		22	138	22	138
PDC Dividend paid		(728)	(1,212)	(728)	(1,212)
NET CASH USED IN FINANCING ACTIVITIES		**8,691**	**4,436**	**8,691**	**4,436**
Decrease in cash and cash equivalents		**(2,292)**	**(1,454)**	**(1,992)**	**(1,096)**
Cash and Cash equivalents at 1 April		**3,763**	**5,217**	**2,655**	**3,751**
Cash and Cash equivalents at 31 March		**1,471**	**3,763**	**663**	**2,655**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2020

1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC Group Accounting Manual 2019/20, issued by the Department of Health and Social Care.

The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Going concern

International Accounting Standards (IAS 1) requires the directors to assess, as part of the account's preparation process, the Foundation Trust's ability to continue as a Going Concern.

The Trust has been in a deficit position for a number of years which means it has been reliant on cash funding from the DHSC to support ongoing operations. This funding has previously been provided as a loan. On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £19,771,000 are now classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

As a result of the Coronavirus pandemic, Payment by Results has been paused to simplify funding and remove administrative burden. It has been replaced instead with a block contract payment from 1st April for an initial period of 6 months based upon historic finances, with a top-up for spend relating directly to Coronavirus. It is noted that this gives a high level of certainty over income over the April-September 2020 period, and that the funding is sufficient to enable the Trust to continue to operate. In addition, Trusts have been provided with an additional month of upfront block funding to ease cash flows and support trusts in paying their suppliers in a more timely manner. Nationally, whilst it is known that NHS funding will continue post September 2020 there is a lack of clarity at present regarding what form that funding will take.

The current shorter term arrangements have resulted in the trust having a lower reliance on future borrowing in the immediate future. If, however, it needs further funding at any point over the coming months there remains a route to funding through the DHSC. As in similar years, the agreement to any further financing will not be agreed until the month immediately preceding the requirement for cash, and thus at the time of completing the Going Concern assessment this information is not available, creating a material uncertainty that may cast significant doubt over the entity's ability to continue as a going concern.

The Trust is also required to assess going concern under the NHS Foundation Trust Annual Reporting Manual 2019/20, which states 'the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern'. The Trust is a specialist provider of orthopaedic services, treating patients not only from the local area for common procedures such as primary hip and knee surgery, but also from across the UK for some of its specialist services,

such as complex spinal deformity (e.g. spinal scoliosis), orthopaedic oncology, bone infection procedures and complex revision surgery. Increases in referrals in many of these areas suggest a continuing need in the UK population that is required to be met, particularly as Coronavirus will undoubtedly place pressure on waiting lists for elective work nationally.

This guidance, in addition to discussions held with NHS Improvement, have allowed the Directors to assess that, on the basis of their enquiries, there is still a reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

As such 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.

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.

1.1 Basis of consolidation

These consolidated financial statements have been prepared incorporating the accounts of the Trust's subsidiary undertaking, The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund (The Charity).

1.2 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 charity is registered with the UK Charities Commission, registration number 1078046.

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 charity's 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; and
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. All investments are held by the associated Charity what have been consolidated within the Trust accounts. The Charity does not hold any property assets. Quoted stocks and shares are included in the statement of financial position at mid-market price, ex div. Other non-current asset investments are included at Trustees' best estimate of market value.

Current asset investments

All investments are held by the associated Charity what have been consolidated within the Trust accounts. The current asset investment comprise cash balances available for investment which are held in capital or income accounts. The investments generate dividends and interest, less any administration costs.

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).

1.3 Critical accounting judgements and key 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 judgements 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.

Critical accounting judgements

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying [the entity's] accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Categorisation of leases as operating or finance leases

Lease arrangements as categorised as either operating leases or finance leases in line with the accounting policy below (see note 1.12).

During 2019/20 the Trust signed a contract for the supply of modular theatres and wards under a new lease arrangement. Due to the material value and term of the contract the treatment of this contract has been assessed carefully to ensure that it is reported accurately within the Trust's financial statements. The lease arrangement has been treated as an operating lease due to the risk and reward of ownership not deeming to be transferred to the Trust which is a material component required to classify the lease as a finance lease.

Sources of estimation uncertainty

Estimates are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The following areas of the financial statements are subject to key estimates and judgements.

Valuation of the Trust's estate

A valuation of the Trust's land and buildings was undertaken with an effective date of 31 March 2020 by the Trust's valuer, Cushman and Wakefield. The valuations have been undertaken applying the principles of IAS 16 *Property, Plant and Equipment* and RICS advises that assumptions underpinning the concepts of fair value should be explicitly stated and identifies two potential qualifying assumptions:

- the Market Value on the assumption that the property is sold as part of the continuing enterprise in occupation" (effectively Existing Use Value); or

- the Market Value on the assumption that the property is sold following a cessation of the existing operations" (in effect the traditional understanding of Market Value).

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. Market activity is being impacted in many sectors. As at the valuation date, the valuer considered that they can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that the valuer is faced with an unprecedented set of circumstances on which to base a judgement. The values in the report have been used to inform

the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

The Department of Health and Social Care has indicated that for NHS assets it requires the former assumption to be applied for operational assets; this is the approach that was taken by the valuer. The Market Value used in arriving at fair value for operational assets is therefore subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

The Trust estimates the pattern of consumption of property, plant and equipment by writing assets down on a straight line basis over useful economic lives. The useful economic lives determined for each asset or group of assets are informed by historical experience or specific information provided by the valuer where appropriate.

Other estimates

Provisions

Estimates and judgements are also made in respect of provisions for liabilities and charges (see Note 16) where there is some uncertainty at the Statement of Financial Position date as to either the timing or amount of the Group's financial liability.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 0.50% (2018/19 0.29%) in real terms.

Contingencies

The NHS Foundation Trust includes in the notes to the financial statements (see note 19) any legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation.

In the view of the Trust there are no further estimates or judgements which if wrong could materially affect the financial performance of the Trust.

1.4 Annual Leave provision

In accordance with the requirement of IAS 19 *Employee Benefits*, the Trust provides for unpaid annual leave carried forward by staff at the year end. The total number of annual leave days that each of the Trust's employees has not taken at the 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.

1.5 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

- The Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;

- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.

The Group Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation is to review the milestones within the individual contracts.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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.

1.6 Expenditure on employee benefits

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that 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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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:-

Employer contribution	3%
Total contribution	8%

In the year to 31 March 2020 the Trust has made contributions of £10,043 to this fund, (2018/19: £4,754).

1.7 Other expenses

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

1.8 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.

1.9 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.

1.10 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. Land, buildings and dwellings are measured at valuation.

The valuation exercise was carried out in December 2019 with a valuation date of 31 March 2020. 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 2020 by Cushman and Wakefield (MRICS).

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. Market activity is being impacted in many sectors. As at the valuation date, the valuer considered that they can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that the valuer is faced with an unprecedented set of circumstances on which to base a judgement. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

The revaluation undertaken at that date has been accounted for in these financial statements as follows:

- Land £5,021,000
- Buildings and Dwellings £31,765,614

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 *Borrowing Costs* for assets held at fair value. Assets depreciation commences when they are brought into use.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

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 *Fair Value Measurement*, if it does not meet the requirements of IAS 40 *Investment Property* or IFRS 5 *Non-current assets held for sale and discontinued operations*.

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 derecognised. 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.

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:

1. Buildings – as per Professional Valuer's estimate. Based on the valuation to 31 March 2020 this ranged from 24 – 56 years.

2. Plant and Machinery

Type	Short life	Medium Life	Long life
Engineering Plant & Equipment	5 years	10 years	15 years
Medical Equipment	2 years	10 years	15 years

3. Transport Equipment – 7 years

4. Information Technology – individually assessed based on type of asset - 3 to 10 years

5. Furniture and Fittings – 2 to 5 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 expenses.

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 Department of Health and Social Care Group Accounting Manual, 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.

Derecognition

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 derecognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished is derecognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor 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.

1.11 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.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

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 its technical feasibility and it resulting in a product or services that will eventually be brought into use; and
- 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.

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 and Social Care, 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 *Government Grants and Disclosure of Government Assistance* 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 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.

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.

1.13 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.

1.14 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 90 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.

1.15 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.

1.16 Clinical negligence costs

The NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to them, which, in return, settles all clinical negligence claims. Although the NHS Resolution 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 NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 16 but is not recognised in the NHS Foundation Trust's accounts.

1.17 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 NHS Resolution 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.

1.18 Contingent liabilities and contingent assets

Contingent liabilities are not recognised, but are disclosed in note 19 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.

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 would be disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.19 Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories:

- financial assets at amortised cost;
- financial assets at fair value through other comprehensive income; and
- financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition. The Trust only holds assets within the first category.

1.19.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.19.2 Impairment

For all financial assets measured at amortised cost, lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at

the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.20 Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

1.20.1 Financial liabilities at fair value through profit and loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss, embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- the amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*, and
- the premium received (or imputed) for entering into the guarantee less cumulative amortisation.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32 *Financial Instruments: Presentation*.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)
- any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care, 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. The PDC dividend calculation is based upon the trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

1.22 Foreign currencies

The Trust functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2020.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.23 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. (see note 22)

1.24 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. (See note 24)

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Accounting Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021/22, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some

leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted. This standard is not expected to have a significant impact on the Trust accounts.

1.27 Exemption from presentation of Trust only Statement of Comprehensive Income

In line with section 5.9 of the GAM, the Group has taken advantage of the exemption to present a Trust only Statement of Comprehensive Income. The Trust had a deficit of £10,726,000 (2018/19 £4,163,000 deficit).

2 Segmental Reporting

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, 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			
		Year Ended 31 March 2020		Year Ended 31 March 2019
	£000	%	£000	%
Income from whole HM Government	79,893	90.85%	76,873	87.90%
Income from non HM Government	8,044	9.15%	10,587	12.10%
	87,937	100.00%	**87,460**	100.00%

All business activities of the Trust are continually reviewed for material segments.

3 Income from activities arising from Commissioner Requested Services and all other activities.

3.1 Income by nature

	Consolidated	
	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Elective income	43,457	46,063
Non elective income	3,267	2,753
Outpatient income	8,789	8,193
Other NHS clinical income	25,624	21,266
Private patient income	1,424	1,725
Total income from patient care activities	**82,561**	**80,000**
Other operating income from contracts with customers:		
Research and development (contract)	353	469
Education and training (excluding notional apprenticeship levy income)	1,870	1,930
Income in respect of employee benefits accounted on a gross basis	1,402	1,164
Other contract income	1,492	1,354
Other non-contract operating income:		
Charitable and other contributions to expenditure	259	79
Total other operating income (excluding PSF)	**5,376**	**4,996**
Provider sustainability Funding	**0**	**2,464**
TOTAL OPERATING INCOME	**87,937**	**87,460**
Commissioner requested services	81,137	78,275
Non-commissioner requested services	6,800	9,185

The Trust has deemed all income from patient care activities as being in relation to commissioner related services except for any private patient income.

3.1.1 Other NHS clinical income

Other NHS clinical income includes:

	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Oncology block contract	6,417	6,251
Physiotherapy services	2,521	2,259
Pension costs funded by NHS England	2,006	0
Critical care bed days	1,999	2,181
Diagnostic imaging	1,734	1,731
Orthopaedic appliances	1,233	1,497
Bespoke prosthesis	1,089	1,027
Pre-operative assessments	1,055	1,008
CQUIN	725	1,610
Podiatry services	418	389
Hospital at home	332	365
Orthotics	242	228
High cost drugs	227	290
	19,998	**18,836**

3.1.2 Other contract income

Other contract income includes:

	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Onsite catering services	266	237
Staff accomodation	95	88
Car park income	413	435
	774	**760**

3.2 Income by Source

	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
NHS Foundation Trusts	1,875	734
CCGs and NHS England	77,996	75,379
Department of Health - other	0	724
Non NHS: Private patients	1,424	1,725
NHS injury scheme (was RTA)	22	36
Non NHS: Other	1,244	1,402
TOTAL INCOME FROM ACTIVITIES	**82,561**	**80,000**

The income for the Charity is not included here as this has been classified as other operating income only.

3.3 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	210	207

4 Operating Expenditure

	Consolidated	
	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Purchase of healthcare from NHS and DHSC bodies	3,422	3,271
Purchase of healthcare from non-NHS and non-DHSC bodies	2,592	2,052
Staff and executive directors costs	56,709	53,596
Non-executive directors	127	117
Supplies and services – clinical (excluding drugs costs)	17,221	15,360
Supplies and services - general	1,114	1,040
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	1,484	1,642
Inventories written down (net including drugs)	2	17
Consultancy	114	166
Establishment	1,378	1,278
Premises - business rates collected by local authorities	218	292
Premises - other	3,296	3,301
Transport (business travel only)	87	114
Transport - other (including patient travel)	40	34
Depreciation	2,322	1,823
Amortisation	372	242
Movement in credit loss allowance: contract receivables/assets	51	(148)
Audit fees payable to the external auditor:		
Audit services - statutory audit	72	47
Other services - audit related assurance services	4	32
Charitable fund independent examination	5	5
Internal audit	74	71
Clinical negligence	3,913	4,210
Legal fees	22	65
Insurance	95	104
Research and development	(17)	37
Education and training	443	329
Operating lease expenditure (net)	797	374
Car parking and security	53	62
Hospitality	21	8
Other losses and special payments - staff costs	8	0
Other losses and special payments - non-staff	1	1
Other services (e.g. external payroll)	91	90
Other NHS charitable fund resources expended	195	109
Other	841	348
OPERATING EXPENDITURE (excluding impairment)	**97,167**	**90,089**
Valuation (gain)/impairment	602	783
TOTAL OPERATING EXPENDITURE	**97,769**	**90,872**

5 Operating leases

5.1 Payments recognised as an expense

	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Lease payments	797	374
TOTAL PAYMENTS	**797**	**374**

This note relates to the main Trust only as the Charity does not hold any operating leases.

The Trust's operating leases for 2019/20 consists of £19,000 (2018/19: £19,000) for the use of an offsite car park, £202,000 in relation to the lease of Mako Robotics equipment (2018/19: £202,000), £315,000 in relation to modular theatres (2018/19: £nil), £4,000 in relation to a lease car (2018/19: £4,000) and the remainder of £257,000 (2018/19: £94,000) relates to plant and equipment.

5.2 Total future minimum lease payments

	Land £000	Buildings £000	Other £000	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
- not later than one year;	20	1,261	470	1,751	507
- later than one year and not later than five years;	90	9,775	700	10,565	750
TOTAL FUTURE PAYMENTS DUE	**110**	**11,036**	**1,170**	**12,316**	**1,257**

This note relates to the main Trust only as the Charity does not hold any operating leases.

6 Finance income and expense

	Consolidated	
	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Interest from deposit accounts	29	17
Investment dividend income	32	32
TOTAL FINANCE INCOME	**61**	**49**

	Consolidated	
	Year Ended 31 March 2020 £000	Year Ended 31 March 2019 £000
Finance lease interest	7	7
Loan interest - DHSC	195	84
Loan interest - Other	30	28
TOTAL FINANCE EXPENSE	**232**	**119**

7 Employee expenses and numbers

	2019/20			2018/19		
	Total	Permanently Employed	Agency	Total	Permanently Employed	Agency
	£000	£000	£000	£000	£000	£000
Salaries and wages	41,737	41,737	0	39,677	39,677	0
Social security Costs	4,128	4,128	0	3,963	3,963	0
Apprenticeship levy	188	188	0	178	178	0
Employer's contributions to NHS Pensions	4,637	4,637	0	4,235	4,235	0
Employer contributions paid by NHSE on provider's behalf (6.3%)	2,006	2,006	0	0	0	0
Agency staff	4,013	0	4,013	5,543	0	5,543
TOTAL EMPLOYEE EXPENSES	**56,709**	**52,696**	**4,013**	**53,596**	**48,053**	**5,543**

7.1 Average number of persons employed (WTE Basis)

	2019/20			2018/19		
	Total	Permanently Employed	Agency	Total	Permanently Employed	Agency
	Number	Number	Number	Number	Number	Number
Medical and dental	128	107	21	130	105	25
Administration and estates	414	370	44	397	349	48
Healthcare assistants and other support staff	161	137	24	149	122	27
Nursing, midwifery and health visiting staff	282	235	47	270	210	60
Scientific, therapeutic and technical staff	122	108	14	128	109	19
TOTAL PERSONS EMPLOYED	**1,107**	957	150	**1,074**	895	179

Note: the information above relates to Trust employees only as the associated charity which has been consolidated into these accounts does not employ any staff.

7.2 Staff Cost reconciliation to operating expenses note

	Consolidated	
	Year Ended 31 March 2020 £000	**Year Ended 31 March 2019 £000**
Employee expenses - Executive Directors	658	875
Employee expenses – Staff	56,051	52,721
Total Employee expenses	**56,709**	**53,596**

7.3 Exit packages

During the year to 31 March 2020 there were no payments made to staff in relation to exit packages, (31 March 2019, nil)

7.4 Retirements due to ill health

During the year to 31 March 2020 there were no early retirements from the Trust agreed on the grounds of ill-health, (31 March 2019, nil).

8 Intangible assets

	Software licences (purchased) £000	Assets under construction	Total £000
Gross cost at 1 April 2019	2,537	24	2,561
Additions - purchased	67	0	67
Reclassifications	266	(24)	242
Gross cost at 31 March 2020	**2,870**	**0**	**2,870**
Amortisation at 1 April 2019	1,172	0	1,172
Provided during the year	372	0	372
Amortisation at 31 March 2020	**1,544**	**0**	**1,544**
Net book value			
NBV - Purchased at 31 March 2020	1,326	0	1,326
NBV total at 31 March 2020	**1,326**	**0**	**1,326**

	Software licences (purchased) £000	Assets under construction	Total £000
Gross cost at 1 April 2018	1,554	59	1,613
Additions - purchased	945	(25)	920
Reclassifications	38	(10)	28
Gross cost at 31 March 2019	**2,537**	**24**	**2,561**
Amortisation at 1 April 2018	930	0	930
Provided during the year	242	0	242
Amortisation at 31 March 2019	**1,172**	**0**	**1,172**
Net book value			
NBV - Purchased at 31 March 2019	1,365	24	1,389
NBV total at 31 March 2019	**1,365**	**24**	**1,389**

This note relates to the Trust only as the Charity does not hold any intangible assets.

Reclassifications are between property, plant and equipment and intangible assets (see note 9)

The minimum and maximum useful economic lives of intangibles are 3 years and 10 years respectively. Useful economic lives reflect the total life of an asset, not the remaining life.

9 Property, plant and equipment for the year ended 31 March 2020

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and POA £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2019	**56,803**	5,021	32,722	825	433	11,916	20	5,775	91
Additions - purchased	**1,838**	0	709	0	0	808	0	321	0
Additions - donated	**204**	0	204	0	0	0	0	0	0
Impairments charged to operating expenses	**(1,619)**	0	(1,375)	(244)	0	0	0	0	0
Reversal of impairments credited to operating expenditure	**1,017**	0	1,017	0	0	0	0	0	0
Impairments charged to the revaluation reserve	**(1,025)**	0	(1,025)	0	0	0	0	0	0
Reclassifications	**(242)**	0	(129)	0	(275)	(79)	0	241	0
Revaluation	**(905)**	0	(879)	(26)	0	0	0	0	0
Disposals	**0**	0	0	0	0	0	0	0	0
Cost or Valuation at 31 March 2020	**56,071**	**5,021**	**31,244**	**555**	**158**	**12,645**	**20**	**6,337**	**91**
Accumulated depreciation at 1 April 2019	**10,674**	0	0	0	0	7,929	18	2,643	84
Provided during the year	**2,322**	0	879	26	0	691	2	720	4
Revaluation	**(905)**	0	(879)	(26)	0	0	0	0	0
Disposals	**0**	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2020	**12,091**	**0**	**0**	**0**	**0**	**8,620**	**20**	**3,363**	**88**
Net book value									
NBV - Purchased at 31 March 2020	**41,290**	5,021	28,813	555	158	3,766	0	2,974	3
NBV - Finance lease at 31 March 2020	**151**	0	0	0	0	151	0	0	0
NBV - Donated at 31 March 2020	**2,539**	0	2,431	0	0	108	0	0	0
NBV total at 31 March 2020	**43,980**	**5,021**	**31,244**	**555**	**158**	**4,025**	**0**	**2,974**	**3**

This note relates to the Trust only as the Charity does not hold any property, plant and equipment.

There is no restriction by the Donor on the use of donated assets.

9.1 Economic lives of property, plant and equipment

The minimum and maximum useful economic lives of each class of asset are given in the table below. Useful economic lives reflect the total life of an asset, not the remaining life.

Type	Min Life Years	Max Life Years
Land	N/A	N/A
Buildings excluding Dwellings (as per valuer's report 31 March 2020)	24	56
Dwellings (as per valuer's report 31 March 2020)	29	29
Transport equipment	7	7
Information Technology	3	10
Furniture & Fittings	2	5
Plant & machinery – Engineering plant & equipment	5	15
Plant & machinery – Medical Equipment	2	15

9.2 Property, plant and equipment for year ended 31 March 2019

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and POA £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2018	**57,141**	5,021	34,183	819	1,917	11,086	20	4,004	91
Additions - purchased	**1,946**	0	461	0	(10)	859	0	636	0
Additions - donated	**334**	0	0	0	334	0	0	0	0
Impairments charged to operating expenses	**(783)**	0	(704)	(79)	0	0	0	0	0
Impairments charged to the revaluation reserve	**(1,126)**	0	(1,126)	0	0	0	0	0	0
Reclassifications	**(28)**	0	542	103	(1,808)	0	0	1,135	0
Revaluation	**(652)**	0	(634)	(18)	0	0	0	0	0
Disposals	**(29)**	0	0	0	0	(29)	0	0	0
Cost or Valuation at 31 March 2019	**56,803**	**5,021**	**32,722**	**825**	**433**	**11,916**	**20**	**5,775**	**91**
Accumulated depreciation at 1 April 2018	**9,532**	0	0	0	0	7,234	16	2,204	78
Provided during the year	**1,823**	0	634	18	0	724	2	439	6
Revaluation	**(652)**	0	(634)	(18)	0	0	0	0	0
Disposals	**(29)**	0	0	0	0	(29)	0	0	0
Accumulated depreciation at 31 March 2019	**10,674**	**0**	**0**	**0**	**0**	**7,929**	**18**	**2,643**	**84**
Net book value									
NBV - Purchased at 31 March 2019	**43,162**	5,021	30,472	825	99	3,604	2	3,132	7
NBV - Finance lease at 31 March 2019	**264**	0	0	0	0	264	0	0	0
NBV - Donated at 31 March 2019	**2,703**	0	2,250	0	334	119	0	0	0
NBV total at 31 March 2019	**46,129**	**5,021**	**32,722**	**825**	**433**	**3,987**	**2**	**3,132**	**7**

This note relates to the Trust only as the Charity does not hold any property, plant and equipment.

There is no restriction by the Donor on the use of donated assets.

9.3 Gains/(Impairments)

	Total 31 March 2020 £000	Operating expenses £000	Revaluation reserve £000
Changes in market place	(1,627)	(602)	(1,025)
TOTAL (IMPAIRMENTS)/GAINS AT 31 March 2020	**(1,627)**	**(602)**	**(1,025)**

	Total 31 March 2019 £000	Operating expenses £000	Revaluation reserve £000
Changes in market place	(1,909)	(783)	(1,126)
TOTAL IMPAIRMENTS AT 31 MARCH 2019	**(1,909)**	**(783)**	**(1,126)**

This note relates to the Trust only as the charity does not hold any assets.

10 Investments

	Consolidated	
	2020	**2019**
Fixed Asset Investments:	**£000**	**£000**
Market value at 1 April	755	757
Additions	146	0
Net loss on revaluation	(105)	(2)
Market value at 31 March	**796**	**755**
Historic cost at 31 March	**931**	**785**

Market value at 31 March	**31 March 2020 £000**	**31 March 2019 £000**
Securities - managed funds	796	755
	796	**755**

Analysis of gross income from investments

Total gross income	**31 March 2020 £000**	**31 March 2019 £000**
Investments in a Common Deposit Fund or Common Investment Fund	**32**	**32**

Note: all investments are held by the Trust's associated charity which has been consolidated into these financial statements.

11 Inventories

	Consolidated	
	31 March 2020	**31 March 2019**
	£000	**£000**
Inventories	6,690	6,752
TOTAL INVENTORIES	**6,690**	**6,752**

	31 March 2020	**31 March 2019**
	£000	**£000**
Inventories recognised in expenses	5,001	5,916
Write-down of inventories recognised as an expense	2	17
TOTAL	**5,003**	5,933

This note relates to the Trust only as the Charity does not hold any inventories.

12 Trade receivables and other receivables

	Consolidated		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Current				
Contract receivables	7,729	6,812	7,729	6,812
Accrued income	763	1,042	763	1,042
Allowance for impaired contract receivables / assets	(797)	(746)	(797)	(746)
Prepayments	856	575	856	575
Interest receivable	0	1	0	1
PDC dividend receivable	19	130	19	130
VAT receivable	740	82	740	82
Other receivables	748	843	748	843
NHS charitable funds: trade and other receivables	12	1	0	0
Total current receivables	**10,070**	**8,740**	**10,058**	**8,739**
Of which receivable from NHS and DHSC group bodies:				
Current	7,550	6,449	7,550	6,449
Non-current	0	0	0	0

12.1 Allowance for credit losses

Note 29.2 Allowances for credit losses - 2019/20

	Consolidated and Trust	
	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April 2019	746	0
Changes in existing allowances	51	0
Allowances as at 31 March 2020	**797**	**0**

	Consolidated and Trust	
	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April 2018	0	894
Impact of implementing IFRS 9 (and IFRS 15) on 1 April	894	(894)
New allowances arising	40	0
Reversals of allowances	(188)	0
Allowances as at 31 March 2019	**746**	**0**

13 Other current assets

13.1 Short-term investments and deposits

The Consolidated group held short-term cash deposits within a multi-asset fund of £8,000 (2018/19: £123,000) managed by Cazenove Capital. The Trust does not hold any short-term cash deposits (2018/19: £nil).

14 Cash and cash equivalents

	Consolidated		Trust only	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Cash and cash equivalents at 1 April	3,763	5,217	2,655	3,751
Net change in year	(2,292)	(1,454)	(1,992)	(1,096)
Cash and cash equivalents at 31 March	1,471	3,763	663	2,655
Broken down into:				
Cash at commercial banks and in hand	808	1,108	0	0
Cash with the Government Banking Service	663	2,655	663	2,655
Cash and cash equivalents as in Statement of Financial Position and Statement of Cash Flows	**1,471**	**3,763**	**663**	**2,655**

15 Trade and other payables

	Consolidated		Trust only	
	Financial liabilities		Financial liabilities	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
NHS Payables	5,550	6,190	5,550	6,190
Trade payables - capital	519	495	519	495
Social security costs	596	560	596	560
Taxes payable	537	539	537	539
Other trade payables	5,609	6,499	5,609	6,499
Accruals	1,168	1,346	1,156	1,204
TOTAL TRADE AND OTHER PAYABLES	**13,979**	15,629	**13,967**	15,487

Other Trade Payables include outstanding pension contributions of £703,000 at 31 March 2020 (31 March 2019: £608,000).

15.1 Other liabilities

	Consolidated and Trust			
	Current		Non-Current	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Deferred income	250	210	0	0
TOTAL OTHER LIABILITIES	**250**	210	**0**	0

15.2 Borrowings

	Consolidated and Trust			
	Current		Non-Current	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
DHSC Loan	19,771	22	0	9,377
Third Party Loans	636	590	687	1,362
Obligations under finance leases	118	114	34	152
TOTAL BORROWINGS	**20,525**	726	**721**	10,891

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £19,771,000 which are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

The interest rates applicable in relation to the third-party loans are 3.64% and 4.5%. The Trust is currently making principal and interest repayments in relation to these loans and they will be fully repaid by February 2023.

15.3 Finance lease obligations

	Consolidated and Trust			
	Net lease liabilities		Gross lease liabilities	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Within one year	118	114	118	129
Between one and five years	34	152	34	188
After five years	0	0	0	0
	152	266	**152**	317
Included in:				
Current borrowings	118	114		
Non-Current borrowings	34	152		
	152	266		

The finance lease is in relation to an MRI scanner.

15.4 Reconciliation of liabilities arising from financing activities

	DHSC loans £000	Other loans £000	Finance leases £000	Total liabilities from financing activities £000
Carrying value at 1 April 2019 - brought forward	9,399	1,952	266	**11,617**
Cash movements:				
Financing cash flows - principal	10,341	(628)	(114)	**9,599**
Financing cash flows - interest (for liabilities measured at amortised cost)	(164)	(30)	(7)	**(201)**
Non-cash movements:				
Additions	0	0	0	**0**
Interest charge arising in year (application of effective interest rate)	195	30	7	**232**
Other changes	0	0	0	**0**
Carrying value at 31 March 2020	**19,771**	**1,324**	**152**	**21,247**

16 Provisions

	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2019	10	289	299
Arising during the year	60	622	682
Utilised during the year	(5)	(21)	(26)
Reversed unused during the year	(5)	(30)	(35)
Unwinding of discount	0	12	12
At 31 March 2020	**60**	**872**	**932**
Expected timing of cash flows:			
not later than one year	60	346	406
later than one year and not later than five years	0	28	28
later than five years	0	498	498
Total expected timing of cash flows	**60**	**872**	**932**

	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2018	10	517	527
Arising during the year	0	0	0
Utilised during the year	0	(81)	(81)
Reversed unused during the year	0	(27)	(27)
Unwinding of discount	0	(120)	(120)
At 31 March 2019	**10**	**289**	**299**
Expected timing of cash flows:			
not later than one year	10	74	84
later than one year and not later than five years	0	49	49
later than five years	0	166	166
Total expected timing of cash flows	**10**	**289**	**299**

This note relates to the main Trust only as the Charity does not hold any provisions.

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 NHS Resolution depending on the incident date.

Early retirement provisions are discounted using HM Treasury's pension discount rate of minus 0.50% (2018/19: positive 0.29%) in real terms. All 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 2019/20: -

Short-term (less than one year)	0.76%
Medium-term (one – five years)	1.14%
Long-term (later than 5 years)	1.99%

Other claims also include a new dilapidations provision in relation to the modular theatres lease.

NHS Resolution as at 31 March 2020 has £4,909,000 (2018/19: £5,308,632) in respect of clinical negligence liabilities of the Trust included in its accounts. The cost of these liabilities would be paid for by NHS Resolution.

17 Contractual Capital Commitments

	Consolidated & Trust	
	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	1,238	1,538
TOTAL CONTRACTUAL CAPITAL COMMITMENTS	**1,238**	1,538

Capital commitments include £572,000 in relation to the development of an onsite laboratory which is being donated by the associated charity, £162,000 in relation of the development of the Knowledge hub to support the training of students from Aston University, £60,000 in relation to a mini C-Arm, £102,000 in relation to general IT upgrades, and £314,000 in relation to general site building works.

18 Revaluation Reserve

	Revaluation Reserve - Property, plant and equipment
	£000
Revaluation reserve at 1 April 2019	3,593
Revaluation loss	(1,025)
Revaluation reserve at 31 March 2020	**2,568**

	£000
Revaluation reserve at 1 April 2018	4,719
Revaluation loss	(1,126)
Revaluation reserve at 31 March 2019	**3,593**

This note relates to the Trust only as the Charity does not hold and assets subject to revaluation.

19 Contingent Liabilities

The Trust is highlighting a contingent liability that relates wholly to an ongoing employment court case in relation to employee's accruing annual leave in relation to overtime hours worked. The Trust has calculated its current liability to be £50,000 (2018/19: £nil). This court case is not directly with the Trust but the outcome will impact all NHS organisations. The timing of the court case and any subsequent rulings is currently unknown.

20 Events after the reporting period

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £19,771,000 as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

The Consolidated Group does not have any other disclosable events which have occurred after the end of the reporting period.

21 Related party Transactions

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 (now NHS Improvement) 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 consolidated group's ultimate controlling party is the Department of Health and Social Care. 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.

Under IAS 24 entities which are related parties because they are under the same governmental control are permitted to give reduced disclosures on those transactions. This note has therefore been prepared under this basis.

The Trust has had material dealings with the following bodies during 2019/20:

Birmingham Community Healthcare NHS Foundation Trust
Birmingham Women's and Children's Hospital NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
Sandwell And West Birmingham Hospitals NHS Trust
St Helens and Knowsley Hospital Services NHS Trust
Walsall Healthcare NHS Trust
NHS Birmingham and Solihull CCG
NHS Cambridgeshire and Peterborough CCG
NHS Cannock Chase CCG
NHS Coventry and Rugby CCG
NHS Derby and Derbyshire CCG
NHS Dudley CCG
NHS East Staffordshire CCG
NHS Gloucestershire CCG
NHS Herefordshire CCG
NHS North Staffordshire CCG
NHS Redditch and Bromsgrove CCG
NHS Sandwell and West Birmingham CCG
NHS Shropshire CCG
NHS South East Staffs and Seisdon Peninsula CCG
NHS South Warwickshire CCG
NHS South Worcestershire CCG
NHS Stafford and Surrounds CCG
NHS Walsall CCG
NHS Warwickshire North CCG
NHS West Leicestershire CCG
NHS Wolverhampton CCG
NHS Wyre Forest CCG
NHS Resolution (formerly NHS Litigation Authority)
NHS England - West Midlands Specialised Commissioning Hub
Department for Work and Pensions
HM Revenue & Customs - VAT
HM Revenue & Customs - Other taxes and duties and NI contributions
NHS Pension Scheme

The Trust has had material dealings with the following bodies during 2018/19:

Birmingham Women's and Children's Hospital NHS Foundation Trust
Department of Health and Social Care
Health Education England
HM Revenue & Customs
NHS Birmingham and Solihull CCG
NHS Dudley CCG
NHS England - West Midlands Specialised Commissioning Hub
NHS Pension Scheme
NHS Redditch and Bromsgrove CCG
NHS Resolution (formerly NHS Litigation Authority)
NHS Sandwell and West Birmingham CCG
NHS South East Staffs and Seisdon Peninsular CCG
NHS South Worcestershire CCG
NHS Walsall CCG
NHS Wyre Forest CCG
University Hospitals Birmingham NHS Foundation Trust
Welsh Assembly Government

The Trust has also received revenue payments from the associated charitable funds where the Trustees are also members of the NHS Trust Board. The Trust charged the charity for finance administration services totalling £14,774 during the year (2018/19: £14,040).

22 Third Party Assets

The Trust held £21,000 in relation to advance payments from private patients in relation to treatment which is yet to take place (2019/20 £2,000). These payments have been included within the Trust's financial statements for 2019/20.

23 Financial Instruments

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 on a rotational basis.

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. Due to COVID-19 normal payments by results contracts have moved to block contracts which has reduced the credit risk further in relation to public sector bodies.

The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the Trade Receivables and Other Receivables note.

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.

Due to COVID-19 normal payments by results contracts have moved to block contracts which has reduced the credit risk further. The Trust will also receive cash from the Financial Recovery Fund to enable to the Trust to achieve a break-even position for 2020/21.

Set out above is an analysis, by category, of the Trust's financial assets and liabilities as at 31 March 2020. Fair value approximates to the book value because of the short maturity of these instruments.

23.1 Financial Assets

		Consolidated			
	Notes	Carrying value 31 March 2020 £000	Fair value 31 March 2020 £000	Carrying value 31 March 2019 £000	Fair value 31 March 2019 £000
Current financial assets					
Receivables - with NHS and DHSC bodies	**12**	7,207	7,207	6,313	6,313
Receivables - with other bodies	**12**	1,248	1,248	1,461	1,461
Investments	**10**	796	796	755	755
Short term investments and deposits	**13.1**	8	8	123	123
Cash and cash equivalents	**14**	1,471	1,471	3,763	3,763
TOTAL FINANCIAL ASSETS		**10,730**	**10,730**	12,415	12,415

		Trust only			
		Carrying value 31 March 2020 £000	Fair value 31 March 2020 £000	Carrying value 31 March 2019 £000	Fair value 31 March 2019 £000
Current financial assets					
Receivables - with NHS and DHSC bodies	**12**	7,207	7,207	6,313	6,313
Receivables - with other bodies	**12**	1,236	1,236	1,460	1,460
Cash and cash equivalents	**14**	663	663	2,655	2,655
TOTAL FINANCIAL ASSETS		**9,106**	**9,106**	10,428	10,428

All financial assets are held at amortised cost.

23.2 Financial Liabilities

		Consolidated			
		Carrying value 31 March 2020	Fair value 31 March 2020	Carrying value 31 March 2019	Fair value 31 March 2019
	Notes	£000	£000	£000	£000
Current financial liabilities					
Borrowings excluding finance leases	**15.2**	20,407	20,407	612	612
Obligations under finance leases	**15.2**	118	118	114	114
Trade and other payables	**15**	12,843	12,843	14,530	14,530
		33,368	33,368	15,256	15,256
Non-current financial liabilities					
Borrowings excluding finance leases	**15.2**	687	687	10,739	10,739
Obligations under finance leases	**15.2**	34	34	152	152
TOTAL FINANCIAL LIABILITIES		**34,089**	**34,089**	26,147	26,147

		Trust only			
		Carrying value 31 March 2020	Fair value 31 March 2020	Carrying value 31 March 2019	Fair value 31 March 2019
		£000	£000	£000	£000
Current financial liabilities					
Borrowings excluding finance leases	**15.2**	20,407	20,407	612	612
Obligations under finance leases	**15.2**	118	118	114	114
Trade and other payables	**15**	12,832	12,832	14,388	14,388
		33,357	33,357	15,114	15,114
Non-current financial liabilities					
Borrowings excluding finance leases	**15.2**	687	687	10,739	10,739
Obligations under finance leases	**15.2**	34	34	152	152
TOTAL FINANCIAL LIABILITIES		**34,078**	**34,078**	26,005	26,005

All financial liabilities are held at amortised cost.

24 Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. The table below records the losses and special payments incurred by the Trust by the type of loss/special payment category:

	2019/20 Total number of cases Number	2019/20 Total value of cases £000	2018/19 Total number of cases Number	2018/19 Total value of cases £000
LOSSES:				
1. Losses of cash due to:				
a. theft, fraud etc	1	0	2	0
c. other causes *	2	0	0	0
2. Fruitless payments and constructive losses	1	1	0	0
3. Bad debts and claims abandoned in relation to:				
c. other	1	0	0	0
4. Damage to buildings, property etc. (including stores losses) due to:				
c. other	1	0	0	0
TOTAL LOSSES	**6**	**1**	**2**	**0**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	1	5	0	0
7. Ex gratia payments in respect of:				
a. loss of personal effects	1	0	2	0
e. Other employment payments (should not include special severance payments which are disclosed below)	1	3	0	0
g. other	5	0	7	1
TOTAL SPECIAL PAYMENTS	**8**	**8**	**9**	**1**
TOTAL LOSSES AND SPECIAL PAYMENTS	**14**	**9**	**11**	**1**

For the period ending 31 March 2020 the Trust had 14 (31 March 2019: 11) separate losses and special payments, totaling £9,000 (31 March 2019: £1,000).

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.

25 Auditor's Liability

The auditor has a limitation of their liability in accordance with their engagement letter signed on 5 February 2019 for the amount of £1 million.

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Annual Report & Accounts 2019/20

Prepared by the Communications Team
roh.comms@nhs.net