NHS

The Royal Orthopaedic Hospital

NHS Foundation Trust

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ANNUAL REPORT AND ACCOUNTS

2020 - 2021

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Annual Report & Accounts 2020/21

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

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Chair and Chief Executive's introduction

2020/21 has been a year of unprecedented circumstances, not only for the Royal Orthopaedic Hospital but for the NHS as a whole. We have seen the NHS experience some of its most challenging times since it was first established in 1948 but also on a positive note, we have also seen how effective the NHS can be and the true dedication of the staff it employs. The impact of the crisis has been significant and has required a number of adaptations to the ROH's usual working practices and patient care. It is important however, that these challenges do not overshadow the incredibly important and innovative work that has been delivered despite these circumstances at the Trust over the past year.

The Trust was not inspected by the CQC during the year given the pause nationally in the inspection programme to allow organisations the time and space to focus on the response to the pandemic. The Trust therefore remains rated as 'Good' across all domains. We did however, undergo an assessment by an external agent to check compliance with the NHS Improvement Well Led framework, a requirement for all NHS foundation trusts every 3-5 years. The outcome of the assessment was presented to the Trust Board over the summer and it showed a positive picture about how the Trust is run and the strength of the governance arrangements in the organisation.

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 improvements in areas around Equality, Diversity and Inclusion, Immediate Managers and bullying and harassment. There were a number of areas, however where we did see a slight deterioration and an action plan is being developed, with wide engagement across the Trust, to implement measures to reverse this picture. Of most significance was the completion rate for the survey being 56%, this being a year on year increase in the response rate from 41% in 2018/19 and 51% in 2019/20.

Following events in Autumn 2019 associated with the Paediatric oncology service that was being run at Birmingham Children's Hospital (BCH), the service was paused to allow for proper review and further refinement of the care pathway. The impact of the COVID 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, for helping us treat our patients during this phase. The service restarted at Birmingham Women's and Children's NHSFT in April 2021.

The Trust has continued to be an active member of the Birmingham and Solihull (BSol) system over the year and has worked closely with local partners to address some of the in-year challenges, most notably the adjustments required as a result of the national legislation to bring into being the Integrated Care Systems (ICS). This will be a matter of significant focus as the BSol ICS develops over the coming months in readiness for its establishment as a legal entity which is expected to take effect from April 2022.

In terms of Board and Executive Team composition, the most significant change was the departure of Yve Buckland as our Chair. We are proud however, that Yve was successful in being appointed to the role of Chair of the BSol ICS, a huge credit to her ability and reputation in the system. Tim Pile, the Board's Vice Chair and Senior Independent Director (SID) was appointed by the Council of Governors to succeed Yve in the role as Chair from January 2021. We wish Yve every success in her new role. During the year the Board also said farewell to Rod Anthony, Audit Committee Chair whose term of office concluded in November 2020. The Council of Governors appointed two new Non-Executive Directors: Gianjeet Hunjan, an experienced qualified accountant, to replace Rod Anthony as Chair of the Audit Committee, and Les Williams, a former longstanding NHS Director who offers a rich skill set and experience in commissioning, strategy and operational management. Ayodele Ajose and Simone Jordan were also confirmed as substantive Non-Executive Directors during the year.

Given the national social distancing requirements imposed as a result of the COVID pandemic, it was difficult during the year to host physical events and celebrations. As the country returns to a degree of normality, the ROH will in its true style celebrate together. Despite the difficulties, we acknowledged International Nurses' Day and Operating Department Practitioner (ODP) Day in May 2020. The Trust also marked the NHS 72nd birthday in July 2020 and lit the hospital in blue light in commemoration of this. Other events that we held during the year included a LGBTQ+ awareness week, organised to promote the inclusive culture we value at the ROH, including raising the new Progress flag, which displays the six rainbow colours of the traditional Pride flag but also incorporates a colourful chevron on the left edge made up of a black and a brown stripe representing marginalised groups of the LGBTQ (lesbian, gay, bisexual transgender and queer) community plus the pink, baby blue and white of the Transgender flag. The work of our equality & diversity network and the Multi Minority Ethnicity Group (MMEG) has been instrumental this year in achieving progress in making the ROH an inclusive and welcoming organisation for all.

The Trust launched an Enabling a Productive Inclusive Culture (EPIC) programme during the year, delivered by West Midlands Leadership Academy. The twelve-month programme supported inclusive learning amongst cohorts of all staff across the organisation and will conclude its final sessions during the coming year.

There was significant focus on health and wellbeing during the year as staff responded to the challenges of the COVID pandemic. There were a number of specific initiatives to keep staff engaged and in touch who were shielding at home or who were redeployed into other organisations to support the system response to the crisis. In addition to these, at the very start of the pandemic when there was national panic over food shortages, we ensured that staff at the ROH were offered some basic goods, such as milk and bread when some of the shelves in local supermarkets were empty of these provisions. In line with the national requirement, all staff were offered free parking, a benefit that we extended beyond that of many other NHS organisations. We welcomed back staff who had been redeployed towards the end of the financial year and thanked them for their dedication and collaborative working at such a

challenging time in a special ceremony. We have been pleased to offer all of our staff a Wellbeing Day in addition to their usual annual leave allowance as a mark of thanks for their efforts during the last year.

Key parts of our Health and Wellbeing offering this year were the COVID and 'flu vaccination programmes. The uptake of the 'flu vaccination reached in excess of 80% for frontline staff this year, a significant achievement and an improvement from the previous year's position. In January 2021 we also commenced our COVID vaccination service for all staff groups in line with the government's prioritisation approach. In just four days, over 75% staff received their first dose of the vaccine, with the second doses booked for the first couple of weeks of April. Thanks are offered to Steve Washbourne, Director of Finance and Julie Gardner, Assistant Director of Finance for leading this impressive programme which goes a long way to protecting our patients, the staff themselves and the general public against the virus.

We are delighted with some more accolades and achievements that the Trust has received during the year, the key highlight being ranked as number 43 within the Top 50 Inclusive Companies, an achievement which reflects the real progress we have made during the year with developing our inclusion agenda. The Trust's modular theatres set up was also entered into some national awards in September and November for 'Healthcare Project of the Year' and 'Best Modular Project'. Both awards were designed to recognise and reward innovation within the healthcare build environment.

We have been fortunate to have been joined in the year by a significant number of new staff into key positions, such as Victoria Clewer our Head of Infection Prevention and Control. Sarah Moulton was appointed as Deputy Chief Operating Officer for Division 1, supporting Marie Raftery, who was also confirmed in post as Deputy Chief Operating Officer for Division 2. We welcomed Dr Andy Toogood as Deputy Medical Director. Thanks are extended to Mr Jamie McKenzie who was appointed as the Guardian for Safe Working Hours.

In terms of the Council of Governors, there were a number of changes, as we said goodbye to Sue Arnott, one of our longstanding governors. We thanked her for all the dedication and time she has given to the ROH during her time as a governor, particularly as a routine observer at the Quality & Safety Committee. We welcomed back Tony Thomas, one of our former governors, who was elected as a member of the Birmingham & Solihull constituency. Two other new public governors joined us during the year, David Roy and Anne Waller and following a change to the Trust's constitution agreed by the Board during the year, we sought a representative from the local community in place of the local MP and were fortunate that Northfield Community Partnership put forward Maxine Shanahan, their Operations Director to sit on our Council of Governors. The Annual General Meeting was held in October which was a virtual event this year, broadcast through social media.

The hospital was given a real boost this year by the opening of the two further new modular theatres and a ward during the winter. When the Trust adapts to the new means of operating impacted by the COVID pandemic, the new areas will help to increase the capacity available for

treating our elective patients in these upgraded facilities and for the local system. In addition to this, the Board approved the purchase of a second MRI scanner which will be commissioned during the coming year and provide additional capacity for diagnostics for the ROH and system partners. Continuing with the theme of improved facilities, the Trust was proud to celebrate the refurbishment of the Knowledge Hub this year, the opening of which was held in August and we were delighted to be joined by Professor Anthony Hilton from Aston University, together with representatives from the architects and builders that oversaw the project. The refresh of the facility is truly impressive and creates a first-class space in which we can offer our much praised educational programme for clinical students from local educational establishments.

There was some key success with attracting funding into our Charity during the year, with over £6,000 raised in the Christmas appeal, this being the highest amount raised in a festive appeal to date. The Trust also received some significant funds from the NHS Charities Together, the funds raised by Sir Cpt Tom Moore during the country's period of lockdown. An initial amount of £100,000 was received which was used to introduce a patient entertainment system. Further funding was received as part of subsequent phases of the bid made. We offer many thanks to Ali Gray who has joined us as the Trust's Charity Manager and has led some incredible work this year.

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

Over the coming year we look forward to our continuing relationship with system partners as the ICS continues to mature and to address the challenges left by the pandemic as we progress through restoration and recovery plans to address the significant backlog of patients waiting to be treated. 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 work, both nationally and internationally. Some truly exciting work is planned going into the coming year with continued investment in the Trust's facilities and innovations, including new robotic technology and improved estates facilities.

As always, 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.

Tim Pile, Chairman

Jo Williams, Chief Executive

PERFORMANCE REPORT

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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 £110 million. It has fourteen operating theatres and 117 beds across six wards, eight of which are on a High Dependency Unit.

The Trust employs circa 1,200 staff including more than 80 Consultant medical staff, each supported by multi-disciplinary clinical teams including surgeons, nurses, anaesthetists, physiotherapists, radiologists, pathologists, occupational therapists and other clinical professionals.

When operating in normal times, only a small amount of emergency and urgent activity is undertaken, generally in the field of spinal disorders; the core business of the ROH is elective surgery, therefore under usual circumstances no trauma activity is usually undertaken in the early stages after injury. During the financial year covered by this report however, the Trust has supported a number of trauma pathways to enable the local system to respond effectively to the COVID pandemic and make best use of intensive care facilities in the region. 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 the 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 ambitions 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 Integrated Care System (ICS) to shape the future of musculoskeletal services and orthopaedic services across the city as the country emerges out of the COVID pandemic and restoration and recovery of services is concluded.

1.3 Planning for the future

The Trust's 'Strategy for Excellence' (2019/20 – 2023/24) was developed in line with a number of key strategic drivers, including the NHS Long Term Plan (published January 2019), the National Orthopaedic Alliance and working in partnership with the Birmingham and Solihull Sustainability & Transformation Partnership (STP). The Trust's vision to be the 'The First Choice for Orthopaedic Care' and the organisation's values of Respect, Compassion, Excellence, Pride, Openness and Innovation remain unchanged (from the previous five year strategy) however the main focus is around five key goals, known as the 'Five Ps':

5Ps	Objective	Where will we be by 2023/24
Patients	Safe, high quality patient care	• Recognised as delivering 'outstanding' care by the CQC • Continue to be in the top 10 hospitals in the country for patient experience, according to the CQC inpatient survey • Deliver sustained reductions in length of stay, making day case surgery a reality for joint procedures • Provide real time access to patients about their care via a patient portal • Regularly submit national grant applications and increase patient participation in research trials
People	A diverse, highly skilled and well supported workforce	• Recognised in the top quartile for staff engagement nationally • Increased diversity of the workforce • Expanded education, training opportunities to staff • Increased opportunities for staff to work across BSOL, through the creation of joint appointments • Development of new roles, including apprenticeship positions
Partnerships	Improved and integrated services	• The creation of an integrated care system for orthopaedic services • High quality orthopaedic care for patients, regardless of where they live or access services across BSOL • Public and patients routinely engaged in service redesign and improvement • Strong commercial and academic partnerships to drive research, education and innovation
Process	Productive and efficient processes	• Manage an increasing proportion of patients on follow-up at home and in community settings

		• Interoperable clinical systems, providing real time information for clinicians through a clinical portal • Theatres running at 95% list utilisation and 90% in-session utilisation, with an increase of at least 1 additional large joint case per list • Deliver effective processes for the identification and monitoring of cost improvement schemes • A high proportion of staff trained in and able to use continuous improvement
Performance	A sustainable future through growth and financial stability	• Upgraded estate, including four new theatres and a new 23 bedded ward • Increase the ROH share of orthopaedic activity across BSOL • Treat 95% patients within 18 weeks across all sub-specialities, exceeding the national target of 92% • See all patients in a maximum of 26 weeks across all sub-specialities • Financial sustainability secured, aligned to an integrated care system for orthopaedics

Although the impact of the global COVID pandemic has deferred some of the work planned in the Strategy for years 1-2, progress is anticipated during the coming year which will be reported to the Trust Board through a quarterly update.

The Trust Strategy is underpinned by a range of 'enabling strategies', one of which is the Clinical strategy. A new Clinical Strategy was developed in 2020-21 which aligns closely to the Trust's five year Strategy, and includes priorities and plans around the changing clinical landscape, increased Musculoskeletal (MSK) demand, meeting patients' expectations, delivering 'more for less', building partnerships through integration, and maximising digital innovation. Central to this strategy will be ROH leading the system wide reconfiguration of MSK services, including the development of a new MSK Academy.

The intention for 2021-22 is to focus on refreshing the five-year strategy in light of the newly formed Integrated Care System, and greater integration across health, social care and the voluntary sector. This will also reflect the challenges that have been posed through the COVID pandemic, and the ROH role in supporting elective backlog recovery for Birmingham and Solihull.

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 is aligned to the 'Five Ps' in the Trust's strategy and the key risks identified during the year and discussed by the Board during the year can be summarised as:

Patients

- There is a risk that there could be cross contamination of patients that are COVID-positive or COVID-possible with non-COVID patients within clinical areas, causing the spread of the virus in a clinical setting
- There is a reluctance by patients to undergo scheduled treatment as a result of the uncertainty created by the COVID pandemic
- There is an increased risk of patient harm for peri-operative patients testing positive for COVID. Patients with COVID have a significant morbidity and mortality.
- The suspension of the Paediatric Oncology service during 2020/21 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
- There is clear evidence that there is a disproportionate impact of COVID on individuals who are from a BAME (Black Asian & Minority Ethnic) background and those at higher risk or vulnerable due to age, gender, underlying health conditions and pregnancy. There is also evidence to suggest that BAME colleagues are less likely to speak up and raise concerns.
- There is a risk that sickness absence may increase as a result of staff exhaustion or emotional strain due to different working patterns and exposure to emotional or stressful situations during the COVID pandemic

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 as a result of a failure to agree a Free Trade Deal at the end of the Brexit transition period
- There is a risk of increased virus transmission and reproduction rates, leading to a second and further waves of the COVID pandemic creating operational pressures in the hospital
- There is a risk that there will be insufficient capacity to manage the activity from the new services being handled by the Trust as part of the restoration and recovery phase
- There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom.
- There is a risk that the current IT capacity and functionality will not support the new ways of working developed during the COVID response, such as virtual clinics, remote operation and videoconferencing

Performance

- The Trust fails to meet the national target of treating 92% and the number of patients waiting 52 weeks increases creating significant delays in patient treatment and as a result of cessation of elective activity mandated as part of the national response to the COVID pandemic
- There is a risk that as a consequence of the current 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

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

In addition to these risks, it should be highlighted that the Trust established a standalone risk register in respect of the potential impact of the COVID pandemic. This was reviewed by Board members on a weekly basis as the primary risk management tool during this exceptional period. In September 2020, the Board agreed that the risks on this risk register be either closed, migrated onto local risk registers, the Corporate Risk Register or the Board Assurance Framework and that the Board Assurance Framework be reinstated as the primary tool for monitoring strategic risk at the Board level.

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 the infection prevention and control framework within the Trust.

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 2020/21, 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 last 12 months have been a unique and challenging period for the NHS, having to initially respond to the COVID pandemic, but then also managing the consequences of it. For the Trust this meant the cancellation of all non-urgent elective activity, initially between March and June, and then again during November through to middle of February, with only a small recovery of activity being possible during the summer and March.

The financial framework across the NHS was also changed to facilitate this emergency response, with provider-based and then healthcare system-based block allocations replacing the normal activity-based tariff and contracting framework.

As such the Trust finished with a deficit of £1.102m, an improvement on a revised planned deficit of £2.568m.

1.6.1 Operational Performance

In March 2020 all non-urgent elective activity was cancelled as part of the system COVID response for Wave 1. Between April-June 2020 the pathways for fractured hips, ambulatory and hand trauma were all moved to the Trust to relieve pressure on UHB.

Whilst elective services were reinstated in July, this initial restoration phase of activity was interrupted in November with the start of Wave 2. The Trust once again became the receiving hospital for ambulatory and hand trauma, whilst some clinical staff also volunteered to support the anaesthetic and Intensive Therapy Unit (ITU) rota at UHB as part of the system response.

With elective services reopening in February, unfortunately the elective activity that the Trust would normally undertake has been significantly impacted. This can be seen in the reduction in performance against the Referral to Treatment Standard, and the increase in the numbers of patients waiting over 52 weeks (which had previously been zero).

Activity Undertaken 2019/20-2020/21

	Actual Treated 2020/21	**Actual Treated 2019/20**
Inpatients	4,212	6,643
Day cases	3,152	7,317
Total Admitted Patient Care	**7,364**	**13,960**
First Appointment	7,701	21,195
Follow Up Appointment	14,115	41,924
Outpatient Procedures	1,345	5,758
Total Outpatients	**23,161**	**68,877**

The Trust has an ambitious plan to recover activity through 2021/22.

Key Performance Indicators at the end of Q4 (March)

Key Performance Indicators	Target	Q4
% incomplete pathways less than 18 weeks	92%	58.27%
Number of patients waiting over 52 weeks	0	142
% urgent cancer referrals seen within 2 weeks wait	93%	100.0%
% patients treated within 31 days of decision to treat	96%	100.0%
% patients receiving subsequent treatment within 31 days (surgery)	94%	100.0%
% cancer patients treated within 62 days of urgent GP referral	85%	56.0%
% patients waiting less than 6 weeks for diagnostic test	99%	99.30%

Referral to Treatment

The Referral to Treatment (RTT) position for March is 58.27% against the National compliance target of 92%. This is reflective of the cessation of elective procedures during 2020/21 in order to undertake core critical services.

There are now 142 patients over 52 weeks. All these patients have or will be reviewed through the harm review process. No harm has been concluded on all patients to date.

Cancer Standards

Performance against the Cancer Standards has remained good all year despite the disruption caused to other elective services. At the end of Quarter 4, only the 62-Day Standard Target was not met, and this remains challenging due to the small number of patients being treated each month (an average of four 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 root 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.

Diagnostic standards

The 6-week diagnostics standard was also achieved at the end of Quarter 4 and reporting times remain some of the best when compared nationally.

1.6.2 Financial Performance

As has been discussed above, the 2020/21 financial year has been unique. In April 2020, NHS England and Improvement (NHSEI) announced the cessation of the normal financial planning and contracting process across the country. Instead, providers were given a fixed funding allocation. For the first half of the year, COVID related expenditure was reimbursed on a retrospective basis, but this was then also moved into a prospective allocation for the second half of the year.

Narrative to the Accounts

This section sets out the key features of the trust's financial performance in 2020/21. 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 the Group within the annual accounts and this commentary. The Group delivered a £1.172m retained deficit for 2020/21 as per the Statement of Comprehensive Income (SOCI). In previous years, a Control Total has been set for the Trust which adjusts the retained deficit for the Group and removes the impact of impairments, donated assets and the Trust's Charity. Although a Control Total was not set for 2020/21, this remains the method that is used to assess the Trust's financial performance.

Financial Performance 2017/18-2020/21

£000s	2020/21	2019/20	2018/19	2017/18
Operating Income (including PSF*)	110,513	87,937	87,460	81,979
Operating Expenses	(110,911)	(97,768)	(90,872)	(83,615)
Operating Surplus / (Deficit)	**(398)**	**(9,831)**	**(3,412)**	**(1,636)**
Net Finance Costs / Other gains and losses	(774)	(1,022)	(1,102)	(1,292)
Retained deficit for the year (per SOCI)	**(1,172)**	**(10,853)**	**(4,514)**	**(2,928)**
Control Total Adjustments:				
CQUIN risk reserve (16/17)				(232)
Reversal of impairments	(449)	602	783	(1,554)
Consolidation of charities	454	196	352	51
Donated assets	65	(159)	(272)	61
Control Total Surplus / (Deficit)	**(1,102)**	**(10,214)**	**(3,651)**	**(4,602)**
FRF** / PSF*	N/A	-	(2,464)	(1,844)
Control Total Deficit (excluding FRF/ PSF*)**	**(1,102)**	**(10,214)**	**(6,115)**	**(6,446)**
Control Total	N/A	(5,312)	(6,615)	(6,619)

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

The table above reconciles the surplus position reported in the Group's SOCI to the performance against its Control Total, and shows the Trust delivered a £1.102m deficit in year. The following control total adjustments are made:

- Impairments (£0.449m). 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, this generated a small net loss and is recognised in the accounts. This is detailed in Note 9.2 and shows a net loss of £0.449m being charged to the SOCI, whilst £0.471m is charged to the revaluation reserve;
- Consolidation of Charities (£0.454m). The accounts are provided in Group form. This adjusts to show Trust transactions only; and
- Donated assets income and depreciation (£0.065m)

The bottom of the SOCI also reflects other comprehensive income (and expenditure) that is not classified as Income and Expenditure. This includes the £0.471m charge to the revaluation reserve as discussed above.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust has met this requirement. Other income received in the financial year is used in support of the Trust's core services of treating orthopaedic patients.

Statement of Financial Position as at 31 March 2021 (SOFP)

The Statement of Financial Position sets out total assets employed by the Group and the Trust.

- Non-current assets (£1.904m increase) – due to purchase of equipment;
- Current assets (£0.942m reduction) – A reduction in the valuation of stock held by the Trust is offset by an increase in cash, leaving a reduction in the value of receivables.
- Current liabilities (£19.772m reduction) – due to a reduction in borrowing as Department of Health & Social Care (DHSC) / NHSE/I Revenue support loans were converted into Public Dividend Capital (PDC) in September 2020. As the conversion had been confirmed before March 2021, the categorisation of the loans had changed from non-current to current liabilities in the 2020/21 accounts.

Statement of Changes in Taxpayers' Equity

This statement reflects a £19.914m increase in the total assets of the Group from a taxpayer point of view, from £27.934m to £47.848m due to:

- Public Dividend Capital (£21.4m increase) – this includes £19.718m of loan re-financing (as above), and £1.682m of additional PDC received to support capital infrastructure.
- £0.471m impairment charge to revaluation reserve;
- £0.601m increase in Charitable Fund Reserve; and
- £1.172m retained deficit for the year.

Statement of Cash Flows for the year ended 31 March 2021

The Group ended 2020/21 with a cash balance of £6.962m, an increase of £5.491m on the previous year end cash balance.

Analytical Review of 2020/21 Annual Accounts

Review of Operating Income

The Group earned income of £110.498m in 2020/21, a rise of £22.561m compared to the previous year (2019/20, £87.937m), this is inclusive of all COVID reimbursement and provider top up funding received. Of this, £93.677m arose from patient care activities, with the remaining £16.821m generated from other operating income.

Review of Operating Expenses

The Group incurred operating expenses of £110.896m in 2020/21, a rise of £13.127m compared to the previous year (2019/20, £97.769m). Pay costs continue to account for most of the expenditure, with £58.997m or 53% (2019/20, £56.836m and 59%).

The increase in expenditure is attributable to the following factors:

- Pay costs increased by £2.141m;
- Purchase of Healthcare from non-NHS increased by £17.587m;
- Supplies & Services reduction by £14.082m;
- Operating Leases increased by £1.508m; and
- Premises expenditure increased by £1.786m.

In addition to Operating Expenditure, there is a net impairment charge of £0.449m.

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 2020/21 Department of Health and Social Care Group Accounting Manual (GAM) and the 2020/21 NHS Foundation Trust Annual Reporting Manual (FT ARM).

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 GAM 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 accounts 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 2022, although the wording of the standard is the foreseeable future and is often assessed as 18 months after the year end i.e September 2022.

In the current year, NHSE/I have confirmed that management's going concern assessment within the NHS can be based on an assessment of whether the services are anticipated to continue. 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, in addition to the huge growth in orthopaedic waiting lists across the UK as a result of the COVID pandemic.
Therefore, this need has 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 24 June 2021

Mrs Jo Williams
Chief Executive
24 June 2021

ACCOUNTABILITY REPORT

Section 1:

Directors' Report

1.0 Directors holding office during 2020/21

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). Resigned with effect from January 2021.

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 continues to act as Chair for Dudley Group of Hospitals NHS Foundation Trust. Yve took up

the post of Chair of the Birmingham and Solihull Integrated Care System (ICS) in January 2021 and resigned from her post as Chair of the Royal Orthopaedic Hospital.

Mr Timothy Pile – Chairman (January 2021 – Present). 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 January 2021). Appointed as Chairman in January 2021, with the first term of office in this role concluding in January 2024.

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.

Following Yve Buckland's resignation in January 2021, Tim, as approved by the Council of Governors, took up post as Chairman, with an initial term of office concluding on 1 January 2024.

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).

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. Jo is the lead Chief Executive for the National Orthopaedic Alliance.

Simone Jordan – Non-Executive Director & Vice Chair. (Term of Appointment as an Associate Non-Executive: 1 July 2017 – 30 June 2019 which was further extended for a further fixed term to 30 June 2020 and then to June 2021). Appointed as a substantive Non-Executive Director from October 2020 and Vice Chair from April 2021.

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.

Simone is Chair of the Staff Experience & Organisational Development Committee and the Nominations and Remuneration Committee.

Mrs Kathryn Sallah – Non-Executive Director & Senior Independent Director (Term of Appointment: First term of Appointment until 31 March 2018, extended until 31 March 2023)

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 consequently has also been the Midwifery Advisor to the Department of Health over several years. Kathryn has developed a keen interest in public health issues, which resulted in her successfully completing a Masters in Public Health at Birmingham University. She has held three 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.

Kathryn took up the role of Senior Independent Director from April 2021 and is also Chair of the Quality & Safety Committee.

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 concluded on 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.

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.

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

David 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.

David is Chair of the Charitable Funds Committee.

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 Masters 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.

Richard is Chair of the Finance & Performance Committee.

Ayodele Ajose – Non-Executive Director (Term of Appointment as an Associate Non-Executive Director: 1 November 2019 – 31 October 2020) Appointed as a substantive Non-Executive Director from 1 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.

Mrs Gianjeet Hunjan - Non-Executive Director (Term of Appointment: First term of Appointment until 30 September 2023)

Gianjeet was appointed as a Non-Executive Director at the Royal Orthopaedic Hospital NHS Foundation Trust on 1 October 2020 and is Chair of the Audit Committee.

Gianjeet is a qualified accountant with extensive experience in the NHS and Education sector. She started her career as a Regional Finance Trainee in the West Midlands and has worked at director level in a variety of health care finance roles within acute services, mental health, forensic sciences and primary care, principally in the West Midlands and North West regions. She has worked at Board level in both Executive and Non-Executive roles. Her interest in education, learning and training extended into Education and supporting businesses through her work with Business Links and the West Midlands Manufacturing Advisory Service.

In addition to her degree in Business Studies and accounting qualification, Gianjeet has a Master of Arts in Finance and Accounting from Leeds Metropolitan University.

Gianjeet is Chair of ACCEA West Midlands and a Governor for Oldbury Academy and Ferndale Primary School. She also serves as a Non-Executive Director for Birmingham and Solihull Mental Health NHS Foundation Trust.

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 and Director of Infection Prevention & Control

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.

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, as well as maintaining 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, 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 Trust's Accountable Emergency Officer (AEO), where he is accountable for leading on major emergency incidents and the implementation of the Trust's Major Incident response. Phil is also the Trust Designated Individual (DI) for Human Tissue and works closely with the Human Tissue Authority to ensure the Trust's compliance with the Human Tissue Act. Phil has led the recent redevelopment of the ROH estate including the new ward and theatres, new pharmacy, the Pre-Operative Assessment Centre (POAC), The Knowledge Hub and the Second MRI Scanner. He is also holds academic and research Chairs at the Universities of Kentucky and Farleigh Dickinson University (USA) and Brunel (UK). He has recently been awarded an Honorary Chair in Health and Life Sciences at Aston University. He has a significant history of senior management positions, which sit alongside a successful research and 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.

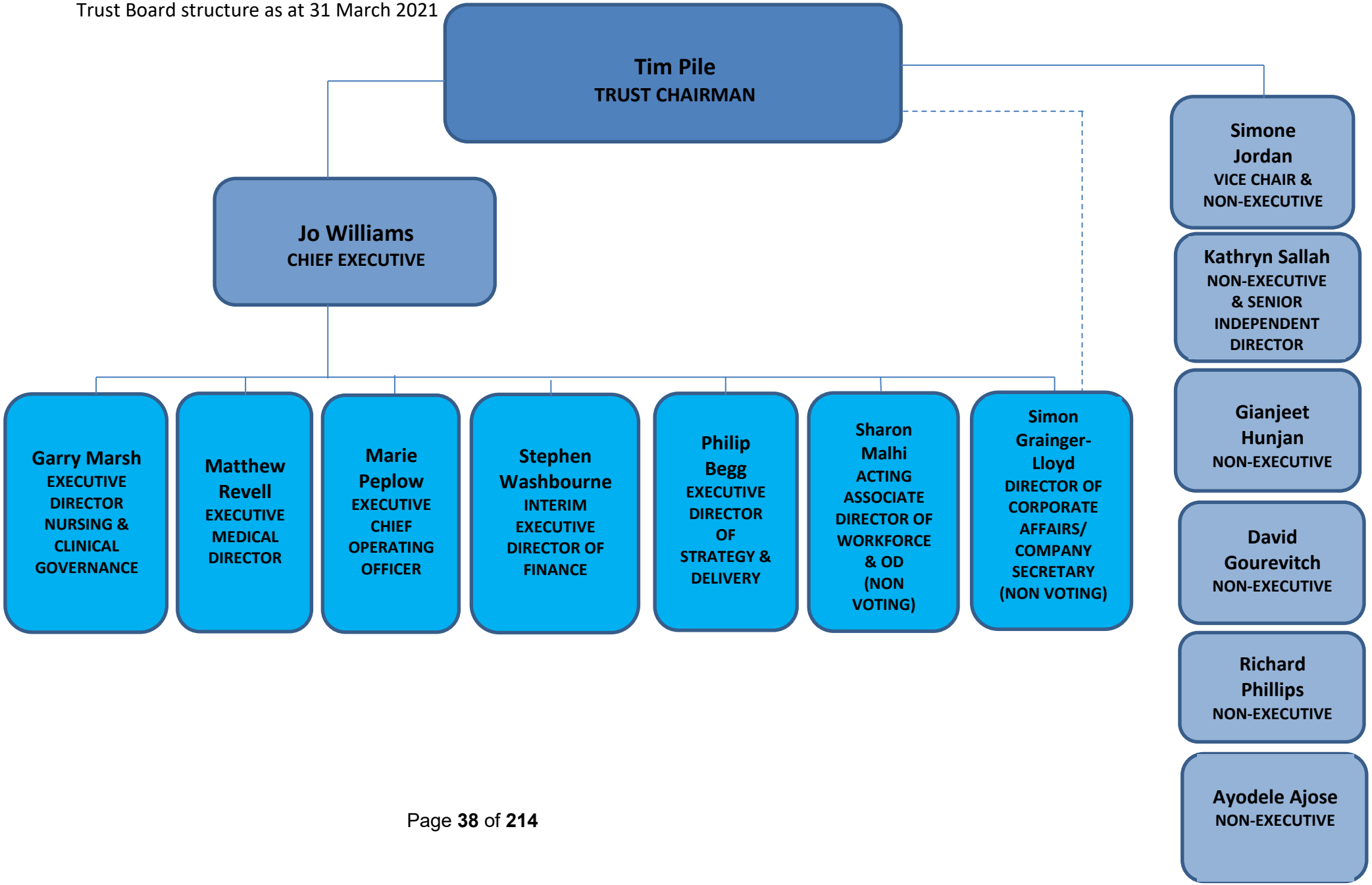
Simon is the ROH's Data Protection Officer. His other portfolio responsibilities include risk management, claims & litigation, Freedom to Speak Up, Freedom of Information and membership.

Mrs Sharon Malhi – Associate Director - Workforce & OD (Non-Voting)

Sharon Malhi joined the Trust in April 2019 and has worked as a Senior HR Professional for over 15 years. Sharon is an Alumni of the NHS HR Graduate Management Training Scheme and gained her membership of the CIPD in 2008 following successful completion of her Post

Graduate Diploma and went on to complete her MA in Human Resources in 2015. Her experience includes service within the public, private and voluntary sectors where she has led on Organisational Development, Learning and Development, Human Resources and Business Development initiatives and she is also a qualified coach, mentor and incident debriefer. She is a Trustee for Victoria Academies Trust and is Joint Senior Responsible Officer for the Leadership and Inclusion workstream across the Birmingham and Solihull Integrated Care System. Sharon was born in Bradford, grew up in Leeds and moved to the West Midlands in 2006.

Trust Board structure as at 31 March 2021



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 2021, 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, a Non-Executive with skills and experience in workforce and innovation & improvement and a Non-Executive with a legal background. The Council of Governors also appointed a new Non-Executive with significant operational, NHS commissioning and strategy experience who joined the Board from 1 April 2021. The Chairman has a wide range of experience in the private sector.

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 Directors 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, particularly at the Non Executive briefing sessions which were added into the Trust's corporate calendar at the start of the COVID pandemic.

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 held during the period of tenure as the ROH Chairman. Dame Yve was Interim Chair of Dudley Group of Hospitals NHS Foundation Trust. 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.

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

During the initial months of 2020/21 the Non-Executive cadre of the Board comprised five Non-Executive Directors, two Associate Non-Executive, plus the Chairman. From October 2020, the two Non-Executive Directors were appointed by the Council of Governors as substantive Board members.

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 appointment of Gianjeet Hunjan as a Non-Executive Director, replacing Rod Anthony as the Chair of the Audit Committee. The Council of Governors also approved the appointment of Leslie (Les) Williams as a new Non-Executive Director commencing from 1 April 2021. In December 2020, the Council of Governors supported the appointment of Tim Pile, former Vice Chair, as the substantive Chairman of the Trust.

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

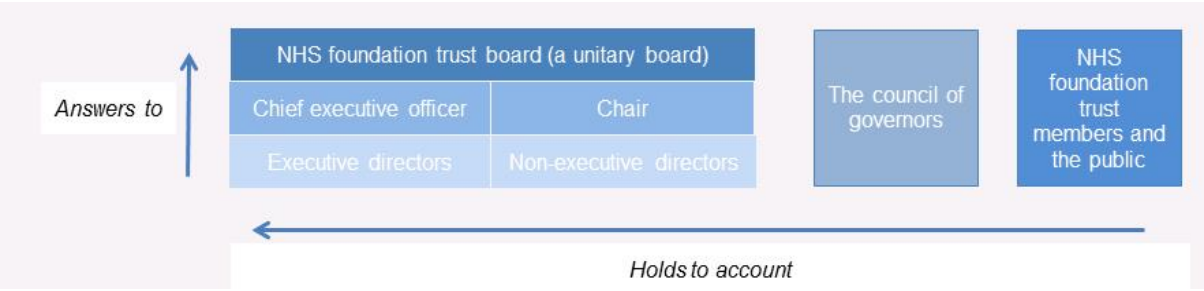
The Board of Directors comprises Executive Directors and Non-Executive Directors. The Executive Directors are employees, led by the Chief Executive Officer and they are responsible for the day-to-day management of the Trust.

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 Vice Chair who is Simone Jordan and a separate Senior Independent Director (SID), a position fulfilled by Kathryn Sallah. The appointment into these positions was approved by the Council of Governors during the year.

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/Managers.

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 he 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 NHS Improvement, 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 in usual times, 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 which operate during usual times, 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 when the organisation is operating in normal conditions.

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 2020/21 there was a continued focus on upward reporting on matters of positive assurance, risks or concerns requiring Board attention, decisions made at the meetings and major work commissioned or underway.

Within the year, in line with the national directive from NHS Improvement, a number of the Committee meetings were scaled back to allow sufficient time to focus on the operational response to the COVID pandemic. The key points of the assurance briefings which replaced the formal meetings continued to be reported to the Trust Board in public and the Quality & Safety Committee operated with a full agenda and reported up to the Board using the standard reporting template.

The Board was also subject to an external well led assessment, the details of which are described in detail in Section 1.15 and in the Annual Governance Statement.

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 during the year by the global COVID pandemic referenced in Section 1.10, when an interim set of governance arrangements was implemented that scaled back the scope of the Board and committee meetings. 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 and then again in early 2021 when the second wave of the pandemic impacted.

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 12 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.

MEMBER	ATTENDANCE										TOTAL
	6/5/2020	3/6/2020	1/7/2020	2/9/2020	7/10/2020	4/11/2020	3/12/2020	13/01/2021	3/02/2021	3/03/2021	
Yve Buckland (Ch)[#1]	✓	✓	✓	✓	✓	✓	✓	✓			8/8
Tim Pile (Ch)[#2]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Kathryn Sallah	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Rod Anthony	✓	✓	✓	✓	✓	✓					6/6
Richard Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
David Gourevitch	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Gianjeet Hunjan						✓	✓	✓	✓	✓	5/5
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Phil Begg	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Marie Peplow	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Stephen Washbourne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Sharon Malhi					✓	✓	✓	✓	A	✓	5/6
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10

KEY:

✓	Attended	A	Apologies tendered
	Not in post or not required to attend		
#1	Chairman until January 2021	#2	Chairman from January 2021

Board Committees

During 2020/21 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 (until November 2020) and Gianjeet Hunjan (from November 2020), who is a finance professional. During 2020/21 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
	11/05/20	19/06/20	24/07/20	21/10/20	22/01/21	
Rod Anthony (Ch)	✓	✓	✓	✓		**4/4**
Gianjeet Hunjan (Ch)					✓	**1/1**
Tim Pile	✓	✓	✓	✓		**4/4**
David Gourevitch	✓	✓	✓			**3/3**
Kathryn Sallah				✓	✓	**2/2**
Executive Directors in attendance						
Steve Washbourne	✓	✓	✓	✓	✓	**5/5**
Garry Marsh	✓	✓	✓			**3/3**
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	**5/5**

KEY:

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

During 2020/21, in line with its approved internal audit plan, the Trust commissioned a number of internal audit reviews. The internal auditors issued ten reports, five of which gave positive assurance (substantial or 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
Data Quality – Electronic Staff Record data	Partial
Human Tissue Act	Substantial
Data Quality – Patient Administration System	Advisory
Secure Remote Working	Reasonable
Clinical Audit	Partial
Data Security and Protection Toolkit	Agreed upon procedures
Health & Safety	Reasonable
Procurement	Reasonable
Freedom to Speak Up	Reasonable
Operational Risk Management & Governance	Advisory

During 2020/21 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 2020/21 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, albeit in a less formal way due to the slimmer agendas during the year as a result of the COVID response;
- During the year the Committee continued to operate with 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 and the Medical Director have also been regular attendees 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 was provided by RSM UK during the year 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. From May 2021, following a robust

procurement exercise, KPMG LLP will provide internal audit services, with the exception of counterfraud.

- In usual times, to strengthen the role of the Audit Committee in holding the Executive to account, a slot is 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. This practice will be reinstated from the summer of 2021.

In 2021/22, the Committee will consider a review of its effectiveness. Members and regular attendees of the Audit Committee will be issued with a questionnaire over summer 2021, 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 is based on approach set out in the Audit Committee Institute Audit Committee Handbook 2014.

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 Quality & Safety Committee meets most months and regularly reviews clinical risks through consideration of an extract of the Corporate Risk Register or 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 safeguarding, research & development 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 using the prescribed 'quadrant' format which has been embedded during the year which subgroup chairs use when they attend by rotation to present to the Committee. The effectiveness of the Committee has also been enhanced during the year by the establishment of a Quality & Safety Executive, which is designed to quality assure information being reported up to the Quality & Safety Committee and to handle some of the more operational matters previously considered by the Committee.

During the year, the Quality & Safety Committee undertook a stocktake of its effectiveness, which considered whether the Committee was performing the key duties of a Board subcommittee as set out in the Code of Governance for Foundation Trusts and also considered the workplans of equivalent committees in other organisations. The outcome resulted in amended programme of work for the committee but a high degree of assurance that the Committee was operating effectively and in line with best practice.

MEMBER	MEETING DATE											TOTAL
	29/4/20	27/5/20	24/6/20	29/7/20*	26/08/20**	30/09/20	28/10/20	25/11/20	27/01/21	24/02/21	31/03/21	
Kathryn Sallah (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/11**
David Gourevitch	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/11**
Simone Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/11**
Jo Williams	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	**10/10**
Garry Marsh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/11**
Matthew Revell	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	**10/10**
Marie Peplow	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	**10/10**
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/11**

KEY: ✓	Attended	A	Apologies tendered
	Not in post/not required	*	The July meeting was an assurance briefing
		**	The August meeting was a stock take meeting

Finance and Performance Committee

The Committee is chaired by Richard Phillips 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 August and December) and regularly reviews finance and performance-related risks through consideration of an extract of the Corporate Risk Register or the Board Assurance Framework.

A key area of focus for the Committee during the year was on the impact of the pandemic on the operational and financial performance of the Trust, particularly given the new pathways that needed to be supported and the amended financial regime. A standing item on the current Committee agendas is the work to 'Refresh and Recover' as the global pandemic recedes. The Committee also continued to receive upward reports from the IM&T Programme Board, the 'Perfecting Pathways' Programme Board Group and the Information Governance Group.

MEMBER	MEETING DATE										
	28/4/20*	26/5/20	23/6/20	28/7/20	29/9/20	23/10/20	24/11/20	26/1/21	23/2/21	30/3/21	
Tim Pile (Ch)	✓	✓	✓	✓	✓	✓	✓				**7/7**
Rod Anthony	✓	✓	✓	✓	A	✓	✓				**6/7**
Richard Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	**	✓	✓	**9/9**
Gianjeet Hunjan							✓	✓	✓	✓	**4/4**
Stephen Washbourne	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	**9/10**
Jo Williams	**	✓	✓	✓	✓	✓	✓	✓	✓	✓	**9/9**
Phil Begg	**	**	✓	✓	✓	✓	A	**	**	✓	**5/6**
Marie Peplow	✓	✓	✓	✓	✓	✓	✓	**	**	✓	**8/8**
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**

KEY:

✓	Attended	A	Apologies tendered
*	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, Simone Jordan and the Chief Executive is the executive lead. The Acting 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, such as the People Plan, Inclusion Strategy and Wellbeing Strategy. 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 or 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
	29/4/20	3/6/20	23/6/20	29/7/20	30/9/20	28/10/20	15/12/20	27/1/21*	24/2/21*	31/3/21*	
Richard Phillips (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Simone Jordan				✓	✓	A	✓	✓	✓	✓	**6/7**
Kathryn Sallah				✓	✓						**2/2**
David Gourevitch						✓	✓			✓	**3/3**
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**
Phil Begg				✓	A	A	✓				**2/4**
Garry Marsh				✓	✓	✓	✓				**4/4**
Matthew Revell				✓	✓	✓	✓				**4/4**
Marie Peplow				✓	✓	✓	✓				**4/4**
Simon Grainger-Lloyd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**10/10**

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 Head of OD & Inclusion, Acting Head of HR Operations 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 2020/21 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 COVID 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 October 2020 meeting. The Committee also considered and approved a new Charity Strategy and a Charitable Funds Committee governance improvement plan.

TRUSTEE	**MEETING DATE**			**TOTAL**
	19/6/20	21/10/20	10/3/21	
David Gourevitch (Ch)	✓	✓	✓	**3/3**
Rod Anthony	✓	✓		**2/2**
Simone Jordan	A	✓	✓	**2/3**
Kathryn Sallah	✓	✓	✓	**3/3**
Richard Phillips	A	A	✓	**1/3**
Yve Buckland				**0/0**
Tim Pile	A	A		**0/2**
Ayodele Ajose		✓	✓	**2/2**
Gianjeet Hunjan			✓	**1/1**
Garry Marsh	A	✓	✓	**2/3**
Stephen Washbourne	✓	✓	✓	**3/3**
Phil Begg	A	✓	A	**1/3**
Jo Williams	✓	✓	✓	**3/3**
Matt Revell	✓	✓	✓	**3/3**
Marie Peplow	A	✓	✓	**2/3**
Simon Grainger-Lloyd			✓	**1/1**

KEY:

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

Nominations and Remuneration Committee (Executive Directors)

The Nominations and Remuneration Committee is chaired by a Non Executive Director, Simone Jordan 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 once.

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	DATE 18/11/2020	TOTAL
Simone Jordan (Chair)	✓	1/1
Tim Pile	✓	1/1
Kathryn Sallah	✓	1/1
Rod Anthony	✓	1/1
Richard Phillips	✓	1/1
David Gourevitch	✓	1/1
Yve Buckland	✓	1/1
Ayodele Ajose	✓	1/1
Gianjeet Hunjan	✓	1/1
Jo Williams		0/0

KEY:

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

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 85.7% of non-NHS invoices (78.4% by value) within 30 days against the target of 95%. Of the remaining balance, 13.8% of invoices were paid late and 0.5% were paid late due to a dispute on the invoice. The Trust did not incur any late payment penalties during 2020/21 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 since its authorisation as a Foundation Trust. 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. The action plan developed in response to the recommendations made by the review was delivered to some degree during 2020/21 and is designed to create a strengthened leadership and governance model for the Trust. Further work will be undertaken during 2021/22 to deliver the actions identified.

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, which has been particularly enhanced by the establishment of the Quality & Safety Executive.

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 2021/22 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 2021/22 in line with the Risk Improvement Strategy developed in September 2020, particularly around better use of the electronic risk management solution, to deliver training on risk management more systematically and to create a higher level of awareness in the organisation about risk identification and management.

In normal times, 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 have been limited opportunities to undertake physical walkabouts during the year due to social distancing and infection prevention and control restrictions created by the pandemic, however the Chair of the Quality & Safety Committee has undertaken a number of virtual walkabouts, having conversations with patients through the use of a 'roving' iPad. 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 response. In addition to the Quality Assurance walkabouts, during the year a 'Chat & Check' Executive walkabouts initiative was established. This allows members of the Executive Team to visit all areas of the Trust by rotation in pairs and hold informal conversations with staff around their experience of working at the Trust which may identify quality issues that need to be handled.

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 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.

During the year, the Trust participated in an assurance inspection by the CQC against a set of key lines of enquiry specifically relating to the Trust's infection prevention and control framework during the pandemic. The outcome of this provided a high degree of assurance that

there were no gaps of significance in the ROH's approach to infection prevention and control during the pandemic.

1.17 Patient Care

The Trust has demonstrated significant progress in delivering its Quality Priorities for 2020/21, which included success in reducing the number of falls which cause harm at the Trust, improving the experience of patients, carers and service users, reducing the number of policies that are beyond their review date and reducing the number of times Outpatient clinic appointments are rescheduled.

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 four new improvement priorities for 2021/22, 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.

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree on payments to NHS Trusts based on delivery of improvement work.

Due to the COVID pandemic, NHS England introduced block payments for all trusts to provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract. This minimised the burden of formal contract documentation and contract management processes, so that staff could focus fully on the COVID response.

These block payments included CQUIN. The operation of CQUIN (both CCG and specialised) for trusts has been suspended for the period from April 2020 to March 2021; providers therefore did not take action to implement CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data.

The provision of Patient Experience services has continued to be monitored during the year; the transition of all Patient Experience data to the Patient Advisory Liaison Service (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 (FFT) in 2020/2021, across all areas and departments. All data was collected via the 'iwantgreatcare' system until February 2021, February and March data was collected internally; all feedback is read on receipt by the Patient Experience Team and action is taken immediately

where necessary. Compliments, concerns and feedback from these are recorded and shared with individuals and teams on weekly basis. In September 2020 the focus of the FFT questions changed to focus on the patients' experience at the Trust rather than the previous focus on how highly they would recommend the Trust. The Trust has maintained a 96.5% positive score for recommendation from June to August 2020 meaning that over 5,500 patients have indicated that they are happy with and would recommend the care that they have received here in the last twelve months. The Trust started measuring patient experience from September 2020 and the average positive score for inpatient areas was 93.41%.

The PALS department has handled over 678 contacts in 2020/2021, which has decreased from the previous year due to the COVID pandemic.

The Complaints Department continues to function effectively in line with the policy developed in 2018.

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 receives 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 going forward.

1.18 Stakeholder Relations

During the year, the Trust has continued to develop its place and contribution within the formative Birmingham and Solihull Integrated Care System (ICS). Alongside this, there has been a requirement to collaborate with specific system partners to support the response to the COVID pandemic by accepting cohorts of patients that are outwith the Trust's traditional elective caseload. At the end of 2021/22 an arrangement was made to support University Hospitals Birmingham NHSFT with the systemwide plan to address the backlog of treatment that had developed over the second wave of the pandemic.

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 were ongoing with partners through 2020/21 around the plans to resume the service, which restarted again in April 2021.

The Trust has also continued to use the robotic technology to assist with joint replacement surgery. The JointCare reunion events, albeit held virtually this year, 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 2021/22 will consider these more fully and pursue those that might be of most value to the Trust and its service users.

The Trust paused its formal Patient Experience & Engagement forums during the year, however there has been much work and good evidence of patient engagement through the pandemic, including specific initiatives such as:

- ✓ Feedback on new website via Healthwatch (April 2020);
- ✓ Discussions with Patient Engagement & Experience Group around virtual consultations (June 2020);
- ✓ Outpatients collected feedback from patients about their experience and potential improvements (July 2020);
- ✓ Public asked to share a note of thanks which were included in staff wellbeing bags (July 2020);
- ✓ Digital participation in public Board meetings, Council of Governors & AGM (September/October 2020);
- ✓ Patients asked for feedback on the design and delivery of new Modular Theatre building;
- ✓ Patient feedback canvassed around planned patient entertainment system;
- ✓ Feedback surveys on orthotics, podiatry and physiotherapy; and
- ✓ Feedback collected from children & young people on design of new Children and Young People Outpatient Department

There are further plans moving into 2021/22, when the impact of the COVID pandemic has been managed, to reinstate the development of the processes to engage members of our patient and public community and reinvigorate the Patient Engagement and Experience Group, 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 once to review executive pay with a view to realigning salaries of the members of the Executive Team to those detailed in national benchmarks. The Nominations & Remuneration Committee supported the implementation of the recommendations at its meeting in November 2020.

The Committee sought the advice of the Acting Associate Director of Workforce & OD 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)
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 substantive CEO is appointed
An explanation of how that component operates	Executive Director Salaries are determined by the Nominations & Remuneration Committee of the Trust Board, informed by benchmark salary derived from established national NHS	Trust Expenses Policy applies to Senior Managers. Taxable benefits incurred fell within the scope of this policy. Levels of benefits reflect national terms	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

	Salary and fees	Taxable Benefits	Annual Performance -related bonuses	Long-term Performance-related bonuses	Pension-related benefits	Other Remuneration
	pay surveys. Executive directors are appointed on a permanent basis under a contract of service at an agreed salary	and conditions for other staff groups to ensure consistency				
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 and other staff exist where overpayments have been made in error or annual leave taken in excess of entitlement.

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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 and guidance received during the year from NHS Improvement, designed to improve the parity of remuneration	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
	between Non Executives and Chair of NHS FTs and NHS trusts		
The maximum that could be paid in respect of that component	The rate of remuneration payable to the Chairman of the Trust is £40,000 pa for up to two days per week. The Vice Chair and the Senior Independent Director are remunerated at a rate of £15,000 pa. The Chair of the Audit Committee is remunerated at £14,567. The current rate of remuneration payable to other Non-Executives is £13,000 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 organisations 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*
4	1204

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%	0
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	£18,626
Provide the total pay bill	£58,997,000

	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: 66.7%

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

Two directors whose remuneration exceeded £150,000 were in post prior to 1 April 2021. The remuneration for each 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	N/A – Resigned with effect from 15/01/2021	Note 1
Mr Timothy Pile **Chairman (from 18 January 2021)**	1 January 2021 as Chairman	31 December 2023	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	N/A – term of office expired on 30/11/2020	Note 1
Mrs Kathryn Sallah **Non-Executive Director**	1 April 2015	31 March 2023	Note 1
Mr Richard Phillips **Non-Executive Director**	1 February 2017	31 January 2023	Note 1
Prof David Gourevitch **Non-Executive Director**	1 February 2017	31 January 2023	Note 1
Ms Simone Jordan **Non-Executive Director**	1 October 2020	30 September 2023	Note 1
Ms Ayodele Ajose **Non-Executive Director**	1 April 2021	31 March 2024	Note 1
Mrs Gianjeet Hunjan **Non-Executive Director**	1 October 2020	30 September 2023	Note 1

Notes:

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

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 2020/21

Name and Title	2020-21 (12 months to 31st March 2021)					
	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	155-160	0	0	0	87.5-90	0
Mr Garry Marsh Executive, Director of Nursing & Clinical Governance	110-115	0	0	0	50-52.5	0
Mr Matthew Revell, Executive Medical Director	160-165 (note 1)	0	0	0	300-302.5	0
Professor Philip Begg, Director of Strategy and Delivery	105-110	0	0	0	142.5-145	0
Mr Stephen Washbourne, Interim Executive Director of Finance	120-125	0	0	0	47.5-50	0
Mrs Marie Peplow, Chief Operating Officer	105-110	0	0	0	172.5-175	0
Mr. Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary	95-100	0	0	0	25-27.5	0
Dame Yve Buckland, Chairman (until 20 January 2021)	25-30	0	0	0	0	0
Mr Tim Pile, Chairman (from 20 January 2021), previously Vice-Chair and Non-Executive Director	20-25	0	0	0	0	0
Mr. Rod Anthony, Non-Executive Director (until 30 November 2020)	5-10	0	0	0	0	0
Mrs. Kathryn Sallah, Non-Executive Director	10-15	0	0	0	0	0
Professor 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
Ms. Ayodele Ajose, Non-Executive Director (from 1 October 2020)	10-15	200				
Ms. Simone Jordan, Non-Executive Director (from 1 October 2020), previously Associate Non-Executive Director	10-15	200	0	0	0	0
Mrs. Gianjeet Hunjan, Non-Executive Director (from 1 October 2020)	5-10	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 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.

4.3 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 2020/21 was £160-165k (2019/20: £155-160k). This was 6.2 times (2019/20: 6.2 times) the median remuneration of the workforce, which was £26k (2019/20: £26k). 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 2020/21, 2 employees (2019/20: 4) received remuneration in excess of the highest-paid director. Annualised remuneration ranged from £7k to £186k (2019/20: £8k to £169k), 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* 2020-21

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 2021 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Cash Equivalent Transfer Value at 31 March 2020 £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	7.5-8	110-115	632	552	71	0
Mr. Garry Marsh, Director of Nursing & Clinical Governance	2.5-5	115-120	652	597	45	0
Mr. Stephen Washbourne, Interim Director of Finance and Performance	2.5-5	125-130	695	636	48	0
Mrs. Marie Peplow, Chief Operating Officer	22.5-25	180-185	1,084	896	173	0
Mr. Matthew Revell, Medical Director	47.5-50	175-180	1,045	732	300	0
Professor. Philip Begg, Director of Strategy and Delivery	5-7.5	55-60	272	126	144	0
Mr. Simon Grainger-Lloyd, Director of Corporate Affairs & Company Secretary	2.5-5	40-45	255	212	26	0

*This element of the annual report has been audited

b) 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 2020 (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. Garry 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. Philip Begg, Director of Strategy and Delivery (Note 1)	(22.5-20)	50-55	126	563	(451)	0

*This element of the annual report has been audited

Note 1 - During the financial year 2019/20 Professor Begg reached the normal pension age for one of his NHS pensions, and as such, there is no longer a transfer out option for this scheme. This is the reason that this CETV has reduced in comparison to 2018/19.

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 not subject to audit

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

	2020-21	**2019-20**
Number of Directors in office*	15*	12*
Number of Directors with expense claims	2	4
Financial value of expense claims made by Directors (£)	390	3,225
Number of Governors in office	18	16
Number of Governors with expense claims	0	0
Financial value of expense claims made by Governors (£)	0	0

*excludes interim Board members, and the Associate Non-Executive Director in the prior year.

Mrs Jo Williams
Chief Executive
24 June 2021

Section 3:

1.0 Staff Report

1.1 Analysis of Average Staff Numbers

Table 1: The Number of Staff employed by the Trust by Whole Time equivalents (WTE)

	2020/21 Total	2020/21 Permanently Employed	2020/21 Agency	2019/20 Total
	Number	**Number**	**Number**	**Number**
Medical and dental	139	126	13	128
Administration and estates	425	382	43	414
Healthcare assistants and other support staff	173	146	27	161
Nursing, midwifery and health visiting staff	290	253	37	282
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	126	122	4	122
Other	0	0	0	0
TOTAL PERSONS EMPLOYED	**1,153**	1,029	124	**1,107**

1.2 Employee expenses and numbers – Trust only

	2020/21			2019/20		
	Total £'000	Permanently Employed £'000	Agency £'000	Total £'000	Permanently Employed £'000	Agency £'000
Salaries and wages	44,441	44,441	0	41,737	41,737	0
Social security costs	4,199	4,199	0	4,128	4,128	0
Apprenticeship levy	194	194	0	188	188	0
Employer's contributions to NHS Pensions	5,053	5,053	0	4,637	4,637	0
Employer contributions paid by NHSE on providers behalf	2,208	2,208	0	2,006	2,006	0
Agency staff	2,713	0	2,713	4,013	0	4,013
TOTAL EMPLOYEE EXPENSES	58,818	56,105	2,713	56,709	52,696	4,013

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.

1.3 Employee expenses

The total Employer Pension contribution payable for the period to 31 March 2021 is £5,053k (31 March 2020 £4,637k).

1.6 Staff breakdown by gender

Table 2: Gender and Role (by headcount) as at 31st March 2021 (Not including bank staff)

Title	Female	Male	Total
Non-Executive Directors	4	3	7
Executive Directors	2	3	5
Other Employees	847	345	1192
TOTAL	853	351	1204

1.7 Staff breakdown by disability

Table 3: Disability and Role (by headcount) as at 31st March 2021 (Not including bank staff)

Title	Yes	No	Not Stated	Total
Non-Executive Directors	0	7	0	7
Executive Directors	0	5	0	5
Other Employees	40	954	198	1192
Total	40	964	198	1204

1.8 Staff breakdown by ethnicity

Table 4: Ethnicity and Role (by headcount) as at 31st March 2021 (Not including bank staff)

Title	BME	White	Not Stated	Total
Non-Executive Director	2	5	0	7
Executive Director	0	5	0	5
Other Employees	323	869	0	1192
Total	325	879	0	1204

1.9 Staff breakdown by sexual orientation

Table 5: Sexual Orientation and Role (by headcount) as at 31st March 2021 (Not including bank staff)

Title	Heterosexual or Straight	Bisexual	Gay or Lesbian	Other Sexual Orientation Not Listed	Undecided	Not Stated
Non-Executive Director	3	0	0	0	0	4
Executive Director	4	0	0	0	0	1
Other Employees	977	4	22	2	1	186
Total	984	4	22	2	1	191

1.7 Sickness Absence

Details of staff sickness absence data can be found via NHS digital publication services on 'NHS Sickness Absence Rates' NHS Sickness Absence Rates - NHS Digital

1.8 Staff 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 is recognised as a 'Disability Confident Committed Employer' through the Government's Disability Confident Scheme which supports employers to make the most of the talents that disabled people can bring to the workplace. The Trust is working towards Level 3 of the scheme - 'Disability Confident Leader.' This means that we actively encourage applications from disabled individuals in accordance with the Equality Act 2010. As an organisation we are committed to attracting, employing, retaining and developing the abilities of disabled staff and this is reflected in the Trust's Recruitment and Selection Policy. This policy is supported by the Trust's Inclusion Policy which reinforces key expectations around equality of opportunity for all in all aspects of employment.

We are committed to making necessary adjustments during the recruitment process. Candidates who have declared a disability through the application process need only to meet the essential criteria of the role to be guaranteed an interview.

Managers ensure that all adverts, job descriptions and person specifications provided by the Recruitment Team do not include statements which could be deemed discriminatory.

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 Trust is committed to supporting staff to remain in work. In addition to a robust Sickness Absence Policy which promotes support for individuals who become disabled during the course of their employment, managers also conduct regular risk assessments with all staff which ensure that those individuals, particularly those who may be most vulnerable due to disability are not adversely affected during the course of their duties and to ensure that the appropriate interventions are in place to support individuals to remain at work. The Trust's policy ensures that NHS guidance, advice and necessary training is provided to managers on the application of the policy.

The Trust recognises that staff with a disability may have unintended increased levels of absence therefore time off for treatment or rehabilitation may be provided as a reasonable adjustment and flexibility is at the heart of the approach that managers are encouraged to take.

The Trust's Human Resources team works closely with the Trust Health and Safety Officer to ensure that reasonable adjustments for staff are considered in a holistic manner by all experts who may be able to support the individual.

Managers are required to undertake regular health and wellbeing conversations with all staff with the aim of proactively understanding how an individual may be better supported. The Trust endeavours to ensure a preventative and supportive approach to support our disabled colleagues.

The Trust also 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.

All staff have access to an Employee Assistance Programme, Staff Counselling and Occupational Health support as well as mental health and manual handling training. During this financial year, staff have been able to self-refer to counselling.

During the COVID pandemic the Chief Executive has played an active part in maintaining contact with our most vulnerable staff who were shielding and absent from work. This included regular communication and updates via e- mail in addition to support calls where the Chief Executive and other colleagues in the Trust could check in and consider what additional support we could be providing to our staff who were having to remain at home.

The Trust is extremely proud of its achievement of the 'Thrive at Work' foundation level status and continues to work towards Bronze level accreditation.

The Trust is committed to the supporting physical and psychological wellbeing of all its staff and the Trust's development of its Health and Wellbeing Strategy 'The Wellbeing Hospital' will encompass the commitment, approach and actions the Trust will take to support all our staff including those who may be affected by disability. During the 2020/21 financial year, the Trust recognised the contribution of all our staff during the COVID pandemic and provided all staff with an additional day's leave – a 'wellbeing day' for all staff to spend as they wish to take some respite from the challenges of the last year. An additional day's leave was also provided for staff working on Christmas Day this year.

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.

The Trust's Education, Learning and Development policy reinforces the Trust's commitment to continuously improve the opportunities available to enable all staff to achieve their full potential. A key principle of the policy is to ensure a fair and systematic approach to identifying and meeting learning needs. Access to education, training and development is as open and flexible as possible, with no discrimination or disadvantage due to protected characteristics. Courses are communicated through the staff communications channels and on the Trust's intranet and should an individual require a more bespoke solution this would be explored by managers with support from the Education and Training Team involving HR if necessary.

All staff are encouraged to access career development and promotion opportunities which are promoted through the Trust's regular communications briefing.

1.8.4 Informing and consulting with our staff

The Trust has a number of formal vehicles where management and staff side meet to discuss employee relations issues.

The Joint Local Negotiating Committee meets quarterly with local and regional medical representatives to discuss the strategic overview for the medical workforce, clinical excellence awards, recruitment and junior doctors.

The Trust Consultative Committee meets bi-monthly to discuss workforce issues related to nonmedical employees of the Trust and is attended by local and regional staff side colleagues and the Trust's Executive Team.

The Trust's Staff Side Chair is an active and valued member of the Trust's People Committee which is also attended by a range of managers from across the Trust to help shape and engage with the Trust's workforce related matters.

Partnership working is at the heart of the Trust's approach to working with our staff side colleagues. During the COVID pandemic, the Trust has implemented weekly virtual staff side meetings attended by the relevant unions and professional bodies with Senior Management including the Chief Executive to proactively address any employee concerns and to feedback on the actions being taken by the Trust to support staff during these unprecedented times.

The Trust has in place a range of 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. The Trust also has increased its social media presence recognising the shift in how people communicate and key updates, access to opportunities and general information is also shared via these means.

The Trust continues to enhance its performance and appraisal policies and practices both of which are key to our staff understanding how their role contributes to the performance of the

Trust. In addition, all staff are encouraged to participate in the Trust's Annual Business Planning process.

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.

1.8.5 Staff Turnover

Staff turnover for the Trust is as reported in the NHS Workforce statistics which can be found on the NHS Digital Website – NHS Workforce Statistics.

1.8.6 Inclusion and Diversity

The Trust is committed to creating an inclusive culture where individuals feel and report a sense of belonging and where each person can bring their whole, authentic self to work without the fear of discrimination. This is mirrored in our approach as a provider of specialist orthopaedic services. We endeavour to ensure that equality, diversity and inclusion are at the centre of our roles as a provider of healthcare services but also as an employer.

The Trust has during the year worked on developing an Inclusion Strategy for sign off in 2021/22 of which the key objectives are to create a truly inclusive environment at the ROH which will continue to improve the patient, colleague and visitor experience through:

- Tackling and removing all forms of discrimination in order to promote equality for all
- Creating an inclusive and healthy ROH culture through Trust values
- Ensuring our Leaders and Managers role model in a compassionate and inclusive way
- Giving colleagues a voice to speak up and ask for access to opportunities
- Being recognised as a Top Inclusive Employer externally through best practice approach

We have further enhanced existing staff networks. The Disability Forum is well established and has run a campaign on supporting people with hidden disabilities to share their experiences. The newly established LGBTQ+ network has successfully taken steps to achieving 'Diversity Champion' accreditation with Stonewall and the Multi Minority Ethnic Group (MMEG) has explored options for implementing a Reverse Mentoring programme. The Trust has been ranked in the Top 50 Inclusive Companies index demonstrating our commitment to embedding an inclusive culture where everybody can thrive.

The Trust has implemented the Enabling Productive and Inclusive Cultures (EPIC) programme to a preliminary cohort of circa 20 people who upon successful completion of the programme will become 'Inclusion Ambassadors' within the Trust embedding and role modelling inclusive behaviours throughout their teams and the Trust. All staff have been provided access to Inclusion masterclasses through the EPIC programme and the Trust.

It is anticipated that all the programmes and activities outlined will increase representation and ensure a diverse workforce at all levels of the organisation. The Staff Engagement and Organisational Development Committee received a regular workforce report detailing the diversity profile of the Trust and this oversight will ensure that actions are taken pro-actively to ensure that the Trust is diverse in its composition.

The Trust has seen slight improvements across the Workforce Race Equality Standards (WRES) indicators and has been amongst the best performing organisations nationally in relation to Indicator 5 – the % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. Actions around Equality and Diversity will be addressed through the Equality and Diversity Action plan which will support the delivery of the Inclusion Strategy.

1.9 Occupational Health and Health and Safety Performance

Health and Safety Executive's (HSE) Relationship with the Healthcare Sector

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

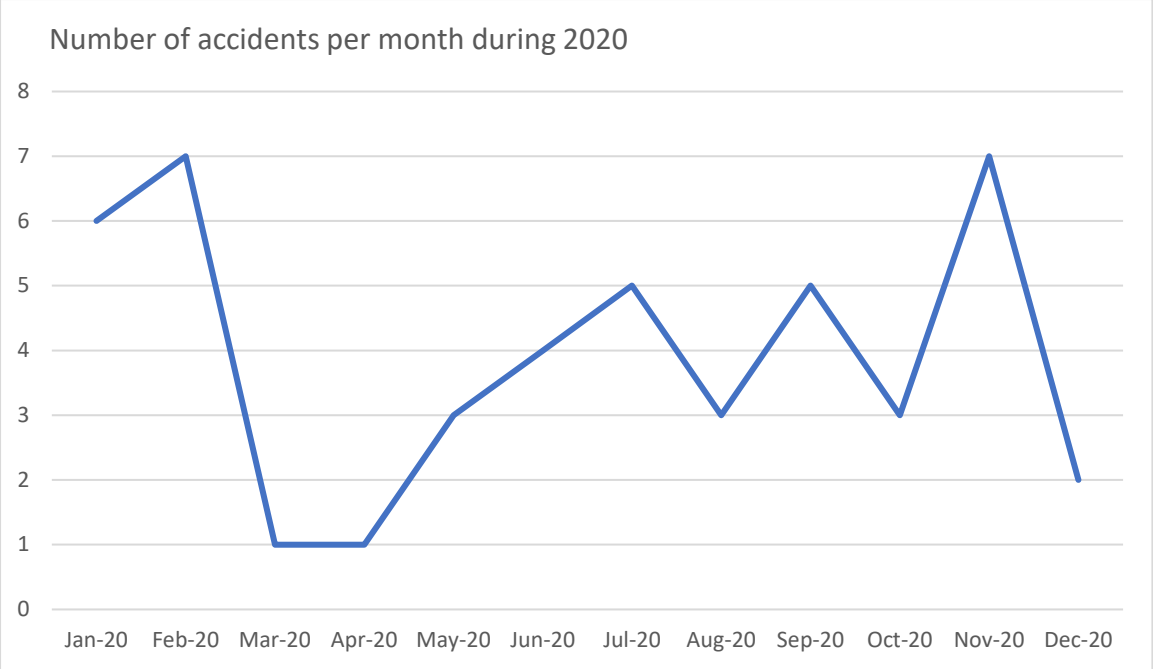
a. Inadequate maintenance of, or training in the use of work equipment needed to diagnose or treat disease or illness.

b. Reported under the 'Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013' (RIDDOR) 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 holder's own internal guidance, or well-established external guidance from others.
e. In general, 'established standards' will not include those that cover drugs and quality of care issues i.e. hydration and nutrition.

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.

Number of accidents per month throughout 2020 (employees/visitors/contractors):



Number of accidents broken down by category. 1 Jan 2020 - 31 Dec 2020.

(Employees/Visitors/Contractors)

Accident Category	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
Manual Handling Injuries	1	0	1	0	1	0	0	0	0	0	0	0
Burns / Scalds	0	1	0	0	0	0	0	1	0	0	0	0
Contact with hazardous substances (COSHH)	0	0	0	0	0	0	0	0	0	1	1	0
Road traffic accident/ incident	0	0	0	0	0	0	0	0	0	0	0	0
Sharps injuries	1	2	0	0	2	1	3	0	2	0	2	1
Slips, trips and falls (staff,	2	2	0	1	0	2	0	2	0	0	0	1

visitors & contractors)												
Impact Injury (with static or moving object)	2	2	0	0	0	1	2	0	3	2	4	0
Total figure for each month	=6	=7	=1	=1	=3	=4	=5	=3	=5	=3	=7	=2

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 to the HSE. During 2020 two RIDDOR reportable incidents were submitted:

Date of Incident	Summary of incident	Date RIDDOR Report submitted to HSE
16 Apr 20	Staff member stepped backwards and fell over a piece of equipment that was being pushed by another member of staff. Concussion. Confirmed no fractures. Occupational Health referral made. Receiving physiotherapy. Over 7-day injury. RIDDOR reportable.	1 May 20
23 June 20	Member of staff collided with a moving piece of equipment on its way to the scene of an accident. Attended x-ray. Sustained a fractured hand. RIDDOR reportable.	28 Jul 20

Health and Safety staff training

Throughout 2019, 47 face-to-face training sessions were delivered. However, due to COVID 2020/21 was a very different matter. Only seven face to face sessions could be delivered. This included:

- Mandatory training
- COSHH training
- Care Certificate training

First-aid training could not be delivered to staff, a matter that has been recognised and was a national issue.

Patient Handling training sessions delivered by Derby Hospitals as part of a Service Level Agreement came to an end as a result of a shortfall in resources to deliver this training. This gave the Trust an opportunity to consider alternative arrangements that could further enhance the quality and effectiveness of training and it was decided to bring the service in-house. Our own Physiotherapy department has taken on the role. Four staff volunteered to attended a Level 3 Safer Patient Handling Course in August 2020 and are suitably qualified in all respects to act as key trainers and deliver training to staff on scheduled dates.

Central Alerting System (CAS) Alerts

From the period 1 January 2020 - 31 December 2020 a total of 55 Alerts were received and subsequently disseminated throughout the Trust for action. All 2020 Alerts completed with none outstanding.

COVID Measures taken to safeguard the health, safety and welfare of staff

The Trust moved quickly and decisively in response to the risks to health posed by COVID. Public Health England led the national response to the global pandemic and published specific guidance aimed at the healthcare sector. Similarly, the Health & Safety Executive issued general guidance aimed at all employers.

The Trust reviewed the guidance and introduced control measures to safeguard the health, safety and welfare of employees, including anyone affected by our undertakings i.e. patients, essential visitors and contractors. The list is not exhaustive, but measures included:-

- Promotion of HSE guidance - 'Working Safely during the COVID Outbreak'.
- Individual office/communal area risk assessments completed by newly appointed Project Support Officers (PSOs). 57 risk assessments conducted in total.
- Temperature checks/hand sanitising and issue of facemasks set up at entrance points.
- Hand sanitiser made available in all work areas.
- Aerosol generating procedures (AGPs) identified and risk assessed.
- Suitable PPE sourced and provided by the procurement department.
- Mask fit testing delivered to staff ensuring respiratory protective equipment fits and is worn correctly. Training records maintained.
- Additional waste bins provided in work areas for safe disposal of facemasks.
- Approximately 120 mental health first aiders on hand to support staff.
- Staff access to Occupational Health Service.
- Wellbeing Officer in situ to support staff.
- Health and Wellbeing initiatives frequently promoted.

- Extensive use of signage throughout the Trust to promote social distancing/rule setting and one-way routes.
- Employees completed a Tier 1 risk assessment to help managers identify BAME and high risk staff with co-morbidities. As a result bespoke control measures were identified to reduce risk to vulnerable individuals.
- Before their 'start date' all new employees completed Tier 1 Risk assessments.
- Virtual BAME support group met regularly to support staff with issues/concerns.
- Regular Communications bulletins were issued reminding staff to self-isolate if diagnosed with COVID or if symptomatic.
- Regular virtual Chief Executive updates to staff via MS Teams were held, including question and answer sessions.
- Face to face staff meetings were discouraged. Use of MS Teams was promoted. Training literature and support was provided by I.T Dept.
- Board room meetings were limited to a maximum number of 9 occupants.
- Extensive use of Perspex screens on reception desks and within office spaces were implemented
- Tables and seating in Cafe Royale were configured to ensure social distancing.
- Hot desking was avoided where possible. Otherwise sanitise after and before each use.
- To reduce the risk of widespread departmental infections managers identified staff who can work from home, ensuring business continuity.
- Annual face to face mandatory training sessions were suspended. The majority of training was undertaken on-line.
- A new Stress Awareness Policy published aimed at helping managers identify the causes of work-related stress, signs and symptoms of stress and strategies to help support individuals or groups.

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: 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.

1.12 Off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2021	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, would be 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 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, would be subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax.

New off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, 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 2020 and 31 March 2021,	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 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

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.

1.13 Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

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

1.14 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.	14

1.15 Exit packages

Exit package cost band (including any special payment element	2020/21 Number of compulsory redundancies Number	2020/21 Number of other departures agreed Number	2020/21 Total number of exit packages by cost band Number	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**
<£10,000	0	0	0	**0**	**0**	**0**
£10,000-£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**
Total number of exit packages by type	0	0	0	**0**	**0**	**0**
Total resource expense (£'000)	0	0	0	**0**	**0**	**0**

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

*This element of the annual report has been audited

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.

1.16 Retirements due to ill health

During the year to 31 March 2021 there were no early retirements from the Trust agreed on the grounds of ill-health (31 March 2020, 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

The Trust has made notable progress in relation to its approach to staff engagement and considers effective staff engagement being core to delivering high quality outcomes for our patients.

During the pandemic, the Trust has had no option but to rely on virtual methods to engage with staff including those who may have had to shield due to the restrictions. Regular listening sessions have taken place with shielding staff and managers' briefings have been taking place bi-weekly throughout the pandemic to ensure that there has been opportunity for two-way feedback.

Virtual walkabouts for Non-Executive Directors are established in addition to Executive Chat and Checks – monthly engagement sessions with teams across the Trust where Executive Directors can engage with people and hear any feedback they may have about working at the Trust and giving staff the opportunity to engage with the Trust Board. The Trust's monthly Team brief provides opportunity for staff to ask questions of the Executive Team on anything they choose to.

The staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 20/21 survey among Trust staff was 56% (2019/2020: 51%). Scores for each indicator together with that of the survey benchmarking group (specialist Trusts) are presented below.

	2020/21		**2019/20**		**2018/19**	
	Trust	**Benchmarking Group**	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
Equality, Diversity & Inclusion	9.3	9.2	9.2	9.2	9.2	9.3
Health and Wellbeing	6.5	6.5	6.3	6.3	6.3	6.3
Immediate Managers	7.2	7.1	7.2	7.1	7.3	7.0
Morale	6.3	6.4	6.4	6.4	6.4	6.3
Quality of Care	7.8	7.9	7.8	7.9	6.9	7.8
Safe environment – bullying and harassment	8.6	8.4	8.3	8.3	8.1	8.2
Safe environment – violence	9.8	9.8	9.9	9.8	9.8	9.7

Safety Culture	6.9	7.0	7.3	7.0	6.9	6.9
Staff Engagement	7.3	7.4	7.5	7.5	7.4	7.4
Team Working	6.8	6.8	6.9	6.9	-	-

In 2020, the Trust has scored above the average for the benchmark group in relation to the following 3 themes:

- Equality, Diversity and Inclusion
- Immediate Managers
- Safe environment – bullying and harassment

There has been a slight decrease in staff engagement in 2020 however this was inevitable as staff focussed on responding to the challenges of the COVID pandemic. The Trust has identified 6 areas of focus which will feature on the Trust's Organisational Action Plan. These are:

- Health, Wellbeing & Safety
- Bullying & Harassment
- Staff Engagement
- Line Managers and Team Working
- Career Progression and Retention
- Engagement with Senior Managers

The Trust has engaged with staff through holding focus groups to share the staff survey results and to gain feedback on the specific actions that are required in relation to the themes that have been identified for improvement. Results are being shared by each Executive portfolio and are being cascaded through Divisional and local meetings with action plans being developed accordingly.

Progress with regards to the organisational action plan will be monitored through the Trust Board and Executive portfolio action plans will be monitored through the Trust's Staff Experience & Organisational Development Committee in addition to local monitoring through Divisional meetings.

2.1 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

In March 2020, it was decided to put on hold Schwartz Rounds, along with other support sessions to allow the staff to concentrate on treating patients through the pandemic. The sessions were restarted in July 2020 and moved from a meeting room setting to virtual. This transition has been successful and subsequent sessions have covered stories from staff members around the pressures of working through a pandemic. Colleagues from the following staff groups have spoken at the Rounds:

- Minority ethnic group
- Shielding staff
- Homeworkers
- Equality and Diversity network member supporting colleagues

- Staff members living with a mental health illness

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

- The fact that it was virtual offered a greater flexibility that allowed me to attend, I regret I have never been to a face-to-face session in the past so have nothing to compare it with but thought it worked really well and would definitely attend more in the future.
- Worked really well on teams and enabled me to join for an hour's meeting that I may not have travelled for.
- The facilitators did a fantastic job as did the speakers, the environment felt really friendly and engaging, I would be keen to attend more rounds in the future. It was great to see potentially sensitive topics discussed openly and without challenge.
- A big thank you to the facilitators for opening up the discussion and to the panellists for sharing their views and experiences with us.
- Important topics to discuss around privilege and representation. Great way to close the Black History Month. The experiences shared were very personal,
- Great round, very insightful and the speakers were great.
- Thought today's SR was timely and beautifully resonant.
- Very powerful stories
- Really well organised and facilitated. Excellent and relevant contributions which really added to the ROH story. Food for thought re: leadership and board roles.
- Very insightful.

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 is responsible for deciding on the direction and planning of future Rounds. The facilitators have given support to other Trusts who had wanted to move their Schwartz Rounds to a virtual format.

2.7 Expenditure on consultancy

Consultancy spend for the year was £149,000 (2019/20, £114k) 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 2020/21

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 there was

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 decision-making, particularly in relation to its response to the COVID pandemic. In addition to formal meetings a series of briefings were organised to keep governors updated on the operational response to the pandemic and to give them an opportunity to seek assurance around how the organisation was functioning during the challenging time.

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
- Estates Strategy & Delivery Group

In usual times, 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 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 met twice during the year, once to oversee the selection and appointment process for Simone Jordan as a substantive Non Executive and the appointment of Gianjeet Hunjan as a new Non Executive and secondly to consider the appointment of Ayodele Ajose as a substantive Non Executive and the appointment of Leslie (Les) Williams as a new Non Executive Director.

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.

1.5 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.

1.6 Public Members

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

During 2020/21 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.

1.7 Staff Members

The Trust has two constituencies within its staff membership:

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

1.8 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 Northfield Community Partnership
- Birmingham City University
- University of Birmingham

During 2020/21 we accommodated and welcomed as a new nomination, the Operations Manager of Northfield Community Partnership.

1.9 Governor Elections 2020/2021

During the year, the Trust conducted Governor Elections to fill seats that had become vacant and used an external company, Civica (formerly 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.

1.9.1 Result: Birmingham and Solihull

On two separate occasions, the following Governor elections were called during 2020 to fill **two** vacancies in the Public Constituency for Birmingham & Solihull:

Election 1

Electorate	3,005
Total number of votes cast (by post: 339 and online: 31)	370
Turnout	12.3%
Invalid votes cast	4
Total valid votes	366

The election was run by an external provider, Civica, and the successful candidate was Anne Waller. Anne was elected for a first term of office of three years which will finish on 5 October 2023.

Election 2

Electorate	3,001
Total number of votes cast (by post: 325 and online: 32)	357
Turnout	11.9%
Invalid votes cast	1
Total valid votes	356

Anthony Thomas was elected for a first term of office of three years which will finish on 31 December 2023. Anthony is a past Governor of the ROH and last served on the Board of Governors in 2017.

1.9.2 Result: Rest of England and Wales

Concurrently with the above (Election 1), an election took place in the Autumn of 2020 to fill **one** seat for the Rest of England and Wales:

Electorate	1,701
Total number of votes cast (by post: 211 and online: 23)	234
Turnout	13.8%
Invalid votes cast	5
Total valid votes	229

Again, this election was also overseen by Civica. David Roy was elected for a first term of office of three years which will finish on 5 October 2023.

1.9.3 Staff Elections and Results

During 2020/21 an election took place for a non-clinical staff governor which ran concurrently with the above.

Number of eligible voters	429
Votes cast online	103
Total number of votes cast	103
Turnout	24.0%
Number of votes found to be invalid	0
Total number of valid votes to be counted	103

David Richardson was elected for a second term of office of three years which will finish on 5 October 2023.

1.9.4 Elections during 2021/2022

A planned election will be undertaken during the Summer of 2021 when the term of office for Governors in the following constituencies will be complete:

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

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.

1.9.5 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.

1.10 Governor Profiles

Profiles for each governor, together with their term of office, who served on the Council of Governors during the period 1 April 2020 to 31 March 2021 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 31 May 2022.

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 has lived in Northfield for the last fifty plus 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's second term of office came to an 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 of office which is due to end on 31 July 2021.

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

- **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 the 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 came to an end on 30 April 2021 and was reappointed for a further three years.

- **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 came to an end on 31 July 2020. Dagmar will be serving a second term of office, for a further three years, which will conclude on 31 July 2023.

- **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 came to an end on 31 August 2020. Hannah will be serving a further three year term and her second term of office will come to an end on 31 August 2023.

- **Northfield Community Partnership** – Maxine Shanahan has been the Operational Manager at Northfield Community Partnership (a charity helping people and community groups in South Birmingham) since the Summer of 2015. Maxine previously spent thirty years at a Further Education College, starting as a Technician and progressing into teaching and contract compliance work. Maxine's first term of office started on 1 January 2021 and runs for three years initially, after which time the host organisation, in agreement with the Trust, can reappoint Maxine for a further term. Maxine's first term of office as Governor with the Trust will come to an end on 31 December 2024.

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 and final 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. Secondly, 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 came to an end on 14 September 2020. David was re-elected for a second term of office which will come to an end on 5 October 2023.

- **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 striven 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.

1.11 Attendance by Governors at Council of Governor Meetings 2020/21

During the period 1 April 2020 to 31 March 2021 the Council of Governors formally met on one occasion with six additional briefing sessions arranged throughout the year to ensure that the governors were informed of the Trust's response to the COVID pandemic. A record of the attendance by each Governor at the formal meeting is included in the table below:

GOVERNOR/CHAIRMAN	DATE	TOTAL
	24/09/20	
Yve Buckland (Ch)	✓	**1/1**
Brian Toner	✓	**1/1**
Kennedy Iroanusi	A	**0/1**
Arthur Hughes	✓	**1/1**
Sue Arnott	✓	**1/1**
Carol Cullimore	✓	**1/1**
Petro Nicolaides	✓	**1/1**
Marion Betteridge	✓	**1/1**
Lindsey Hughes	A	**0/1**
Richard Burden	A	**0/1**
Liz Clements	✓	**1/1**
David Robinson	✓	**1/1**
Dagmar Scheel-Toellner	✓	**1/1**
Hannah Abbott	✓	**1/1**
Adrian Gardner	A	**0/1**
Karen Hughes	A	**0/1**
David Richardson	✓	**1/1**
Gavin Newman	✓	**1/1**

KEY:

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

A record of attendance by Board members at the Council of Governor meeting during 2020/21 is provided in the table below:

BOARD MEMBERS	MEETING DATE
	24/09/2020
Tim Pile	✓
Kathryn Sallah	A
Rod Anthony	✓
David Gourevitch	✓
Richard Phillips	A
Simone Jordan	✓
Ayodele Ajose	✓
Jo Williams	✓

In addition to the formal meeting, the Council of Governors was provided with a summary of the Non Executive appraisals at a special briefing convened on 29 October 2020.

The Annual General Meeting was held on 24 September 2020 and was broadcast via social media as individuals were not encouraged to physically attend the event in order to comply with social distancing requirements.

1.12 Council of Governor Meetings

Topics covered at the formal meeting included:

- External well led assessment outcome
- 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
- Update on restoration and recovery
- Staff survey results
- Chair and Non-Executive appraisals, including Fit & Proper Persons Test update
- Update on the work of the Board Committees
- Progress with governor elections

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.

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, in usual times Non-Executive Directors of the Trust regularly attend meetings and provide updates to the Council of Governors on their work and the work of the Board. Given the national mandate to scale back non-essential meetings during the year, the Non-Executives were only able to attend the one formal meeting that was held where they provided an overview of the work of their respective Board Committees.

1.13 Governor Training and Induction

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

At the November briefing of the Council, the governors were given an overview of the core skills and responsibilities of a governor, this being a session delivered by the Deputy Company Secretary from the Dudley Group NHS Foundation Trust.

Acknowledging that there is more that can be done to train our governors, as the impact of the pandemic subsides work will be undertaken in 2021/22 to further develop additional training sessions, including creating a forum for sharing best practice between our peer organisations.

There were four new members of the Council of Governors elected and appointed during the year. The current induction process includes a welcome meeting with the Chair, Chief Executive and Director of Corporate Affairs & Company Secretary 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. In usual times, a site tour is also provided for new governors.

On 31 March 2021, Petro Nicolaides (Public Governor) and Tony Thomas (Public Governor) attended a webinar for governors organised by the Trust's external auditors, Deloitte LLP.

1.14 Effectiveness of the Council of Governors

During the year there 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.

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

1.15 The Council of Governors' Register of Interests

The Register is available for inspection on application to the Trust's Director of Corporate Affairs & 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.

1.16 Engaging Our Membership

Due to the COVID pandemic and social distancing measures outlined by the government, we were forced to cancel all physical events and convert meetings to virtual wherever possible.

Events included our governor drop in sessions, work experience groups and Max Harrison lectures whereby all members are invited to engage with us.

Communication with members virtually has continued. We are able to connect with 22% of members (1083) who have provided email addresses and opted into regular communication. Throughout 2020 these members have been contacted on a monthly basis with regular updates from both the Trust and Charity with news and engagement opportunities.

On average we have a 10-15% open and click rate on links within the mailouts sent.

78% of members do not currently receive regular communication from us unless around upcoming election and voting opportunities. In 2021/22 we are looking into more opportunities to connect with members physically by utilising the mandatory election notifications sent to all members' homes. We are hoping we can include member news within these in the future to reduce mailout costs.

Member Events

Annual General Meeting (AGM)

Our Annual General Meeting was virtually held in September 2020 via Facebook live due to the success of previous years as well as social distancing guidelines. The link was sent to all members who provided email addresses via our monthly update.

Filming via Facebook live gives us an advantage as the public are still able to listen and view our AGM video. Currently the video has had 1.3k views and 123 reactions.

Member Recruitment

Although the strategy for this year focussed specifically on engagement rather than recruitment, there have been some small steps taken in order to actively recruit new members. Some of the usual ways in which we recruit members have been ceased due to cancellation of events within the Trust.

Actions taken over the last year include:

- Social media campaigns once a quarter to advertise the benefits of membership and encourage engagement in virtual meetings/surveys.
- Information is provided at junior doctor induction and simulated patients day.
- All staff leavers are sent information regarding Foundation Trust membership and how to apply.
- All charity donors were sent information regarding foundation trust membership and how to apply.

Recruitment methods to start again in 2021/22 when restrictions allow are:

- Membership is given a place in the hospital's newspaper distributed across the hospital to both patients and staff. This launched in May 2021.
- Membership presence at all Harrison Lectures and any additional public teaching sessions.
- Membership session at the yearly work experience sessions, and encourage all individuals to sign up.

In order to support the Hospital, we are aware the Trust needs to continue to recruit a broad range of members from a variety of backgrounds, including hard-to-reach areas. We are working with the whole ROH team, seeking new opportunities to reach more patients, families and our local community with our marketing.

1.17 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 Director of Corporate Affairs & 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.

1.18 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

	2020-2021	**Next year (estimated)**
Public constituency		
At year start (April 1)	4,793	4,774
New members	31	300
Members leaving	84	100
At year end (March 31)	4,774	4,974
Staff constituency		
At year start (April 1)	1,147	1,208
New starters	157	171
Staff leavers	106	115
At year end (31 March)	1,206	1,262

* Leavers on flat turnover rate of 8.46%

** New starters increase of 8.67%

1.19 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	323,164
17-21	39	102,801
22+	4,518	948,493
Socio-economic groupings*:		
AB	1,184	106,635
C1	1,349	157,272
C2	1,027	94,575
DE	1,160	158,372
Gender analysis		
Not Stated	84	0
Male	1,821	679,255
Female	2,869	695,203

*Social Grade	Description
AB	Higher & intermediate managerial, administrative, professional occupations
C1	Supervisory, clerical & junior managerial, administrative, professional occupations
C2	Skilled manual occupations
DE	Semi-skilled & unskilled manual occupations, Unemployed and lowest grade occupations

1.20 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 60 people who support our staff and enhance patient experience through a variety of roles. They 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 2020/2021
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	Accountability Report (Section 1 (1.3):

	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).	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 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.	Accountability Report (Section 1 (1.11): Directors Report)
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 members of the public can gain access to the registers instead of listing all the interests in the annual report.	Alternative disclosure Accountability Report (Section 1 (1.1): Directors 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 refreshed Patient Engagement & Experience framework will ensure that there are adequate mechanisms for harnessing the views of the public and patients. Further work is planned to strengthen the representation of the Council of Governors on trustwide corporate committees or groups as restrictions required as a result of the pandemic are lifted.

Jo Williams
Chief Executive

24 June 2021

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 Trust remained within Segment 2 through the financial year 2020/21.

Jo Williams
Chief Executive

24 June 2021

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 used 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
24 June 2021

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 2021 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.

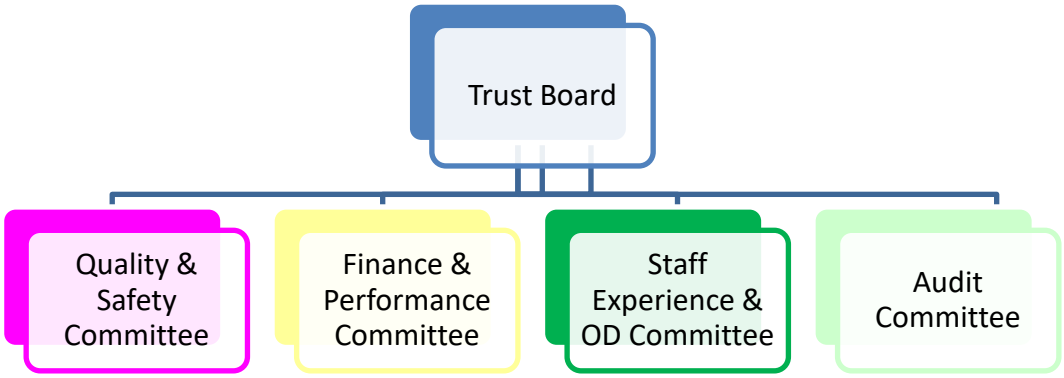


Figure 1: Trust Board & Committee structure

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 a Non Executive Director 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 Director. 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 or Board Assurance Framework, which also includes risks pertinent to the remit of the Committee.

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

During 2020/21, a national directive was issued by NHS Improvement aimed at reducing the burden of administration during the pandemic, which suggested that the usual operation of the Board committees, apart from the Committee with oversight of Quality, be scaled back to essential business only. This was agreed by the Trust Board at its April 2020 meeting, with assurance briefings being held in place of full Committee meetings until September 2020. The same arrangement was implemented in response to the second wave of the pandemic for the period January 2021 to April 2021.

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 relevant 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 its public sessions at least four times per year. In 2019/20, the BAF was realigned 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 building on the work

undertaken in 2020/21 to align the system to the organisational structure, further work is planned through 2021/22 to develop the functionality of this system.

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 content of which has been refreshed during the year. The Corporate Governance Manager/Assistant Company Secretary or the Risk & Policy Officer 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. As part of the Risk Improvement Strategy developed during the year, there are plans to develop a Standard Operating procedure in 2021/22 setting out the key elements of discussion needed around risk at these corporate forums. A training package will also be developed and delivered to a set of risk champions who will act as the primary local sources of expertise on risk management within the Trust.

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. Further work is planned to strengthen the processes for learning lessons from incidents, Root Cause Analyses, complaints, Freedom to Speak Up concerns and litigation. A formal "lessons-learned" annual report will be developed during the forthcoming year.

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.

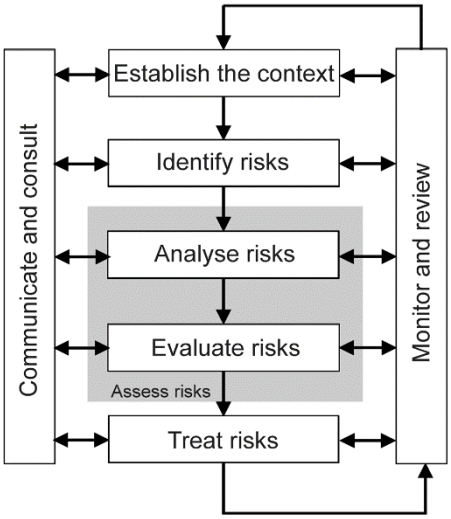


Figure 2: Risk management process

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 miss 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.

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. A further session is scheduled in the strategic Board workplan for December 2021 to create a more developed 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 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 safeguarding and infection control. Within the year a Quality & Safety Executive has been established to streamline some of the reporting by the governance groups and provide an additional level of oversight before upwardly reporting to the Quality & Safety Committee. The Quality & Safety Executive meets monthly during the week before the Quality & Safety Committee and upwardly reports using the standard 'quadrant' format that is used as a standard way of reporting for all Board Committees, setting out: matters to escalate/key risk, positive assurances gained, decisions taken and major actions commissioned or underway. This format is also used by those reporting into the Quality & Safety Executive and other bodies within the workplan of the Quality & Safety Committee.

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

The clinical outcomes data is reviewed by the Audit Quality Improvement Learning & Analysis (AQILA) panel, a further subgroup of the Quality & Safety Committee with a remit that is complementary to the agenda of the Clinical Quality Group.

Although formal walkabouts have not been possible in all cases this year, some Board members have carried out virtual walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients and staff and others. The Executive Team also conduct a monthly 'Chat & Check' walkabout, visiting areas of the Trust in rotation to understand staff's experience of working at the Trust and to undertake a physical inspection of the areas in which staff are working. The formal programme of Quality Assurance walkabouts has been suspended this year. This will recommence when social distancing guidance is relaxed and the sessions are led by the

Clinical Governance Team and involve Non-Executives, patient representatives and members of the Council of Governors, together with operational managers.

The Executive Team hosts a monthly briefing with staff from across the Trust, for dissemination of key messages to teams and to receive feedback from the organisation. The Chief Executive has also arranged special briefings on significant matters of interest to the wider organisation, including the impact of the pandemic on the organisation during 2020/21. In addition to this, Non-Executive and governor briefing sessions and were held during the year in addition to or as a replacement of formal meetings to ensure that information flows were maintained during this challenging time.

The Trust was last formally inspected by the CQC in October 2019, which reviewed 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 2020/21 there has been continued good progress with delivery of our CQC action plan.

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 work to 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.

Monthly meetings are held between the CQC Relationship Manager and the Director of Nursing & Clinical Governance.

4.4 How risks to data security are being managed and controlled

The Acting Head of IT 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 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. Encrypted datasticks are not permitted and 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 2 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. 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 of cyber security and the confidentiality and security of information.

No incidents have been notified to the ICO/DHSC in the Data Security Incident Reporting Toolkit.

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 areas where the Trust Board has been focussing its attention in 2020/21.

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
FINANCE & IT			
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 continues to deliver consistent deficits and requires cash support to continue day to day operations, attracting regulatory attention and potential intervention under the oversight framework	IY/F	• As part of the national COVID response, the Trust is currently (20/21) receiving fixed contract income, based on the 19/20 Mth 9 position Whilst we expect costs to exceed this income as activity increases in the coming year, discussions are underway with NHS Improvement around how the income would need to change to reflect that. • Development of a system wide financial plan • Implementation of a second phase to the theatres development Outcome assessment: • Reported financial position monitored by the Finance &

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
			Performance Committee on a monthly basis
There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom.	The Trust is vulnerable to a cyberattack, thereby comprising 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	IY/F	• Automated process implemented to patch corporate windows servers and c. 50 other high risk software monthly. • Work completed and underway to reduce the number of unsupported systems hosted by the Trust. • Cyber security Board level champion appointed and is creating networking opportunities with other organisations with a view to strengthening advice & support • Disaster recovery testing has been completed and the disaster recovery plan has been strengthened to enable testing of the full recovery of all Trust data • System wide cyber security and IT review is underway, the outcome of which will be reported in Quarter 1 2021/22 and will implement any recommendations from the system wide review that is currently underway • The Trust will continue to work through the mitigations to ensure that the Trust's systems are as protected as possible Outcome Assessment:

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
			• Compliance against the Data Security and Protection Toolkit • IT security incident reports
OPERATIONAL PERFORMANCE			
The Trust fails to meet the national target of treating 92% of patients, and patients waiting 52 weeks increases creating significant delays in patient treatment and as a result of cessation of elective activity mandated as part of the national response to the COVID pandemic.	• Patients wait excessively long time before treatment • Potential deterioration or harm to patients • Regulatory oversight regime invoked	IY/F	• Delivery of restoration and recovery plans. • Progression of second phase of modular theatres programme and second MRI Scanner. • Continued transformation of Outpatients services maximising the digital opportunities. • Embedded harm review patients for those waiting excessively long times Outcome Assessment: • Routine monitoring against constitutional standards • Outcome of harm reviews • Opinion of regulatory bodies • Progress with systemwide refresh and recovery
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 2020/21 • Theatre close down routine maintenance during period when there was cessation of elective activity • Phase 2 of the modular theatres set up becoming operational during the final

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
			quarter of 2020/21, with the project being delivered on time Outcome Assessment: • Increased theatre utilisation • Reduction in hospital-instigated cancellations • Approvals from the Medical Devices Advisory Group • Progress with key capital workstreams in the 'Perfecting Pathways' Programme
Failure of the UK to secure a free trade agreement when the Brexit transition period ends	The Trust may experience supply chain disruption, resulting in difficulties in maintaining usual services	IY	Mitigation/Controls: • Trust has in place supply chain contingency strategies developed as part of its business continuity plans • Discussion channels in place with NHS Supply Chain to allow for any risks to be anticipated • Supply needs discussed with commercial partners where needed Outcome Assessment: • Service delivery maintained post January 2021
PATIENT SAFETY			
There is a risk that there could be cross contamination of patients that are COVID-positive or COVID-possible with non-COVID	Nosocomial infection of patient cohorts and outbreaks	IY	Mitigation/Controls: • Pre-operative self-isolation regime • COVID tests on two occasions pre-admission

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
patients within clinical areas, causing the spread of the virus in a clinical setting			• Designation of COVID-managed and COVID-protected wards • Adherence to Personal Protective Equipment (PPE) guidance • Revised estates set up to allow for social distancing • Increase in cleaning hours • Enhanced oversight by Infection Prevention and Control Committee Outcome assessment: • Numbers of nosocomial infections reported • Breaches to adherence of national PPE guidance • Daily COVID SitReps
The suspension of the paediatric oncology service at Birmingham Children's Hospital NHSFT creates long delays for patients requiring surgery, leading to poor patient experience, clinical outcomes and disenfranchisement of the oncology consultants	Poor patient experience, adverse clinical outcomes and low staff morale	IY/F	Mitigation/Controls: • Paediatric transition/transfer programme • Harm review process • 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) • Joint plans for service resumption from April 2021.

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
			Outcome assessment: • Patients continue to receive surgery at the RNOH • Service resumes in April 2021.
WORKFORCE			
There is clear evidence that there is a disproportionate impact of COVID - 19 on individuals who are from a BAME (Black & Ethnic Minority) background and those at higher risk due to age, gender, underlying health conditions and pregnancy ('vulnerable groups').	High sickness absence levels in key staff groups	IY	Mitigation/Controls: • Risk assessments carried out for all BAME staff and those who fall into vulnerable groups • Occupational Health providing support for any complex cases. • Targeted work to encourage staff from a BAME background to accept a vaccination Outcome assessment: • Daily COVID SitRep figures for staff sickness by group and ethnicity • Sickness absence reports to Staff Experience & OD Committee
There is a risk that sickness absence may increase as a result of staff exhaustion or emotional strain due to different working patterns and exposure to emotional or stressful situations	High sickness absence levels in key staff groups	IY	Mitigation/Controls: • Sickness absence rates are monitored on a monthly basis through the operational workforce dashboards and on a weekly basis through the Board Scorecard on a weekly basis. • The national and regional offers regarding staff health and wellbeing have been promoted to all staff including

RISK	CONSEQUENCE	IN YEAR/ FUTURE	HOW THEY ARE/WILL BE MANAGED AND MITIGATED AND HOW OUTCOMES ARE/WILL BE ASSESSED
during the COVID pandemic			in house support from trained mental health first aiders. • Routine review of annual leave being taken. • Check in meetings with staff redeployed to other organisations to support the system response Outcome assessment: • Daily COVID SitRep figures for staff sickness by group and ethnicity • Sickness absence reports to Staff Experience & OD Committee • Staff survey results around health and wellbeing

Although these were the risks discussed by the Board in 2020/21, it should be highlighted that from March 2020, the Trust experienced a new set of risks with a more immediate focus, as a result of the impact of the global COVID 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.

The decision was taken by the Board in September 2020 to migrate the risks on the COVID risk register either onto the Board Assurance Framework, Corporate Risk Register or local risk register depending on the risk score and focus. Some risks were also closed as the impact of the pandemic had lessened.

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 last CQC report highlighted that there is clarity regarding reporting lines and accountabilities between these bodies and within the year there have been examples of topics remitted to other committees, which are then reported back to the originating committee.

Within the year, the Trust also received the outcome of the external assessment of the NHS Improvement Well Led Framework which highlighted that there was a good level of control and governance in the organisation. The amber/red rating for the Key Line of Enquiry 'Are there clear and effective processes for managing risk, issues and performance?' reflected that the Trust's activity position was below expectations and therefore this presented a risk in terms of the Trust's overall financial position. This was a matter with which the Trust had little control given that this related to the impact of the pensions tax regime on individuals who would usually support additional theatre sessions who were reluctant to do so given the potential tax liability associated with doing so.

In terms of risks, the key two during the year concern the ability of the Trust to achieve its constitutional standards given the impact on the Trust's operations by the need to support the system response to the pandemic and towards the end of the year, restoration and recovery.

A further risk concerns the current robustness of the risk management arrangements at a divisional and local level, a matter identified in an advisory review undertaken by the Trust's internal audit function in Quarter 4 of 2020/21. The issues identified were already known to the Trust and the Risk Improvement Strategy developed in September 2020 will address these issues during 2021/22.

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 given 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 Committees 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.

The Risk Improvement Strategy developed in September 2020 contains a number of key actions to further improve and embed risk management within the organisation over the coming year, including development of a Standard Operating Procedure around the discussions and decision-making when risk is considered at the various corporate meetings; risk management training, both bespoke and a standard package; improved system functionality; and heightened awareness of risk management in general.

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 Quality & Safety Committee reviews complaints, incidents and litigation 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 Improvement, CQC, NHS England, 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, the functionality of which will be revisited during the coming year.

As a consequence of the restrictions imposed by the pandemic, the ability to engage with stakeholders and the public through the structured governance structure has been limited this year. However the opportunity has been taken to engage on the following activities and to manage any risks from the patient and public perspective:

- ✓ Discussions with Patient Engagement & Experience Group around virtual consultations (June 2020)
- ✓ Outpatients collected feedback from patients about their experience and potential improvements (July 2020)
- ✓ Digital participation in public Board meetings, Council of Governors & AGM (September/October 2020)
- ✓ Patients asked for feedback on the design and delivery of new Modular Theatre building
- ✓ Patient feedback canvassed around planned patient entertainment system
- ✓ Feedback surveys on orthotics, podiatry and physiotherapy
- ✓ Feedback collected from children & young people on design of new Children's and Young People's Outpatient Department
- ✓ Virtual 'Coffee Catch Up' meetings with those participating in the JointCare pathway

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 within the Birmingham and Solihull Integrated Care System (ICS). This document is to be refreshed in line with the NHS People Plan over the coming year.

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 progressed its 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. The Trust is actively engaged with work to develop the ICS workforce plan and this work will be progressed through the ICS 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 these are revisited through triangulation meetings through 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 benefits from technological workforce solutions such as Allocate to support e-rostering and e-job planning and this has also been rolled 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 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.

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 and Trust Board 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.

Further work is planned over the coming year to strengthen the processes to mandate that staff routinely declare any interest they may have and the use of functionality in the Trust's Electronic Staff Record (ESR) will be used to support this.

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 Pension 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 Staff Experience & OD Committee reviews the position against the Workforce Race Equality Standards (WRES) and Disability Workforce Disability Equality Standards (WDES) and Equality & Diversity Standards (EDS2) as part of its routine workplan. The Trust has in place a Multi Minority Ethnicity Group (MMEG) which has been established within the year.

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 COVIDpandemic took effect, the divisions 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 2021/22 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 annual National Cost Collection (NCC) is now implemented and mandated. This has replaced the previous Reference Cost collection. The Trust is adhering to the national costing guidance and is providing detailed Patient level information to NHSE/I, achieving a 92% score within NHSI's costing assurance tool (against a national average of 81%). The Trust continues to develop and improve the way in which costs are being reported and allocated in conjunction with clinicians.

The expected direction of travel from NHSE/I is a transition to quarterly costing collections to provide enhanced understanding of the cost of services within the NHS during and post the COVID pandemic.

The Trust has taken a more prominent role in developing the systemwide financial plan this year in line with the intentions set out in the White Paper for the establishment of Integrated Care Systems (ICS) and collaborative working.

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.

6.0 Information Governance

During the year, the Trust reported 24 incidents relating to information governance and data security. None of these met the threshold for reporting to the Information Commissioner and/or the DHSS.

For the remaining incidents common themes are carelessness such as sending documentation for other patients in with correspondence and 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 root causes and any training needs. This is monitored by the Information Governance Group and messages are cascaded to staff via training and awareness. Any patients affected by data breaches, either with them reporting issues or being impacted, are informed if needed and provided with explanations and apologies.

7.0 Data quality and governance

The Trust has a number of operational and clinical systems that collect and store data about patients. This data is critical to the running of the Trust to ensure effective and timely care to patients and enables the Trust to plan and make future business decisions. High quality data is essential to aid business intelligence reporting and ensure operational efficiency. Ways in which the Trust ensures good data quality include:

- There is a Data Quality Group chaired by the Executive Chief Operating Officer and includes key stakeholders members from the business intelligence, operations, education and training teams. This group monitors data quality KPIs, audits and addresses any risks and issues as they arise.
- The Business Intelligence team carries out over 75 automated data quality checks on Trust data, creating reports which highlight data quality issues. These are shared on the Health Informatics dashboard accessible by operational staff to action and resolve.
- The Trust has a Data Validation team focusing on waiting list management which identifies and resolves errors caused by data quality.
- The Trust has a Systems Training Advisor whose role is to support staff carrying out system training on key patient systems with an emphasis on accurate and timely record keeping.

- Clinical coders regularly advise consultants to ensure accuracy and depth of coding

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 report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, and its committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I can place reliance on the Head of Internal Audit Opinion for 2020/21, 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 ten assurance reports issued, five provided positive (either substantial, reasonable) assurance opinions, two negative (partial) assurance opinions and two advisory reports. The further audit undertaken was around the Data Security and Protection Toolkit, where there was agreement on the procedures. The opinion in the overall 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 Data Quality – Electronic Staff Records (ESR) data review identified one low and six medium priority actions (some of which included sub-actions) and no high priority actions. In summary the key recommendations were:

- Ensuring that the most current policy around sickness absence management was available on the Trust's intranet and the version control record was updated to reflect the changes that had been made to the policy.
- Improvements needed to ensure that there was clarity in the relevant policies around the process for inputting information into the Board and Committee performance reports and the process to be followed to quality check reports, prior to review.
- Provide greater visual guidance on the process for updating performance reports.
- Ensuring that any planned changes to the Key Performance Indicators or their success rates be presented to the Trust Board for approval.
- Consider whether to monitor mandatory training performance against the national target of 95% as opposed to the Trust target of 93%.
- Clarify in Board and Committee reports that the performance data is reliant on timely update of performance data with ESR, thus is subject to change.

- Gain a common understanding between HR and the Business Intelligence Team as to how sickness performance is calculated and that this is consistent with peer organisations.
- Ensure that mandatory training completed by employees is reflected on ESR in a timely way.
- Implement a more robust quality assurance check of the information prior to inclusion in a Board or Committee report to be released. This is to include sample checks.
- Update templates used to record Key Performance Indicators with the most up to date information.

In terms of the Clinical Audit review audit, three low and five medium priority recommendations were made, these being:

- Improved cross referencing between the Clinical Audit and Service Evaluation policies
- Ensuring that evaluation registration forms are completed and improving the housekeeping of the oversight of the registration process for audits.
- Clarity within the policy that the report template may not always need to be used but where it is not, then all necessary information will be included to allow a thorough review prior to sign off.
- Clinical leads to fully populate all areas of the action plans to ensure that the action plan mirrors those recorded in the final report.
- Raise awareness and provide training in clinical audit processes.
- Ensure that all fields in the audit plan are populated and reference numbers should run on sequentially.
- The clinical lead for audit to ensure that assessment of clinical audit proposals for approval include consideration of the linkage to Board or Divisional-level assessed risks.
- There are to be regular updates on clinical audit at the divisional Board meetings.

Reports providing a positive assurance opinion included the Human Tissue Act compliance; Secure Remote Working; Health & Safety; Procurement; and Freedom to Speak Up.

The effectiveness of our systems has also been considered through an external well led assessment, the final report from which was received in the last year. The conclusion of the report was that *'Our overall view is that the Trust Board performs well and displays a significant number of attributes of a high performing Board and well governed Trust. The Board is sighted on its current and future challenges and has developed plans to address them. The area of most challenge for the Trust currently is its financial position and this drives the Amber/Red score in Key Line of Enquiry 5. We have made 22 recommendations, none of which are rated as high priority. Many of the recommendations made are to allow extension of your existing process to reach best practice'*

Other steps taken during 2020/21 to maintain and improve the Trust's systems of internal control include:

- the Audit Committee receives 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 annual work plan for the Board has been revised and a Board strategic work & development plan has been produced.
- virtual walkabouts have been introduced to compensate for the limitations on physical events.
- Additional briefing sessions were held for Board members and governors to provide assurance that there was a tight system of control and robust response through the first and second waves of the pandemic.
- Some Non Executive Directors took the opportunity to join operational meetings to gain additional assurance and to offer support.
- Executive 'Chat and Check' visits have been introduced to provide an opportunity for staff to describe to the Executive Team their experience of working at the hospital and for the team to undertake a review of the physical working environment.
- delivery of the 'Team Brief' presentation has been widened to include all members of the Executive Team.
- a Board Scorecard was introduced at the height of the first wave of the pandemic to provide oversight of key metrics, including staff sickness absence, activity, numbers of COVID-positive patients being treated in the Trust, new national guidance issued, incidents, infection control activity and performance against constitutional standards.
- A separate COVID risk log was established to provide the Board and the Executive Team with a closer focus on key risks during the response to the pandemic.
- A Risk Improvement Strategy was developed which set out the plan for addressing some of the technical, organisational and educational challenges with the risk management framework in the Trust.
- Virtual 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.
- The implementation of the Audit Quality Improvement Learning & Analysis panel to strengthen the oversight of key clinical processes, such as clinical audit and lessons learned.
- Appointment of a new Deputy Chief Operating Officer and a Deputy Medical Director.
- The HR processes in the Trust have been further improved, with the development of a business partner approach.
- During the year, the Chair left the Trust to take up the role as Chair of the Birmingham & Solihull Integrated Care System. She was replaced by the existing Vice Chair and the Senior Independent Director role and Vice Chair positions were separated. The Council of Governors interviewed and approved the appointment of the two Associate Non-Executive Directors as substantive Non-Executive Directors. The Board was also joined by two new Non-Executive directors, one to replace the outgoing Chair of Audit Committee and another with an operational & strategic background.
- The advertisement for Freedom to Speak Up champions to support the Freedom to Speak Up Guardian was issued.
- The Board work and development plan was refreshed and further work is planned in 2021/2022 to create a more strategic focus on board development activities.

During the year and in line with the assurance in the Head of Internal Audit's Opinion, there were no significant areas of weakness in internal control highlighted.

9.0 Conclusion

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 I am able to take sufficient assurance that overall the Trust has a sound system of internal control.

The Trust is committed over 2021/22 to the continued development of our governance and control system building on the progress and learning undertaken in 2020/21.

Chief Executive Date: 24 June 2021

The Royal Orthopaedic Hospital NHS Foundation Trust

Consolidated Accounts for the year ended 31 March 2021

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

Report on the audit of the financial statements

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 Trust (the 'Foundation Trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the Foundation Trust's affairs as at 31 March 2021 and of its 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; and
- the related notes 1 to 24.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers on page 71;
- the table of pay multiples on page 73;
- the table of pension benefits of senior managers on page 74;
- the analysis of staff numbers and costs on page 78 and 79; and
- the table of exit packages on page 94.

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.

Basis for qualified opinion

At the time of the physical counting of inventories at 31 March 2020, 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 of £6.7m held at 31 March 2020. Consequently we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary or whether there was any consequential effect on the operating expenses for the year ended 31 March 2021. In addition, were any adjustment to the inventory balance be required, the performance report would also need to be amended.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice 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 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.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Foundation Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the Foundation Trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

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

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 course of 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 this gives rise to a material misstatement in the financial statements themselves. 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 held as at 31 March 2020 or whether there was any consequential effect on the operating expenses for the year ended 31 March 2021. We have concluded that where the other information refers to the operating expenses, it may be materially misstated for the same reason.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, 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 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 they have been informed by the relevant national body of the intention to dissolve the Foundation Trust without the transfer of the Foundation Trust's services to another public sector entity.

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.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the Foundation Trust and its control environment, and reviewed the Foundation Trust's documentation of its policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the Foundation Trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the Foundation Trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018, relevant employment legislation and clinical standards.

We discussed among the audit engagement team, including relevant internal specialists such as IT and industry specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management ,internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion, except for the possible effects of the matter described in the basis for qualified opinion section of our report:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the Foundation Trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the Foundation Trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Respective responsibilities of the accounting officer and auditor relating to the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the Foundation Trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the Foundation Trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the Foundation Trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement 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; 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.

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.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report) and the work necessary to issue our statement on consolidation schedules. We are satisfied that our remaining work in these areas is unlikely to have a material impact on the financial statements.

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 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
29 June 2021

Audit certificate issued subsequent to opinion on financial statements

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 29 June 2021, we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 29 June 2021, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 29 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources and the work necessary to issue our statement on consolidation schedules. We have now completed our work in this area.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of The Royal Orthopaedic Hospital NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

I C Howse.

Ian Howse, CPFA, CPA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
Cardiff, United Kingdom
20 September 2021

FOREWORD TO THE ACCOUNTS

The accounts for the year ended 31 March 2021 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 2021

		Consolidated	
		Year Ended 31 March 2021	Year Ended 31 March 2020
	Notes	£000	£000
Income from patient care activities	3.1	93,677	82,561
Other operating income	3.1	16,821	5,376
Operating expenses	4	(110,447)	(97,167)
Net Impairment loss on land and buildings	9.2	(449)	(602)
Operating Deficit		**(398)**	**(9,832)**
Finance Expenses			
Finance income	6	38	61
Finance expense - financial liabilities	6	(27)	(232)
Finance expense - unwinding of discount on provisions	16	(19)	(12)
PDC dividends payable	1.19	(766)	(839)
Net Finance Expenses		**(774)**	**(1,022)**
DEFICIT FOR THE YEAR		**(1,172)**	**(10,854)**
Other comprehensive (expense)/income			
Will not be reclassified to income and expenditure:			
Impairment loss on land and buildings	9.2	(471)	(1,025)
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/ (losses) on investment	10	157	(105)
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(1,486)**	**(11,984)**
TRUST ONLY COMPREHENSIVE EXPENSE FOR THE YEAR		**(2,087)**	**(11,751)**

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 214 form part of these accounts.

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2021

		Consolidated		Trust only	
		31 March 2021	31 March 2020	31 March 2021	31 March 2020
Non-current assets	**Notes**	**£000**	**£000**	**£000**	**£000**
Intangible assets	8	1,255	1,326	1,255	1,326
Property, plant and equipment	9	45,798	43,980	45,798	43,980
Investments	10	953	796	0	0
Total non-current assets		**48,006**	**46,102**	**47,053**	**45,306**
Current assets					
Inventories	11	1,800	6,690	1,800	6,690
Trade and other receivables	12	8,492	10,070	8,492	10,058
Short-term investments and deposits	13.1	43	8	0	0
Cash and cash equivalents	14	6,962	1,471	5,703	663
Total current assets		**17,297**	**18,239**	**15,995**	**17,411**
Current liabilities					
Trade and other payables	15	(11,438)	(13,979)	(11,396)	(13,967)
Borrowings	15.2	(848)	(20,525)	(848)	(20,525)
Provisions	16	(2,758)	(406)	(2,758)	(406)
Other liabilities	15.1	(344)	(250)	(344)	(250)
Total current liabilities		**(15,388)**	**(35,160)**	**(15,346)**	**(35,148)**
Total assets less current liabilities		**49,915**	**29,181**	**47,702**	**27,569**
Non-current liabilities					
Borrowings	15.2	(1,038)	(721)	(1,038)	(721)
Provisions	16	(1,029)	(526)	(1,029)	(526)
Total non-current liabilities		**(2,067)**	**(1,247)**	**(2,067)**	**(1,247)**
Total assets employed		**47,848**	**27,934**	**45,635**	**26,322**
Financed by taxpayers' equity					
Public Dividend Capital		58,536	37,136	58,536	37,136
Revaluation reserve	18	2,098	2,569	2,098	2,569
Charitable fund reserve		2,213	1,612	0	0
Income and expenditure reserve		(14,999)	(13,383)	(14,999)	(13,383)
Total taxpayers' equity		**47,848**	**27,934**	**45,635**	**26,322**

The financial statements were approved by the Audit Committee and authorised for issue on behalf of the

Board of Directors on 24 June 2021 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 2021

		Consolidated					Trust only			
		Total	Public Dividend Capital	Revaluation Reserve	Charitable Fund Reserve	Income and Expenditure Reserve	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
		£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	9.1	**(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 losses on investments	10	**(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)

		Total	Public Dividend Capital	Revaluation Reserve	Charitable Fund Reserve	Income and Expenditure Reserve	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2020		**27,934**	37,136	2,569	1,612	(13,383)	**26,322**	37,136	2,569	(13,383)
(Deficit) for the year		**(1,172)**	0	0	444	(1,616)	**(1,616)**	0	0	(1,616)
Valuation loss on property, plant and equipment	9.1	**(471)**	0	(471)	0	0	**(471)**	0	(471)	0
Public dividend capital received		**21,400**	21,400	0	0	0	**21,400**	21,400	0	0
Fair value gains on investments	10	**157**	0	0	157	0	**0**	0	0	0
Taxpayers' Equity at 31 March 2021		**47,848**	58,536	2,098	2,213	(14,999)	**45,635**	58,536	2,098	(14,999)

HE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

CONSOLIDATED AND TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2021

		Consolidated		Trust only	
		Year Ended 31 March 2021	Year Ended 31 March 2020	Year Ended 31 March 2021	Year Ended 31 March 2020
	Notes	£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit		(398)	(9,832)	(804)	(9,672)
Non-cash income and expense					
Depreciation and amortisation	4	2,840	2,694	2,840	2,694
Donated assets		0	0	0	(204)
Impairments	9	462	1,619	462	1,619
Reversal of impairments	9	(13)	(1,017)	(13)	(1,017)
Decrease/(Increase) in Trade and other receivables	12	1,788	(1,431)	1,788	(1,431)
Decrease in Inventories	11	4,890	62	4,890	62
Decrease in Trade and other payables	15	(4,345)	(1,544)	(4,345)	(1,544)
Increase in Other Liabilities	15.1	94	40	94	40
Increase in Provisions	16	2,836	621	2,836	621
Movement in Charitable fund working capital		42	(140)	0	0
Other movements in operating cash flows		3	0	0	0
NET CASH FROM/(USED IN) OPERATING ACTIVITIES		**8,199**	**(8,928)**	**7,748**	**(8,832)**
Cash flows used in investing activities					
Interest received		0	30	0	30
Purchase of intangible assets	8	(371)	(67)	(371)	(67)
Purchase of Property, Plant and Equipment		(3,362)	(2,018)	(3,362)	(1,814)
NET CASH GENERATED USED IN INVESTING ACTIVITIES		**(3,733)**	**(2,055)**	**(3,733)**	**(1,851)**
Cash flows from financing activities					
Interest element of finance lease		(2)	(7)	(2)	(7)
Capital element of finance lease rental payments		(118)	(114)	(118)	(114)
Interest element of loans		(78)	(224)	(78)	(224)
Other Capital receipts		1,177		1,177	
Movements on loans from the Department of Health and Social Care	15.2	(19,718)	10,341	(19,718)	10,341
Movements on other loans	15.2	(648)	(599)	(648)	(599)
PDC received		21,400	22	21,400	22
PDC Dividend paid		(988)	(728)	(988)	(728)
NET CASH GENERATED FROM FINANCING ACTIVITIES		**1,025**	**8,691**	**1,025**	**8,691**
Increase/(Decrease) in cash and cash equivalents		**5,491**	**(2,292)**	**5,040**	**(1,992)**
Cash and Cash equivalents at 1 April		**1,471**	**3,763**	**663**	**2,655**
Cash and Cash equivalents at 31 March		**6,962**	**1,471**	**5,703**	**663**

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 2020/21, 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

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

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 Charity"). 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. No adjustments were identified.

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 Cazenove for the management of the investment portfolio and are apportioned on the basis of fund values. The Charity is not currently incurring any investment management costs as part of its arrangement with Cazenove.

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 of which there were none at the year end.

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 Income 2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System/level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for

the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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 an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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.

1.4 Expenditure on employee benefits

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes 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 employer's pension contributions payable to that scheme for the accounting period. The contributions are charged to operating expenses as they become due.

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

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 2021 the Trust has made contributions of £9,165 to this fund, (2019/20: £10,043).

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.5 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.

1.6 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.

1.7 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.

1.8 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; and
- 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 desk top valuation exercise was carried out in March 2021 with a valuation date of 31 March 2021. Valuations are carried out by professionally qualified valuer's in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent asset valuations were undertaken on 31 March 2021 by Cushman and Wakefield (MRICS).

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

- Land £0
- Buildings and Dwellings (£920,000)

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 2021)	23	55
Dwellings (as per valuer's report 31 March 2021)	28	28
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

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 de-recognised. Retentions that do not generate additional future economic benefits or service potential are charged to the Statement of Comprehensive income when final payment is made.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated by straight line method. Freehold land is considered to have an infinite life and is not depreciated.

Assets under construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

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

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once the criteria in IFRS 5 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 and the assets are not revalued, except where the ‘fair value less costs to sell’ falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished is de-recognised 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.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

1.9 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.

1.10 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 on inception.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment, with depreciation calculated over the shorter of the lease period or the useful economic life of the asset. Useful economic lives are calculated in line with those included in Note 1.8.

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.

1.11 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.

Only items with a unit value of £250 or above are recognised as inventories, with the remaining items considered to be consumables.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles

of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.12 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.

In the statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on Demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.13 Provisions

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

1.14 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.

1.15 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.

1.16 Contingent liabilities and contingent assets

Contingent liabilities are not recognised, but are disclosed 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.

1.17 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 de-recognised 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.

1.17.1 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.

1.17.2 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.

1.18 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 de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

1.18.1 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.

1.19 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, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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.

1.20 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 2021.

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.

1.21 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 21).

1.22 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 23).

1.23 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.

1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

1.25 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 2020/21. 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 2022. 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 2022, 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 0.91% 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 2022 for existing finance leases.

For leases commencing in 2022/23, 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 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 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.

1.26 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 £1,102,000 (2019/20 £10,726,000 deficit).

1.27 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 1.10).

During 2020/21 the Trust signed a contract for the supply of additional modular theatres and wards as an extension to an agreement signed in the last financial year. 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 2021 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).

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 0.95% (2019/20 0.50%) in real terms.

1.28 Annual Leave accrual

In accordance with the requirement of IAS 19 *Employee Benefits*, the Trust accrues 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.

1.29 Revenue

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

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 2021		**Year Ended 31 March 2020**
	£000	**%**	**£000**	**%**
Income from whole HM Government	91,911	83.18%	79,893	90.85%
Income from non-HM Government	18,587	16.82%	8,044	9.15%
	110,498	100.00%	**87,937**	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 2021 £000	Year Ended 31 March 2020 £000
Block Contract system envelope	66,275	0
Elective income	0	43,457
Non-elective income	0	3,267
Outpatient income	0	8,789
Other NHS clinical income	26,769	25,624
Private patient income	633	1,424
Total income from patient care activities	**93,677**	**82,561**
Other operating income from contracts with customers:		
Research and development (contract)	367	353
Education and training (excluding notional apprenticeship levy income)	2,156	1,870
Top Up Funding	10,079	0
Income in respect of employee benefits accounted on a gross basis	1,210	1,402
Other contract income	306	1,492
Contributions to expenditure COVID consumables	2,068	0
Other non-contract operating income:		
Charitable and other contributions to expenditure	635	259
Total other operating income	**16,821**	**5,376**
TOTAL OPERATING INCOME	**110,498**	**87,937**
Commissioner requested services	93,044	81,137
Non-commissioner requested services	17,454	6,800

The Trust has deemed all income from patient care activities as being in relation to commissioner related services except for any private patient income.

As noted above. The revenue from NHS England and the CCGs disclosed in the reporting year are block contract payments with additional top-ups, the comparative year was disclosed under activity based ‘payments by results’ methodology. There is no longer any differentiation of this type due to the revised NHS funding regime due to the COVID-19 pandemic.

3.1.1 Other NHS clinical income

Other NHS clinical income includes:

	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Top Up Funding	10,079	0
Oncology block contract	0	6,417
Physiotherapy services	0	2,521
Pension costs funded by NHS England	2,208	2,006
Critical care bed days	0	1,999
Diagnostic imaging	0	1,734
Orthopaedic appliances	0	1,233
Bespoke prosthesis	0	1,089
Pre-operative assessments	0	1,055
CQUIN	0	725
Podiatry services	0	418
Hospital at home	0	332
Orthotics	0	242
High cost drugs	0	227
Contributions to expenditure PPE	2,068	0
	14,355	**19,998**

	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Onsite catering services	163	266
Staff accommodation	48	95
Car park income	7	413
	218	**774**

3.1.2 Other contract income

Other contract income includes:

	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Onsite catering services	163	266
Staff accommodation	48	95
Car park income	7	413
	218	**774**

3.2 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	250	210

4 Operating Expenditure

	Consolidated	
	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Purchase of healthcare from NHS and DHSC bodies	3,126	3,422
Purchase of healthcare from non-NHS and non-DHSC bodies	20,179	2,592
Staff and executive directors costs	58,867	56,709
Non-executive directors	130	127
Supplies and services – clinical (excluding drugs costs)	3,139	17,221
Supplies and Services Clinical - Utilisation of consumables donated for COVID response	1,868	0
Supplies and services - general	873	1,114
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	1,134	1,484
Inventories written down (net including drugs)	200	2
Consultancy	149	114
Establishment	1,205	1,378
Premises - business rates collected by local authorities	296	218
Premises - other	5,082	3,296
Transport (business travel only)	39	87
Transport - other (including patient travel)	46	40
Depreciation	2,398	2,322
Amortisation	442	372
Movement in credit loss allowance: contract receivables/assets	111	51
Audit services - statutory audit	76	72
Other services - audit related assurance services	0	4
Charitable fund independent examination	5	5
Internal audit	70	74
Clinical negligence	3,913	3,913
Legal fees	18	22
Insurance	120	95
Research and development	17	(17)
Education and training	467	443
Operating lease expenditure (net)	2,305	797
Car parking and security	131	53
Hospitality	18	21
Other losses and special payments - staff costs	0	8
Other losses and special payments - non-staff	19	1
Other services (e.g. external payroll)	96	91
Other NHS charitable fund resources expended	160	195
Other	3,748	841
OPERATING EXPENDITURE (excluding impairment)	**110,447**	**97,167**
Valuation impairment	449	602
TOTAL OPERATING EXPENDITURE	**110,896**	**97,769**

5 Operating leases

5.1 Payments recognised as an expense

	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Lease payments	2,305	797
TOTAL PAYMENTS	**2,305**	**797**

This note relates to the main Trust only as the Charity does not hold any operating leases.

The Trust's operating leases for 2020/21 consists of £19,000 (2019/20: £19,000) for the use of an offsite car park, £180,000 in relation to the lease of Mako Robotics equipment (2019/20: £202,000), The reduction is due to the suspension of the lease for 3 months at the beginning of the Pandemic, £1.8m in relation to modular theatres being the first full years charge (2019/20: £315,000), £4,000 in relation to a lease car (2019/20: £4,000) and the remainder of £100,000 (2019/20: £257,000) relates to plant and equipment.

5.2 Total future minimum lease payments

	Land £000	Buildings £000	Other £000	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
- not later than one year;	20	2,151	493	2,664	1,751
- later than one year and not later than five years; an	69	8,604	322	8,995	10,565
- greater than five years.	0	8,627	0	8,627	0
TOTAL FUTURE PAYMENTS DUE	**89**	**19,382**	**815**	**20,286**	**12,316**

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 2021 £000	Year Ended 31 March 2020 £000
Interest from deposit accounts	0	29
Investment dividend income	38	32
TOTAL FINANCE INCOME	**38**	**61**

	Consolidated	
	Year Ended 31 March 2021 £000	Year Ended 31 March 2020 £000
Finance lease interest	2	7
Loan interest - DHSC	0	195
Loan interest - Other	25	30
TOTAL FINANCE EXPENSE	**27**	**232**

7 Employee expenses and numbers

	2020/21 Total £000	2020/21 Permanently Employed £000	2020/21 Agency £000	2019/20 Total £000	2019/20 Permanently Employed £000	2019/20 Agency £000
Salaries and wages	44,441	44,441	0	41,737	41,737	0
Social security Costs	4,199	4,199	0	4,128	4,128	0
Apprenticeship levy	194	194	0	188	188	0
Employer's contributions to NHS Pensions	5,063	5,063	0	4,637	4,637	0
Employer contributions paid by NHSE on provider's behalf (6.3%)	2,208	2,208	0	2,006	2,006	0
Agency staff	2,713	0	2,713	4,013	0	4,013
TOTAL EMPLOYEE EXPENSES	**58,818**	**56,105**	**2,713**	**56,709**	**52,696**	**4,013**

7.1 Average number of persons employed (WTE Basis)

	2020/21 Total Number	2020/21 Permanently Employed Number	2020/21 Agency Number	2019/20 Total Number	2019/20 Permanently Employed Number	2019/20 Agency Number
Medical and dental	139	126	13	128	107	21
Administration and estates	425	382	43	414	370	44
Healthcare assistants and other support staff	173	146	27	161	137	24
Nursing, midwifery and health visiting staff	290	253	37	282	235	47
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	126	122	4	122	108	14
Other	0	0	0	0	0	0
TOTAL PERSONS EMPLOYED	**1,153**	1,029	124	**1,107**	957	150

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 2021 £000's	**Year Ended 31 March 2020 £000's**
Employee expenses - Executive Directors	745	658
Employee expenses - Staff	58,122	56,051
Total Employee expenses	**58,867**	**56,709**

7.3 Exit packages

During the year to 31 March 2021 there were no payments made to staff in relation to exit packages, (31 March 2020, £nil).

7.4 Retirements due to ill health

During the year to 31 March 2021 there were no early retirements from the Trust agreed on the grounds of ill-health, (31 March 2020, £nil).

8 Intangible assets

	Software licences (purchased) £000	Assets under construction	Total £000
Gross cost at 1 April 2020	2,870	0	2,870
Additions - purchased	371	0	371
Gross cost at 31 March 2021	**3,241**	**0**	**3,241**
Amortisation at 1 April 2020	1,544	0	1,544
Provided during the year	442	0	442
Amortisation at 31 March 2021	**1,986**	**0**	**1,986**
Net book value			
NBV - Purchased at 31 March 2021	1,255	0	1,255
NBV - Donated at 31 March 2021	0	0	0
NBV total at 31 March 2021	**1,255**	**0**	**1,255**

	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 - Donated at 31 March 2020	0	0	0
NBV total at 31 March 2020	**1,326**	**0**	**1,326**

This note relates to the Trust only as the Charity does not hold any intangible assets.

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 2021

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2020	**56,071**	5,021	31,244	555	158	12,645	20	6,337	91
Additions - purchased	**5,136**	0	1,233	0	2,010	1,468	63	362	0
Impairments charged to operating expenses	**(462)**	0	(453)	(9)	0	0	0	0	0
Reversal of impairments credited to operating income	**13**	0	13	0	0	0	0	0	0
Impairments charged to the revaluation reserve	**(471)**	0	(471)	0	0	0	0	0	0
Revaluation	**(858)**	0	(858)	0	0	0	0	0	0
Disposals	**0**	0	0	0	0	0	0	0	0
Cost or Valuation at 31 March 2021	**59,429**	**5,021**	**30,708**	**546**	**2,168**	**14,113**	**83**	**6,699**	**91**
Accumulated depreciation at 1 April 2020	**12,091**	0	0	0	0	8,620	20	3,363	88
Provided during the year	**2,398**	0	839	19	0	686	0	852	2
Impairments charged to revaluation reserve	**0**	0	19	(19)	0	0	0	0	0
Revaluation	**(858)**	0	(858)	0	0	0	0	0	0
Disposals	**0**	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2021	**13,631**	**0**	**0**	**0**	**0**	**9,306**	**20**	**4,215**	**90**
Net book value									
NBV - Purchased at 31 March 2021	**41,550**	5,021	27,735	546	2,168	3,532	63	2,484	1
NBV - Finance lease at 31 March 2021	**1,177**	0	0	0	0	1,177	0	0	0
NBV - Donated at 31 March 2021	**3,071**	0	2,973	0	0	98	0	0	0
NBV total at 31 March 2021	**45,798**	**5,021**	**30,708**	**546**	**2,168**	**4,807**	**63**	**2,484**	**1**

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.

The Charity do not hold any tangible fixed assets.

9.1 Property, plant and equipment for year ended 31 March 2020

There is no restriction by the Donor on the use of donated assets.

	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.

9.2 Gains/(Impairments)

	Total 31 March 2021 £000	Operating income £000	Operating expenses £000	Revaluation reserve £000
Changes in market place	(920)	0	(449)	(471)
TOTAL IMPAIRMENTS AT 31 March 2021	**(920)**	**0**	**(449)**	**(471)**

	Total 31 March 2020 £000	Operating income £000	Operating expenses £000	Revaluation reserve £000
Changes in market place	(1,627)	0	(602)	(1,025)
TOTAL IMPAIRMENTS AT 31 MARCH 2020	**(1,627)**	**0**	**(602)**	**(1,025)**

This note relates to the Trust only as the charity does not hold any assets.

10 Investments

	Consolidated	
	2021	2020
Fixed Asset Investments:	**£000**	**£000**
Market value at 1 April	796	755
Additions	0	146
Net loss on revaluation	0	(105)
Fair Value movements	157	0
Market value at 31 March	**953**	**796**
Historic cost at 31 March	**931**	**931**

Market value at 31 March	**31 March 2021 £000**	**31 March 2020 £000**
Securities - managed funds	953	796
	953	**796**

Analysis of gross income from investments

Total gross income	**31 March 2021 £000**	**31 March 2020 £000**
Investments in a Common Deposit Fund or Common Investment Fund	**38**	**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 2021	**31 March 2020**
	£000	**£000**
Inventories	1,800	6,690
TOTAL INVENTORIES	**1,800**	**6,690**

	31 March 2021	**31 March 2020**
	£000	**£000**
Inventories recognised in expenses	8,558	5,001
Write-down of inventories recognised as an expense	200	2
TOTAL	**8,758**	5,003

During the year the Trust received Personal Protective Equipment (PPE) from the Department of Health & Social Care. Any remaining PPE at the year end has not been included within inventories due to the low residual value.

12 Trade receivables and other receivables

	Consolidated		Trust	
	2021	2020	2021	2020
	£000	£000	£000	£000
Current				
Contract receivables	2,104	7,729	2,104	7,729
Accrued income	1,386	763	1,386	763
Allowance for impaired contract receivables/assets	(908)	(797)	(908)	(797)
Prepayments	4,517	856	4,517	856
Interest receivable	0	0	0	0
PDC dividend receivable	241	19	241	19
VAT receivable	621	740	621	740
Other receivables	531	748	531	748
NHS charitable funds: trade and other receivables	0	12	0	0
Total current receivables	**8,492**	**10,070**	**8,492**	**10,058**
Of which receivable from NHS and DHSC group bodies:				
Current	3,085	7,550	3,085	7,550
Non-current	0	0	0	0

12.1 Allowance for credit losses

	Consolidated and Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2020	797	0
Changes in existing allowances	111	0
Allowances as at 31 March 2021	**908**	**0**

	Consolidated and Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2019	746	0
Changes in existing allowances	51	0
Allowances as at 31 March 2020	**797**	**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 £43,000 (2019/20: £8,000) managed by Cazenove Capital. The Trust does not hold any short-term cash deposits (2019/20: £nil).

14 Cash and cash equivalents

	Consolidated		Trust only	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Cash and cash equivalents at 1 April	1,471	3,763	663	2,655
Net change in year	5,491	(2,292)	5,040	(1,992)
Cash and cash equivalents at 31 March	6,962	1,471	5,703	663
Broken down into:				
Cash at commercial banks and in hand	1,259	808	0	0
Cash with the Government Banking Service	5,703	663	5,703	663
Cash and cash equivalents as in Statement of Financial Position and Statement of Cash Flows	**6,962**	**1,471**	**5,703**	**663**

15 Trade and other payables

	Consolidated		Trust only	
	Financial liabilities		Financial liabilities	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
NHS Payables	599	5,550	599	5,550
Trade payables - capital	2,293	519	2,293	519
Social security costs	1,223	596	1,223	596
Taxes payable	0	537	0	537
Other trade payables	5,213	5,609	5,213	5,609
Accruals	2,110	1,168	2,068	1,156
TOTAL TRADE AND OTHER PAYABLES	**11,438**	13,979	**11,396**	13,967

Other Trade Payables include outstanding pension contributions of £724,000 at 31 March 2021 (31 March 2020: £703,000).

15.1 Other liabilities

	Consolidated and Trust			
	Current		Non-Current	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Deferred income	344	250	0	0
TOTAL OTHER LIABILITIES	**344**	250	**0**	0

15.2 Borrowings

	Consolidated and Trust			
	Current		Non-Current	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
DHSC Loan	0	19,771	0	0
Third Party Loans	675	636	0	687
Obligations under finance leases	173	118	1,038	34
TOTAL BORROWINGS	**848**	20,525	**1,038**	721

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 the existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

The interest rates applicable in relation to the third-party loans are 3.64% (HP outstanding amount of ££279,067) and 4.5% (Dell, outstanding amount of £166,868). The Cisco loan carries no interest charges (the outstanding amount of £229,372). 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 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Within one year	173	118	173	118
Between one and five years	692	34	692	34
After five years	346	0	346	0
	1,211	152	**1,211**	152
Included in:				
Current borrowings	173	118	173	118
Non-Current borrowings	1038	34	1,038	34
	1,211	152	**1,211**	152

£34,000 of the finance lease commitment is in relation to an MRI scanner (£152,000 for 2019/20). With the remainder of £1,177,000 relating to Theatre Equipment (£nil 2019/20).

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 2020 - brought forward	19,771	1,323	152	**21,246**
Cash movements:				
Financing cash flows - principal	(19,718)	(648)	(118)	**(20,484)**
Financing cash flows - interest (for liabilities measured at amortised cost)	(53)	(25)	(2)	**(80)**
Non-cash movements:				
Additions	0	0	1,177	**1,177**
Interest charge arising in year (application of effective interest rate)	0	25	2	**27**
Other changes	0	0	0	**0**
Carrying value at 31 March 2021	**0**	**675**	**1,211**	**1,886**

16 Provisions

	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2020	60	872	932
Arising during the year	10	2,907	2,917
Utilised during the year	(20)	(61)	(81)
Reversed unused during the year	0	0	0
Unwinding of discount	0	19	19
At 31 March 2021	**50**	**3,737**	**3,787**
Expected timing of cash flows:			
not later than one year	50	2,708	2,758
later than one year and not later than five years	0	291	291
later than five years	0	738	738
Total expected timing of cash flows	**50**	**3,737**	**3,787**

	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**

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 0.95% (2019/20: minus 0.50%) 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 2020/21:

Short-term (less than one year)	-0.02%
Medium-term (one – five years)	0.18%
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 £6,157,000 (2019/20: £4,909,000) 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 2021	**31 March 2020**
	£000	**£000**
Property, plant and equipment	3,289	1,238
TOTAL CONTRACTUAL CAPITAL COMMITMENTS	**3,289**	1,238

Capital commitments include £629,000 for electronic prescribing, £575,000 for a new MRI scanner, £328,000 relates to the Pharmacy relocation, £213,000 for Pre-Op Assessments and Therapies refurbishment and £203,000 for a learning and development suite.

18 Revaluation Reserve

	Revaluation Reserve - Property, plant and equipment
	£000
Revaluation reserve at 1 April 2019	2,569
Revaluation loss	(471)
Other reserve movements	0
Revaluation reserve at 31 March 2020	**2,098**

	£000
Revaluation reserve at 1 April 2020	3,594
Revaluation loss	(1,025)
Other reserve movements	0
Revaluation reserve at 31 March 2021	**2,569**

This note relates to the Trust only as the Charity does not hold and assets subject to revaluation.

19 Events after the reporting date

There are no adjusting subsequent events post the balance sheet date.

20 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 2020/21:

Birmingham Women's and Children's NHS Foundation Trust

University Hospitals Birmingham NHS Foundation Trust

NHS Birmingham and Solihull CCG

NHS Dudley CCG

NHS Herefordshire and Worcestershire CCG

NHS Sandwell and West Birmingham CCG

NHS South East Staffs and Seisdon Peninsula CCG

NHS Walsall CCG

Health Education England

NHS Resolution

Department for Work and Pensions

HM Revenue & Customs

The Trust has had material dealings with the following bodies during 2019/2020

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 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 £15,200 during the year (2019/20: £14,774).

21 Third Party Assets

The Trust held £22,955 in relation to advance payments from private patients in relation to treatment which is yet to take place (2019/20 £21,000). These payments have been included within the Trust's financial statements for 2020/21.

22 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 auditor 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 2021 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 block contracts in the financial year, which were paid a month in advance. The Trust aims to fund capital schemes by internally generated funds. In addition, the Trust can borrow from the Department of Health's financing facility or commercially. The Trust is therefore not exposed to significant liquidity risk.

Set out below is an analysis, by category, of the Trust's financial assets and liabilities as at 31 March 2021. Fair value approximates to the book value because of the short maturity of these instruments.

22.1 Financial Assets

		Consolidated			
	Notes	Carrying value 31 March 2021 £000	Fair value 31 March 2021 £000	Carrying value 31 March 2020 £000	Fair value 31 March 2020 £000
Current financial assets					
Receivables - with NHS and DHSC bodies	**12**	2,844	2,844	7,207	7,207
Receivables - with other bodies	**12**	269	269	1,248	1,248
Investments	**10**	953	953	796	796
Other current assets		0	0	0	0
Short-term investments and deposits	**13.1**	43	43	8	8
Cash and cash equivalents	**14**	6,962	6,962	1,471	1,471
		11,071	11,071	10,730	10,730
Non-current financial assets					
Trade and other receivables		0	0	0	0
TOTAL FINANCIAL ASSETS		**11,071**	**11,071**	10,730	10,730

		Trust only			
		Carrying value 31 March 2021 £000	Fair value 31 March 2021 £000	Carrying value 31 March 2020 £000	Fair value 31 March 2020 £000
Current financial assets					
Receivables - with NHS and DHSC bodies	**12**	2,844	2,844	7,207	7,207
Receivables - with other bodies	**12**	269	269	1,236	1,236
Other current assets		0	0	0	0
Cash and cash equivalents	**14**	5,703	5,703	663	663
		8,816	8,816	9,106	9,106
Non-current financial assets					
Trade and other receivables		0	0	0	0
TOTAL FINANCIAL ASSETS		**8,816**	**8,816**	9,106	9,106

All financial assets are held at amortised cost.

22.2 Financial Liabilities

		Consolidated			
		Carrying value 31 March 2021	Fair value 31 March 2021	Carrying value 31 March 2020	Fair value 31 March 2020
	Notes	£000	£000	£000	£000
Current financial liabilities					
Borrowings excluding finance leases	**15.2**	675	675	20,407	20,407
Obligations under finance leases	**15.2**	173	173	118	118
Trade and other payables	**15**	13,759	13,759	12,843	12,843
		14,607	14,607	33,368	33,368
Non-current financial liabilities					
Borrowings excluding finance leases	**15.2**	0	0	687	687
Obligations under finance leases	**15.2**	1,038	1,038	34	34
TOTAL FINANCIAL LIABILITIES		**15,645**	**15,645**	34,089	34,089

		Trust only			
		Carrying value 31 March 2021	Fair value 31 March 2021	Carrying value 31 March 2020	Fair value 31 March 2020
		£000	£000	£000	£000
Current financial liabilities					
Borrowings excluding finance leases	**15.2**	675	675	20,407	20,407
Obligations under finance leases	**15.2**	173	173	118	118
Trade and other payables	**15**	13,717	13,717	12,832	12,832
		14,565	14,565	33,357	33,357
Non-current financial liabilities					
Borrowings excluding finance leases	**15.2**	0	0	687	687
Obligations under finance leases	**15.2**	1,038	1,038	34	34
TOTAL FINANCIAL LIABILITIES		**15,603**	**15,603**	34,078	34,078

All financial liabilities are held at amortised cost.

23 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:

	2020/21 Total number of cases Number	2020/21 Total value of cases £000	2019/20 Total number of cases Number	2019/20 Total value of cases £000
LOSSES:				
1. Losses of cash due to:				
a. theft, fraud etc.	0	0	1	0
b. overpayment of salaries etc.				
c. other causes	0	0	2	0
2. Fruitless payments and constructive losses	0	0	1	1
3. Bad debts and claims abandoned in relation to:				
a. private patients	18	1	0	0
b. overseas visitors				
c. other	47	2	1	0
4. Damage to buildings, property etc. (including stores losses) due to:				
a. theft, fraud etc				
b. stores losses				
c. other	0	0	1	0
TOTAL LOSSES	**65**	**3**	**6**	**1**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	2	2	1	5
6. Extra contractual to contractors				
7. Ex gratia payments in respect of:				
a. loss of personal effects	3	1	1	0
b. clinical negligence with advice				
c. personal injury with advice	1	6		
d. other negligence and injury				
e. Other employment payments (should not include special severance payments which are disclosed below)	1	2	1	3
f. Patient referrals outside the UK and EEA Guidelines				
g. other	5	5	5	0
h. maladministration, no financial loss	0	0	0	0
8. Special Severance payments	0	0	0	0
9. Extra statutory and regulatory	0	0	0	0
TOTAL SPECIAL PAYMENTS	**12**	**16**	**8**	**8**
TOTAL LOSSES AND SPECIAL PAYMENTS	**77**	**19**	**14**	**9**

For the period ending 31 March 2021 the Trust had 77 (31 March 2020: 14) separate losses and special payments, totaling £19,000 (31 March 2020: £9,000).

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.

24 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 2020/21
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