# The Royal Orthopaedic Hospital NHS Foundation Trust

## Annual Report and Accounts for the year ended 31 March 2013

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

**Contents** **2012/13**

## 1. Chairman's Message

'I became interim Chairman in November 2012 following the resignation of Laurence James who had successfully chaired the Trust for four years and under whom I had worked as a non-executive director throughout that period. Laurence had chaired the Trust in his own inimitable way – on site three days a week, often seen walking round the organisation talking to staff at all levels and leading the Board fairly and firmly through some challenging decisions. He has been missed by many staff and Board colleagues and we wish him well.

Coming into the role having previously been Vice Chairman, I had some experience of chairing key meetings and knew how my colleagues around the Board table behaved. Nonetheless, the situation which precipitated the need for me to become Chairman had caused concerns among the executive team and among my non-executive colleagues. Our Chief Executive of only six months was on long term sick and this left a void at the very top of the organisation. At the same point, the Trust's doctors expressed real concern at the way in which some of the agreed structural and organisational changes were being implemented within the organisation.

Despite all this upheaval, even allowing for the co-incidental resignation of our Finance Director, Steve Bloomer and the changes in non-executives as a result of coming to the end of their terms of office, the organisation has remained stable and has continued to perform well throughout the year.

My thanks for this must go in no small measure to Graham Bragg who, after enjoying only six weeks' retirement, returned to take the helm and lead the team. Everyone rallied round and as a result of the hiatus there followed a period of true consolidation which resulted in a very firm foundation for the future in which all staff were far more engaged than they had been before.

Early in 2013 we were able to appoint both a Medical Director and Deputy Medical Director from among our own staff and thus secure the three days a week of senior clinical leadership essential to taking forward the organisation.

My personal thanks go to all the staff who have maintained professionalism despite these significant changes. Our patients will have been unaware of the underlying uncertainties. This view was reinforced in January when our three new non-executive directors took up post and affirmed the view that the mood seen by a member of the public was of a caring, committed and fit for purpose organisation.

Our Medical Director of many years, Mr Andrew Thomas, stepped down from his role. I should like to convey the Board's thanks for his work and commitment over many years. Particular mention must go to Steve Bloomer our Director of Finance who left during the year to take up a senior role in London.

The Trust will, I feel sure, face the economic challenges which beset all public sector organisations with the same vigour and commitment as they have demonstrated in tackling the people issues of the past few months. The strength of the team and its skills are key to the future of The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) and in these hands I feel sure the trust will go from strength to strength.'

**Chris Monk, Acting Chairman to end March 2013**

From April 1st the Trust appointed a new Chairman, Bryan Jackson.

'In my opening address to staff I explained my ambition for excellence – moving from good to great. I encouraged everyone to work as a team in order to provide the very best services to patients and to be proud of what I see as a hidden gem in the NHS. Few trusts can evidence such consistent financial excellence without any sacrifice of patient care and that is something to be proud of at a time when there is so much talk of very different experiences. In my initial review of the organisation – both from its paper-based evidence and from talking to staff and patients it is clearly a very special hospital. The staff are keen and committed and proud to work here. Patients compare us to other trusts and say how clean our wards are and how fantastic the nursing care is. We are not perfect and recognise that there are areas where we need to improve and we often take extra and sometimes brave steps to trigger change.

Over the next year I intend supporting the top team to re-group after the hiatus of the last few months and to work closely with clinicians and their support teams, so that they are fully engaged in developing plans for the future.

I am pleased to have been appointed as Chairman and to introduce the 2012/13 Annual Report and Accounts and to sign them on behalf of the Trust.

**Bryan Jackson, CBE**

## 2. Chief Executive's Report

At the beginning of April 2012, the Trust Chief Executive, Donal O'Donoghue was beginning to debate with the senior team a vision for the future of the Trust that would enhance clinical engagement. Key to this was the restructuring of operational management to put clinicians in leadership roles and to implement service line management. This would be supported by the implementation of a dedicated Trust Business and Learning Day where, as far as possible, business stopped for one day a month and all staff could participate in discussing performance and quality and take part in professional development. By August 2012, the structure of seven clinical directorates covering each of the sub-specialties in the organisation was established and the new model was on trial. Each directorate has a Clinical Director (all but one of whom is a doctor), a Directorate Manager and a Matron or senior nurse. This triumvirate works together to oversee the comprehensive delivery of patient care.

The structure was welcomed and the implementation of this significant change, while not without some issue, went well.

In October 2012, Donal faced the news of his own health issues and it soon became clear that his treatment regime and the essential priority that he focus on his treatment and recovery, necessitated the Trust making interim arrangements for its leadership.

Having only retired in July, and having returned in September to offer mentoring to the new Clinical Directors, I was invited to once more act as Acting Chief Executive Officer (CEO). I accepted, not only to cover for Donal but also in recognition that in order to tackle some of the issues now being raised by the Trust's doctors, it was essential that they could work with someone in whom they had trust and confidence – someone they knew.

My first weeks at the turn of the year were spent in active dialogue with doctors and any other staff who wanted to express views. We used the Trust Business and Learning days to give out messages and hear concerns in an increasingly well-attended public forum attracting between 12 and 15% of our staff. My executive colleagues were hugely supportive and as the year ended, the mood had not only settled but turned to something very positive.

The Trust has continued to play its part both within the health economy and in the wider community. With an ageing population the demand for orthopaedic services will continue to grow and the Trust has carefully managed patient expectations. Trust membership has been consulted on a range of service developments and we have incorporated these ideas into our business systems wherever possible. We are a partner in the Northfield Business Improvement District and have a seat on its board. In this way we are engaged in our local area's development within the context of a fast changing urban expansion taking place less than 3 miles away.

At the Board we have accommodated changes in executives and non-executives such that of the thirteen round the table only myself and the Director of Nursing, Strategy and Governance were in post in April 2012 and only four of the seven Non-Executive Directors (NEDs) remain in post. Corporate memory is buffered by other attending colleagues, but the dynamic has changed and is now set fair for a future where engagement is real rather than an ambition.

But what of performance? Well, we have continued to deliver very strong financial performance and our operational performance continues to be very sound. The challenges of delivering waiting time targets across all our sub-specialties remains and will continue to challenge us from time to time. This year has been unusual in that for the first time I can remember, we have had major sickness among consultants. I must pay tribute to our Clinical Director for Paediatrics who sadly died in November 2012 after battling his illness and yet still maintaining his clinical activity insofar as he could. The tributes to him were many and

he is sadly missed. At the same time, the introduction of the Trust Business and Learning day impacted on activity – taking out a day a month which had to then be re-allocated elsewhere.

In the summer of 2013 the Trust will open its new Admissions and Day-Case Unit which will provide a brand new facility for patients who are just with us for a day. The Trust has, yet again, been able to make this investment entirely within its own resources and this completes the building program for outpatients' access to the Trust.

The Trust had an unannounced Care Quality Commission visit in December 2012 which necessitated action plans to quickly bring services back to the very best standards. Although their concerns were minor, this forcefully demonstrated that their expectation is for 100% compliance at all times and for the last quarter of the period the Trust worked hard to develop an approach to quality which would be able to achieve this wherever possible.

All in all, 2012/13 was a year of change and challenge. For information relating to what's next for the ROH please refer to page 15, the "Forward Look" section.

I would like to conclude by expressing my thanks in recognition of the efforts of all staff. We rose to the challenge and have achieved our business plan for the year, treated patients effectively and also set in place a strategic refresh for the coming three years.

**Graham Bragg, Acting Chief Executive**

### 3. Operating and Financial Review 2012/13 - Summary of Financial Performance

2012/13 was another challenging year for NHS finances, with continued pressure on providers and health economies to meet the growing demand for NHS services and to make improvements in quality within limited financial resources.

The national tariff was reduced by 1.8%, cutting £1.2m from Trust resources, whilst an additional £2.1m was required to meet unavoidable pay and non-pay pressures. In the Trust's favour, an additional 1% of income was made available to expand Commissioning for Quality and Innovation (CQUIN) schemes, increasing the potential funding available for meeting all the Trust's quality targets to 2.5% of contracted healthcare income (£1.3m).

In order to meet these pressures and to deliver a £2m financial surplus that would allow continued investment in the Trust's infrastructure, the ROH set itself a cost improvement target of £3.8m (5.5%). It was expected that achievement of these challenging targets would support the Trust to record a Monitor Financial Risk Rating of 4 and maintain a level of organisational independence.

Based on these targets, as agreed by the Board of Directors and the Council of Governors, the financial performance of the ROH during 2012/13 can be measured as follows:

| **Financial Objective** | **Outcome** | |
|---|---|---|
| Deliver a minimum surplus of £2m | Surplus achieved £2.2m | |
| Achieve a Monitor Financial Risk Rating of 4 | Achieved a rating of 5 | |
| Deliver £3.8m in cost reduction | Achieved £3.8m | |
| Deliver a capital programme of £6.8m | Achieved £4.4m | |

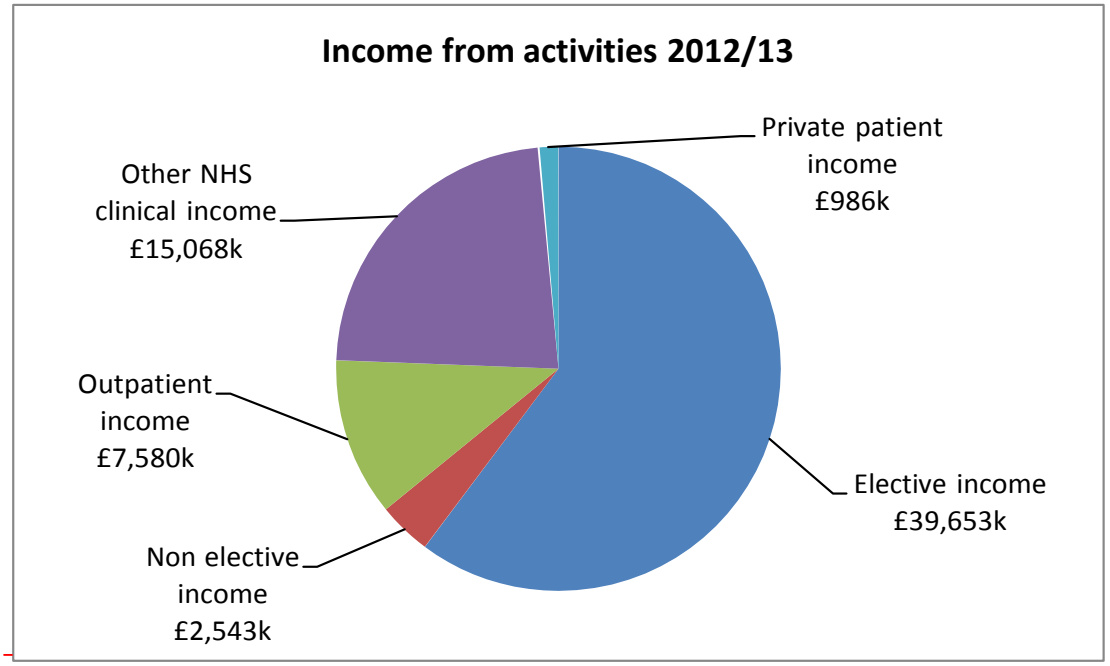
The reduced spending on capital projects arose because anticipated IT schemes did not commence in advance of agreement on a Trust wide IT strategy.

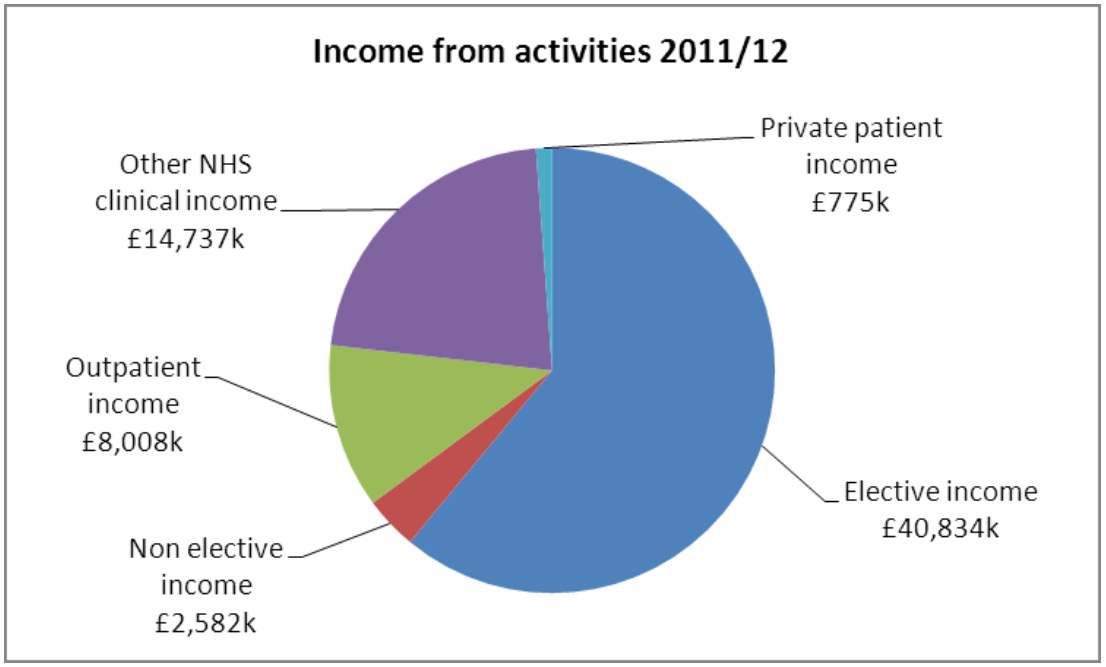
2012/13 saw a significant drop in activity levels performed by the ROH as the Trust dealt with unprecedented sickness levels in its medical staff along with the impact of changes in referral and treatment pathways. Whilst reducing overall patient numbers in some areas, this leads to a more complex casemix of activity as increasingly difficult cases are referred to the Trust for treatment.

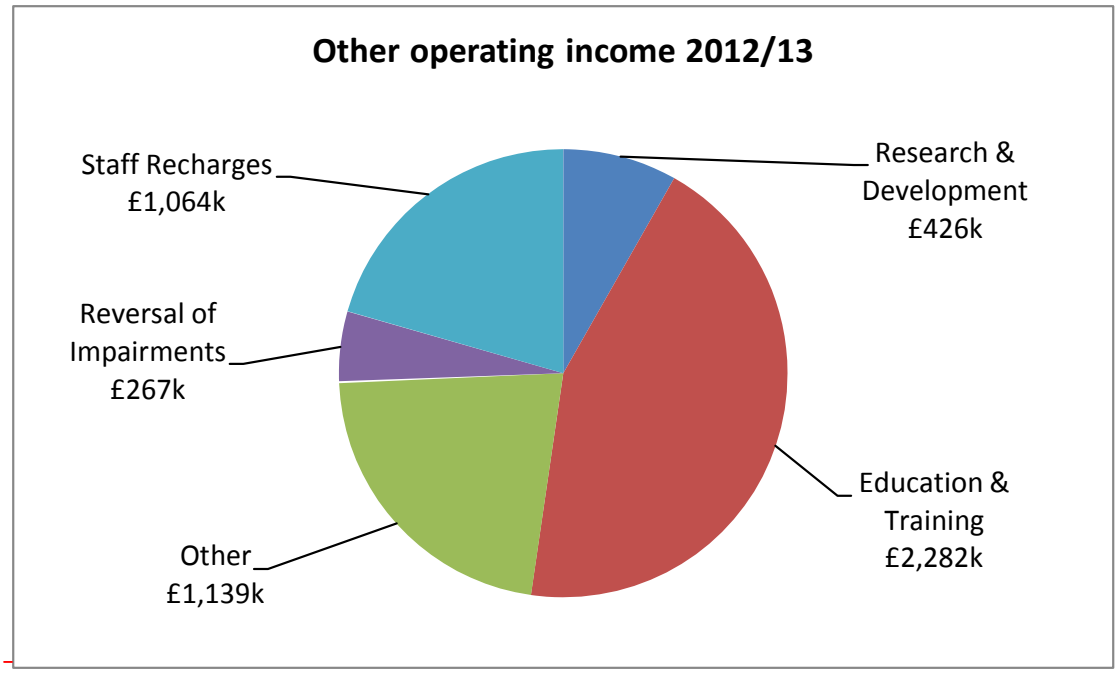
| | **2012/13** | | | **2011/12** | |
|---|---|---|---|---|---|
| | **Actual Treated** | **Plan to Treat** | **Variance against Plan** | **Actual Treated** | **Variance against 11/12 Actual** |
| Elective | 6,815 | 7,082 | (267) | 7,344 | (529) |
| Non-Elective | 429 | 478 | (49) | 535 | (106) |
| Day Cases | 6,161 | 6,520 | (359) | 6,560 | (399) |
| **Total Admitted Patient Care** | **13,405** | **14,080** | **(675)** | **14,439** | **(1,034)** |
| First Appointment | 16,669 | 16,986 | (317) | 17,355 | (686) |
| Follow Up Appointment | 39,769 | 40,584 | (815) | 42,361 | (2,592) |
| Outpatient Procedures | 7,800 | 8,712 | (912) | 8,330 | (530) |
| **Total Outpatients** | **64,238** | **66,282** | **(2,044)** | **68,046** | **(3,808)** |

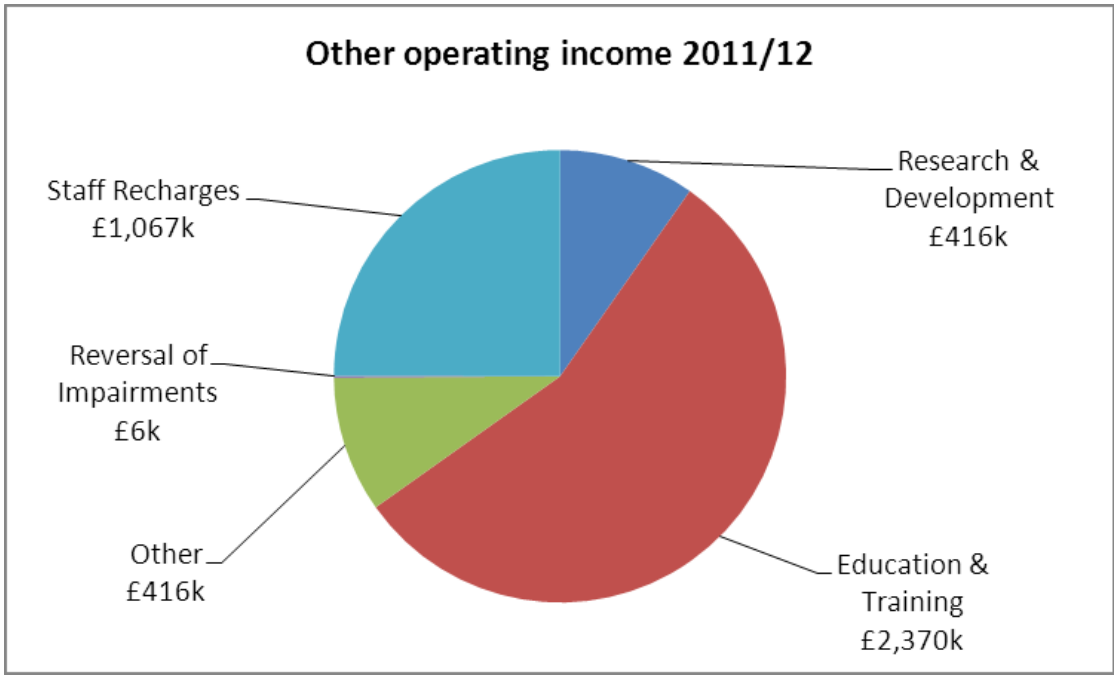
Despite the loss of income as a result of these activity changes, the Trust exceeded its surplus target of £2m by £0.2m. This was achieved partly through judicious financial planning and partly through non-pay costs failing in line with the reduced activity levels.

In order to deliver the savings required to maintain the Trust's financial stability, significant efforts have been targeted at improving the efficiency of processes within the hospital. Since April 2009, the ROH have rented theatre and ward capacity from a local private provider to meet the demand for healthcare from our patient population. Developments in out of hospital treatment pathways and improvements in theatre efficiency have enabled the Trust to repatriate offsite activity onto our main Woodlands site from 1st April 2012, saving £2.4m per annum. In addition to this, we continued to review all key areas of non-pay spend to ensure that all items were procured as economically as possible, thereby maximising the resources available to invest in improvements in patient care.






**Private Patient Income**

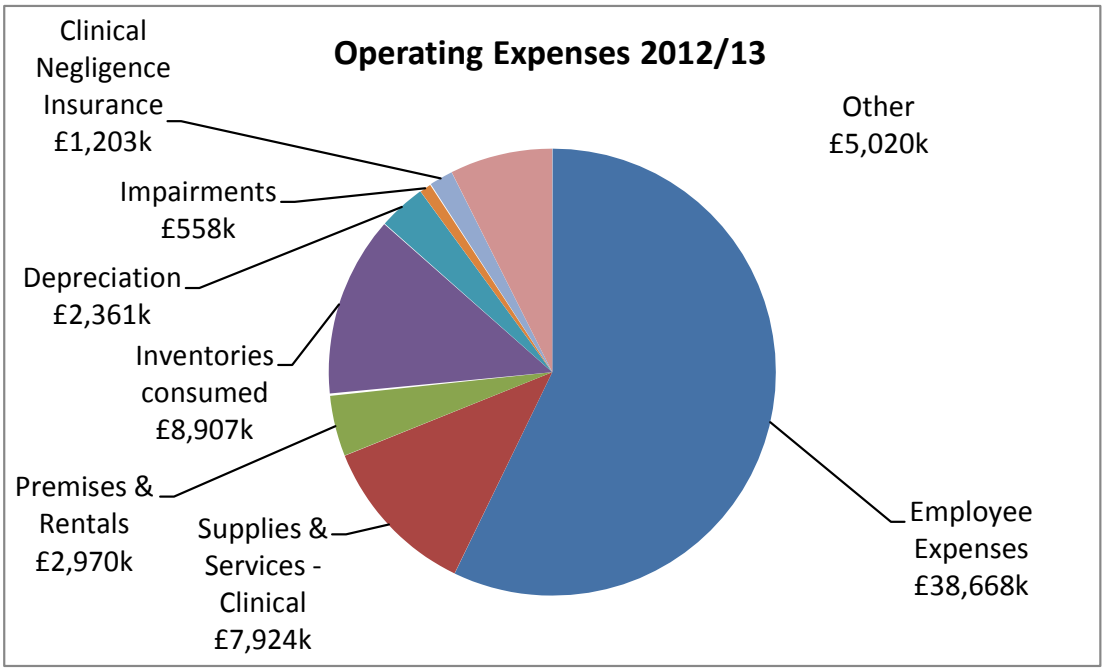
The Health and Social Care Act 2012 removed the requirement for Foundation Trusts to limit income from private patients to below their original private patient cap. The new act still requires that Foundation Trusts derive the majority of their income through NHS services, and requires that governors provide approval where the proportion of a Foundation Trust's income that is derived from private patients increases by greater than 5%.

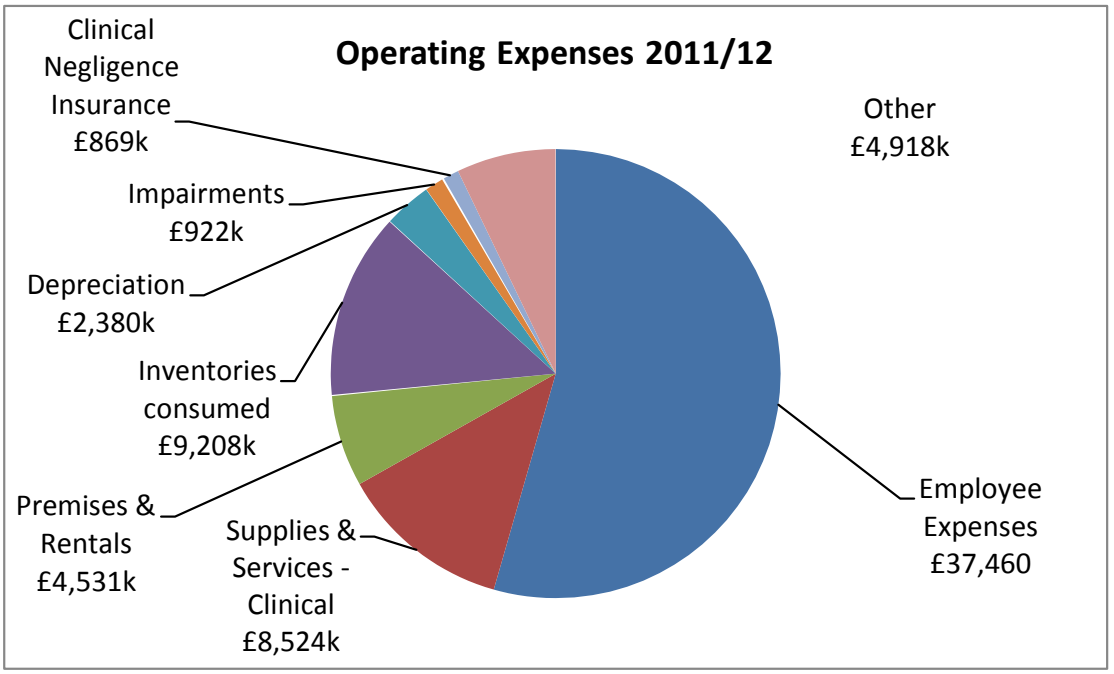
The proportion of patient related income derived from private patients in 2012/13 was 1.50% (£986,000) as compared to 1.16% (£775,000) in 2011/12. In both years, the amount of private patient income generated is significantly below the original cap, which was in excess of 4%.

**Non NHS income**

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. In 2012/13, the Trust generated £67,856,000 income from the provision of goods and services of the health service in England. This equated to 95.6% of the Trust's total income, ensuring that the Trust met the requirements of this regulation. Plans are in place to ensure the Trust continues to meet the requirements of this regulation in future years.

The principle of providing high quality care to NHS patients is fundamental to the Trust, and any contribution generated from income received from sources outside the NHS is utilised to ensure that this principle is maintained.



## Capital Expenditure & Liquidity

The Trust invested £4.4m in capital schemes in 2012/13, utilising the cash surpluses generated in previous years. Capital investment is vital to the on-going success of the hospital, ensuring that patients are treated in modern, clinically appropriate facilities with the advanced equipment required to maintain our status as an internationally renowned specialist centre for orthopaedic surgery.

The main schemes delivered in 2012/13 included:

- The development of our new Admissions and Day Case Unit, due to be opened in Summer 2013, which will significantly improve the healthcare experience for our day case patients whilst supporting a more logical and efficient flow of patients throughout the hospital.
- Completion of our new restaurant, significantly improving the dining facilities for our patients and visitors.
- New medical equipment, including new operating tables in theatres, a second spinal cord monitoring unit to provide further resilience for our spinal deformity surgery and various improvements in x-ray and anaesthetic monitoring equipment.

The Trust finished the year with a strong liquidity position of £21.4m against a plan of £18.5m which will enable us to continue to invest in improving property, plant and equipment. The Trust has a £16m capital plan for the next three years including:

- Completion of our new Admissions and Day Case Unit.
- Theatre developments, including the modernisation of some existing theatres and the development of improved on-site decontamination facilities.
- Significant investment in IT infrastructure and information systems to fundamentally improve the availability and timeliness of clinical data and further improve patient experience and efficiency.

## Charitable Funds

The Board of Directors is the Corporate Trustee to The Royal Orthopaedic Hospital NHS Foundation Trust Charity. The Trustees ensure that the donations are spent in accordance with the objectives of each fund and monitors this throughout the year.

Charitable Funds provide support and enhance the care of patients and the welfare of Trust staff.

To donate to the Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund or get involved in raising funds please contact the Finance Department on 0121 685 4000.

## Monitor Risk Ratings

At the end of each quarter the Trust is assessed by its regulator and receives a rating. Those ratings are shown below.

A financial risk rating of five denotes a Trust with the lowest level of financial risk and one being the highest.

| 2012/13 | Annual Plan | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| Financial risk rating | 4 | 4 | 5 | 5 | 5 |
| Governance risk rating | Amber-Green | Green | Green | Amber-Green | Amber-Green |

| 2011/12 | Annual Plan | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| Financial risk rating | 4 | 3 | 4 | 5 | 5 |
| Governance risk rating | Amber | Amber | Amber | Green | Green |

The Amber-Green ratings in the final two quarters of 2012/13 have been caused by breaches in one of the referral to treatment waiting time targets set by the NHS.

Our end of year Financial Risk Rating of 5 is broken down as follows:

| Monitor Financial Metric | Actual | Plan |
|---|---|---|
| EBITDA margin | **3** (8.3%) | **3** (7.4%) |
| EBITDA Achieved (%) | **5** (111.7%) | **5** (100.0%) |
| Net Return after Financing | **5** (4.0%) | **4** (2.5%) |
| I&E Margin | **5** (4.0%) | **5** (3.5%) |
| Liquidity Risk (days) | **5** (84 days) | **5** (70 days) |
| **OVERALL RATING** | **5** | **4** |

## The Forward Look

The historical strength and stability of the ROH provides an excellent starting point for dealing with the considerable financial pressures that the health economy continues to face, however it is acknowledged that the NHS as a whole needs to fully address the challenges posed by an ageing population, the rising cost of medical technology and growing expectations of the healthcare service. For organisations like the ROH to succeed and prosper, we need to be clear that we are delivering the priorities that are important to our patients – providing high quality patient care in a safe and friendly environment, enabling a smooth and stress-free patient journey.

These priorities are emphasised through our "Getting it Right" programme, which over the last 12 months has driven improvements in a number of our internal processes. We have redesigned our pre-operative assessment process, introducing a rapid assessment in outpatients alongside the piloting of booked admissions. These processes will ensure that, on the day that a decision is made that a patient requires surgery; they will leave hospital knowing that they are medically fit for that surgery and with an agreed date for the surgery to take place.

The "Getting it Right" programme has also concentrated on increasing the flexibility of our nursing service to provide appropriate care for patients in the ideal setting. Our award winning Bone Infection Unit has enabled patients who would previous have spent two months in hospital having infections treated with antibiotics to be cared for at home, with regular support from our nurses and therapists, ensuring high quality patient care without the need to be away from their family and friends.

In common with all NHS organisations, the ROH faces a number of risks and uncertainties as we move into the new financial year. The changing commissioning landscape, alongside significant pressures on health economy budgets as a result of on-going austerity measures and the recent high profile issues around emergency access, adds uncertainty to our funding streams going forward. This uncertainty is being managed and mitigated, and the Trust has been successful in tying up the vast majority of our planned activity into contractual baselines for 2013/14.

We are also working closely with our partners within the health economy to support work on addressing the current emergency issues, identifying opportunities where the capacity we can offer as an elective unit can help to relieve pressures faced by other providers.

The Trust has also highlighted staff engagement as a key to our success and it is clear that without this engagement, there is a risk to the Trust's ability to innovate and develop as an organisation. Significant progress has been made on this issue over the last 6 months, and it remains a key priority for the Trust in 2013/14.

It is clear that all NHS organisations need to be innovative and flexible to meet the challenges that financial austerity places on the health service, and the ROH are committed to tackling these challenges with a clear goal to get it right to deliver a high quality, value for money, service to our patients.

## 4. Quality Report and Account 2012/13

# Our Commitment

TO CONTINUAL QUALITY IMPROVEMENT

In 2012/13, the Trust continued to embed its Strategy for the hospital that is built around quality and excellence in all that we do.

# Our Vision

TO BE THE FIRST CHOICE FOR ORTHOPAEDIC SERVICES FOR PATIENTS, CARERS AND COMMISSIONERS

We will continue to be an organisation with:

- A single clinical specialty focus.
- A passion for developing ways to improve outcomes.
- Quality assured service options designed to address needs of patients, carers and commissioners.
- A brand that is itself a mark of excellence.

We will…

- Aim to offer the widest possible access to the best orthopaedic services delivering outstanding quality. This includes making sure that every element of the patient and carer experience is of a consistently high standard however challenging this might be.
- Attract, retain and develop skilled and engaged clinical, managerial and support staff to deliver world class specialist orthopaedic services to people across the UK.
- Involve patients in the development of our services.
- Offer a choice of orthopaedic services in a range of settings.
- Develop services so that they can be delivered in the most appropriate manner for our patients. This will mean offering care closer to home wherever it is possible and clinically appropriate.
- Work in partnership with other stakeholders such as those in primary care, other referring Trusts and academic institutions to continuously improve the whole patient experience
- Work with partners to provide much more than health services – offering applied research and clinical trial facilities, academic training at undergraduate and postgraduate level, a comprehensive range of therapies and private patient facilities.
- Lead and support clinical research and educate up and coming consultants and healthcare practitioners in the very best techniques.
- Actively encourage and lead clinical and service innovation to continually push the boundary of the orthopaedic specialty.
- Have the most informed and involved membership.

As an organisation we are committed to improving the quality and safety of our services for all of our patients and staff and we continue to focus on the values we have set as a hospital in order to do this. These are:

- Quality
- Integrity
- Leadership
- Innovation
- Partnership

Quality is at the core of decision making in our Hospital. We should never be complacent and should be constantly striving to improve. This has been very true this year and there have been many examples of improvements in quality and care which have been of considerable benefit to our patients. There have been examples of initiatives that haven't worked as well as we would have hoped but this has been recognised and alternative ways are being sought.

At Board level, our patients are very important to us and it is our quality of care, their safety and experience that drives the Board Agenda. We listen to "Patient Stories", picked at random and extract the lessons to be learnt in order to inform our quality improvements. Our executives and non-executives undertake regular visits to the wards, theatres and other areas of the Hospital. This year has seen the creation of seven clinical directorates and it is our intention that the non-executives and representatives of our Governors will link with these directorates with the aim of improving the quality of care to our patients.

We have a good reputation as a specialist orthopaedic centre but we cannot rest on our laurels! The health economy is constantly changing and quite rightly the patient has more choice on their healthcare provision. It is therefore important to us that our care should be second to none and that our outcomes are at the highest level. I know that our staff have the ability, attitude and loyalty to support us in constantly striving to achieve even better outcomes in quality and care that will benefit our patients. However, we are mindful that what may be regarded as a small improvement can be of enormous benefit to those under our care.

Before becoming Acting Chairman last November, I was a non-executive for six years and I continue to be impressed by the passion and commitment of our staff. They all know that there is always room to improve the experience of our patients which is why they and the Board regard Quality as our central focus.

Chris Monk - Acting Chairman

From August 2012 we have set time aside each month to ensure all of our new directorate teams have protected time to focus on how they can work together to improve the quality of patient care. We have continued our service transformation programme, Excellent Health, with improvements seen in the reduction in waiting times in x-ray as well as pre-operative assessment. During the year we have undertaken work to refresh the Trust's strategy and staff from all areas of the workforce have contributed to this.

# Visibility of our Senior Management Team

The Chief Executive has introduced weekly drop in sessions as an opportunity for staff to meet with him on a one to one basis. These are confidential and staff are able to bring any issues they wish to those meetings.

Quality rounds are undertaken by the Director of Nursing and Governance and her team of Senior Nurses (Matrons). Each non-executive director has been involved in visiting clinical areas and departments and the Chairman is regularly seen on independent walkabout throughout the organisation.

These walkabouts consist of a mixture of measureables; the quality round tool used by the Matrons covering all aspects of safety, effectiveness and experience, prompts from the CQC Essential Standards for Quality and Safety used by Board members as part of the Care Quality Commission visits, as well as the opportunity to collect softer information directly from staff and patients.

Strategy workshops have been held over the year that have given staff at all levels of the organisation the opportunity to participate in the development of the future strategic direction of the organisation and share their ideas with the senior management team.

The Project Management Office (PMO) continues to oversee the delivery of a wide range of quality and efficiency programmes and is another forum where the senior team meet with frontline staff both within the PMO meeting structure and also as part of the walkabouts to track the progress of projects that are underway.

Trust Business and Learning Days were introduced during the year to enable the whole organisation to have time to focus on business and educational priorities. As part of the day there is an Executive Question Time, a forum where key messages are shared with staff but also where any member of staff can ask questions of the executive team.

# Putting systems in place to give assurances

## PATIENT SAFETY IS AT THE CENTRE OF EVERYTHING WE DO

The Trust commitment to quality patient care is reflected in its governance structure. The Integrated Governance Committee (IGC) looks in detail at a range of quality issues and key indicators are reviewed by the Board at each meeting with quarterly declarations on quality being supported by a statement from the Integrated Governance Committee (IGC). Executive committees with responsibility for quality matters report to IGC on a planned and regular basis and their chairs report in person as part of the independent assurance process.

In addition to the key indicators the Board receives a monthly report from the Director of Nursing and Governance providing more detail on patient safety and experience matters. Together these give the Board an overall ‘story’ on quality within the hospital.

We have also received external and independent assurance on a number of key quality issues from the CQC, West Midlands Quality Review Service and our lead commissioners (Birmingham Cross City Clinical Commissioning Group). All of these visits have provided us with assurance in key quality areas as well as indicating areas where further work is required. We will be focussing on these during the coming year.

# Thank you

TO ALL THOSE WHO HAVE HELPED UNDERTAKE THIS WORK IN THE LAST YEAR

The Trust can be justifiably proud that the vast majority of its patients would recommend its services to others. It is also good to be able to report improvements in so many areas – pressure ulcers, compliance with venous thrombo-embolism prophylaxis and of course infection rates which remain low.

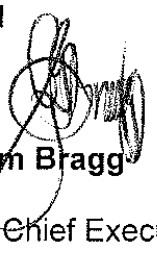
Over the last year we have worked hard to deliver against our priorities – many of which were derived from patient feedback on areas where they felt we could improve our service and this report demonstrates solid progress in that regard.

Our Director of Nursing and Governance provides context for the Board with at least two patient stories at every meeting – usually from those who have had a less than perfect experience - and this retains a sharp focus on what matters most to our patients. All our staff are keen to do of their best and they welcome external scrutiny and although always disappointed when imperfections are spotted, they are always proactive and committed to making improvements.

It is within this context - knowing that, as an organisation we listen to feedback, act upon it and learn - that I can give assurance that this report really does reflect the quality of our organisation.

I can confirm that to the best of my knowledge the information in this document is accurate.

Signed



**Graham Bragg**

Acting Chief Executive

# 2.1 Progress against quality improvements priorities for 2012/13

In our 2011/12 Quality Account/report we set a range of priorities for 2012/13 that were agreed by the Board and patient, public and staff stakeholders as important areas to focus on. The following tables show how we have performed against those priorities with further information available in Part 3.

**Table 2 – Quality improvement priorities for 2012 / 13 that were achieved**

| Achieved | |
|---|---|
| **Improvement priority** | **Performance** |
| **SAFETY** | |
| **90% of patients will be assessed for risk of venous thrombo-embolism** | Target > 90%<br><br>Achieved 92% |
| **Zero never events** | Target 0<br><br>Achieved 0 |
| **EFFECTIVENESS** | |
| **To reduce the number of grade 3&4 pressure ulcers by 30%** | Achieved<br><br>Grade 3 & $ pressure ulcers reduced from 14 grades to 7 therefore (50% reduction) with a 44% reduction in pressure ulcers overall |
| **To improve adherence with appropriate chemical VTE prophylaxis in line with the CQUIn target** | Achieved |
| **EXPERIENCE** | |
| **Improve the % of patients reporting in the national survey that they receive information about their medication** | Achieved<br><br>In all questions related to information about medication the Trust scored better than average |
| **Reduce the number of patients experiencing delays in the x-ray department** | Achieved – waiting times continue to reduce from an average of 43 minutes at the end of last year to an average of 36 minutes by March 2013. |

**Table 3 Quality improvement priorities for 2012 / 13 that were not achieved**

| Not achieved | |
|---|---|
| **SAFETY** | |
| **To ensure actions from SIRIs are completed within agreed timescales** | Not achieved – monitoring via Ulysses (our computerised system) has started in March 2013 |
| **EXPERIENCE** | |
| **To reduce the % of patients who rated hospital food as poor as reported in the national survey to <12%** | Not achieved<br><br>Target <12%<br><br>Not achieved (12.8%) Although his represents an improvement from last years score of 13.6% we did not meet our original target |
| **EFFECTIVENESS** | |
| **To reduce the length of time patients are starved before surgery to < 10 hours** | Not achieved (13.5hours) This represents a small reduction from last years figure of 13.8 hours)<br><br>Target < 10 hours |

# 2.2 Quality Improvement Priorities for 2013 / 14

| PRIORITIES | RATIONALE | MEASURING, MONITORING AND REPORTING |
|---|---|---|
| **1. SAFETY** | | |
| **95% of patients will be assessed for risk of venous thrombo-embolism (blood clots)**<br><br>(*This is also sometimes known as deep vein thrombosis or DVT and there are national guidelines on how to reduce this risk)* | This continues to be both a national and local priority | This will be measured monthly and reported via the corporate performance report to the Board. |
| **% prevalence of falls with harm is <2.5% as reported via the Safety Thermometer** | This continues to be both a national and local priority | This will be measured monthly and reported via the quarterly Quality Report to the Integrated Governance Committee. |
| **To ensure actions from all SIRIs are completed within agreed timescales** | This has been identified as a local improvement target to ensure learning from SIRIs is embedded | This will be measured quarterly and reported via the Quality Report to the Integrated Governance Committee. |
| **2. EFFECTIVENESS** | | |
| **To reduce the length of time patients are starved before surgery to < 10 hours**<br>*(Reducing starvation times before surgery is known to improve recovery)* | This continues to be a local priority as, although improvements have been made with increasing fluid intake, food intake has not seen the same improvement | This will be measured bi-annually and reported via the Quality Report to the Integrated Governance Committee. |
| **To reduce the number of avoidable pressure ulcers from 34 to 23 with no avoidable grade 3s or 4s** | This continues to be a national and local priority ensuring the progress made last year in reducing these continues over the forthcoming year | This will be measured monthly and reported via the corporate performance report to the Board. |
| **To reduce 30 day surgical site infection rate from 1.9% to 1.5% for primary hips and 4.9% to 4.5% for primary knees.** | This continues to be a local priority as a specialist orthopaedic hospital | This will be measured quarterly and reported via the Infection Control Committee report to the Integrated Governance Committee |
| **3. EXPERIENCE** | | |
| **A reduction in PALs contacts relating to appointments from 104 in Q4 of 2012/13 to <50 in Q4 of 2013/14** | This has been identified by all stakeholders as a local priority | This will be measured quarterly and reported via the Quality Report to the Integrated Governance Committee. |
| **To improve waiting times in OPD, setting a baseline in Q1 with an improvement target to deliver in Q4** | This has been identified by all stakeholders as a local priority | This will be measured quarterly and reported via the Quality Report to the Integrated Governance Committee. |

| | | |
|---|---|---|
| **To reduce the numbers of patients reporting in the national patient survey that the quality of the food was poor to <12%** | The patient survey continues to identify that this is an area where we have not achieved the improvements we had hoped for.<br><br>The external support to make improvements in this area during the autumn demonstrates some improvement and we are committed to ensuring this is sustained | This will be measured quarterly and reported via the Quality Report to the Integrated Governance Committee. |

# 2.3 Statements of assurance from the Trust Board

## 2.3.1 Review of services

*During 2012/2013 The Royal Orthopaedic Hospital NHS Foundation Trust provided four NHS services (trauma and orthopaedic, neurosurgery, pain management and general medicine).*

*The Royal Orthopaedic NHS Foundation Trust has reviewed all the data available to it on the quality of care in all four of these NHS services.*

*The income generated by the NHS services reviewed in 2012/13 represents 5% of the total income generated from the provision of NHS services by The Royal Orthopaedic Hospital NHS Foundation Trust for 2012/13.*

The review of patient safety, experience and clinical effectiveness has been undertaken in a number of ways including:

- Quality rounds are undertaken by the Senor Nurses (Matrons) in all clinical areas to observe practice, seek feedback from patients and support staff.

- Ward key performance indicators have been developed that are measured each month and reported to the Board. This allows key elements of safety, experience and effectiveness to be reported by ward directly to the Board.

- Leadership walkabouts are undertaken by executive directors and have developed from an initial focus on safety to cover a broader range of quality issues.

- Non-executive directors also undertake regular walkabouts in the organisation and have specific links to both clinical and non-clinical areas.

- The Trust has been involved in a number of external reviews including a commissioner led unannounced inspection and an internally initiated peer review from the West Midlands Quality Review Service looking at theatres and anaesthetics. Whilst each review provided some assurance they also identified areas for further work that are being addressed within the organisation.

- During the year the Trust has been inspected by the CQC in relation to Outcomes 2, 9, 13 and 17 within the Essential Standards of Quality. These inspections identified that the Trust met the requirements of outcomes 2, 13 and 17 but found minor concerns for outcome 4 and 9. An action plan to address these concerns is in place and will be completed by August 2013

- A Trust Board workshop on quality was held in June 2012 with a focus on safety and patient experience. Speakers at the workshop included patients and carers along with colleagues from the retail and airline industry.

- The Integrated Governance Committee review the quality governance framework on a quarterly basis with an improvement in self-assessment scores seen over the year. Internal audit also conducted a piece of advisory work to inform our approach to the quality governance framework.

- Patient stories are presented at Board meetings to share directly with Board members the experiences of our patients to ensure these are at the forefront of our minds when making decisions about the organisation.

## 2.3.2 Participation in Clinical Audit

*During 2012/13 4 national clinical audits and no national confidential enquiries covered NHS services that The Royal Orthopaedic Hospital NHS Foundation Trust provides.*

*During 2012/3 The Royal Orthopaedic Hospital NHS Foundation Trust participated in 4 national clinical audits and no national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.*

*The national clinical audits and the national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2012/13 were:*

1. *National Joint Registry – hip and knee replacement*
2. *Patient Reported Outcome Measures – hip and knee replacement*
3. *Pain Database*
4. *Cardiac Arrest*

*The national clinical audits and national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry*

| *Audit* | *Participation* | *% Cases submitted* |
|---|---|---|
| *NJR* | *Yes* | *47% submitted. 53% awaiting completion or submission (Apr 12-Jan 13 data)* |
| *PROMS* | *Yes* | *96% hips (Apr 12-Jan 13)*<br>*95.62% knees (Apr 12-Jan 13)* |
| *Pain Database* | *Yes* | *N/a – no individual cases. Trust registered for phase 1 - organisational part of audit. Awaiting updates on phase 2.* |
| *Cardiac Arrest* | *Yes* | *100% eligible cases submitted.* |

*The reports of these 4 national clinical audits were reviewed by the provider in 2012/2013 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:*

- The level of compliance with the NJR and PROMS has continued to attain high levels this year. NJR data is now being used in performance appraisals of surgeons by clinical directors. PROMS data has been reviewed at Integrated Governance and has provided assurances regarding the quality of outcomes in hip and knee replacement. PROMS reports have shown that the Trust is above the national average in all cases.

*The reports of 78 local audits were reviewed by the provider in 2012/13 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:*

- To implement the newly enhanced audit database and ensure all audits are registered, reported and reviewed via the system to enable better reporting and review of all audit activity in the Trust. Links to be formed with the other departmental audit databases such as Oncology, Pharmacy audits, infection control audits and the recently enhanced Health and Safety audit programme.
- Produce information for GP's regarding the Back Pain Clinic including criteria for urgent and routine referrals. Review information sent out to patients, and monitor patients not seen within 6 weeks of referral over a 3 month period to evaluate reasons.
- To continue the monthly health records reviews, with results reported at Performance and Directorate meetings. Central database to be set up to enable direct input and analysis.
- To continue to use HED data to monitor outcomes on mortality, length of stay, day case conversion, readmission rates, VTE data, and revision rates.
- Share WHO report findings with relevant staff, and devise and implement action plans to monitor and improve quality of WHO Safety Briefings.
- To continue to improve and re-audit the review of venous thrombo-embolism (blood clot) risk assessments carried out and the frequency in which they are done
- To ensure all staff as well as patients and relatives are aware of the importance of plaster care instructions.
- Improve compliance of dementia assessments (for emergency admissions aged 75 years and over) through communication with various staff groups, and include those over 65.
- Continue improvement in prescribing practice as per Medicines policy. Improve compliance with recording of omitted doses. Spot checks of drug charts and other areas relating to medicines safety/management
- Continue to educate staff in plaster management, improve documentation, compare practice at other trusts and pre-operative education especially with high risk groups.

*"The year saw surgeon level data reaching the boardroom and being fed back to clinicians. A major development of the audit programme is due for roll-out in March 2013, aiming to improved monitoring and managing of audit activity"*

***Mr Matt Revell, Clinical Director, Clinical Outcomes***

The Integrated Governance Committee has held a number of detailed discussions on clinical audit during the year to further develop the clinical audit programme moving forward.

## 2.3.3 Participation in clinical research

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

*The number of patients receiving NHS services provided by The Royal Orthopaedic Hospital NHS Foundation Trust in 2012/2013 that were recruited during that period to participate in research approved by a research ethics committee was 785.*

*The Royal Orthopaedic Hospital NHS Foundation Trust was involved in conducting 43 clinical research studies in orthopaedics during 2012/13. Over the same period, mortality amenable to healthcare/mortality rate from causes considered preventable in orthopaedics changed from the previous year by **x** %. The improvement in patient health outcomes in The Royal Orthopaedic Hospital NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatments for patients.*

*There were 47 clinical staff participating in research approved by a Research Ethics Committee at The Royal Orthopaedic Hospital NHS Foundation Trust during 2012/13. These staff participated in research covering 7 sub -specialties.*

*As well, in the last three years, 1 publication has resulted from our involvement in National Institute for Health research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.*

There have been 20 publications generated from other research activity during this period (appendix 1).

*"Research activity within the Trust has grown significantly within the last four years. We have a dedicated onsite research team who support researchers both internally and from outside organisations to ensure that we are improving patient care through the acquisition of new knowledge, whilst protecting our patients"*

***Mr Edward Davis, Director of Research & Development***

## 2.3.4 Goals agreed with commissioners

### Use of the CQUIN payment framework

*A proportion of The Royal Orthopaedic Hospital NHS Foundation Trust's income in 2012/2013 was conditional on achieving quality improvement and innovation goals agreed between The Royal Orthopaedic Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.*

*The total amount of income conditional upon achieving quality improvement and innovation goals in 2012/13 was £1,324,512. The payment made to the Trust was £1,226,112, an achievement of 93% of the total potential value.*

*Further details of the agreed goals for 2012/2013 and for the following 12 month period are available on request from the Trust's Head of Commissioning, Gareth Hyland, Gareth.Hyland@nhs.net.com)*

## 2.3.5 Statements from the Care Quality Commission

The Care Quality Commission (CQC) is an independent regulator of health and social care and replaced the Healthcare Commission. Foundation Trusts must register with the CQC and it can inspect and assess the Trust across a wide range of performance indicators at any time during the year.

*The Royal Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'.*

*The Care Quality Commission has not taken any enforcement action against The Royal Orthopaedic NHS Foundation Trust during 2012/2013.*

## 2.3.6 NHS Number and General Medical Practice Code Validity

*The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 2012/2013 Secondary Uses Service for inclusion in Hospital Episode Statistics which are published in the Data Quality Dashboard from HSCIC. The percentage of records in the published data*

*-which included the patients' valid NHS Number was:*

- *99.6% for admitted patient care*
- *99.9% for outpatient care*

*-which included the patient's valid General Practitioner Registration Code was*

- *100% for admitted patient care*
- *100% for outpatient care*

*The Royal Orthopaedic Hospital NHS Foundation Trust's Information Governance Assessment score for 2012/2013 was 74 % and was graded 'satisfactory'.*

*The Royal Orthopaedic Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission*

*All services were included and the results should not be extrapolated further than the actual sample audited.*

*The Royal Orthopaedic Hospital NHS Foundation Trust will be taking the following action to improve data quality :*

To continue with the Data quality Group comprising Director of Operations, Deputy Finance Director, Data Quality Manager, Information Governance Manager, and representatives from Nursing, IT and front line operations. This group addresses issues and risks, monitors action plans, performance through agreed KPIS and an Audit plan,

The Data Quality Policy has been refreshed to reflect a strategic change in approach whereby responsibility for addressing data quality is devolved to departments and system/information asset owners with the aim of getting data quality right first time. Staff are supported by the Data Quality Manager who coordinates initiatives, carries out targeted audits and provide advice and guidance.

The Trust consistently meets or exceeds the national benchmark for the data items listed in the Data Quality dashboard produced by the Health and Social Care Information Centre (HSCIC) for inpatients and outpatients.

Clinical coding consistently reaches a high standard (see below) and further improvements have been made through implementation of a Clinician Communication Strategy which engages clinicians in the coding process through 6 monthly open sessions.

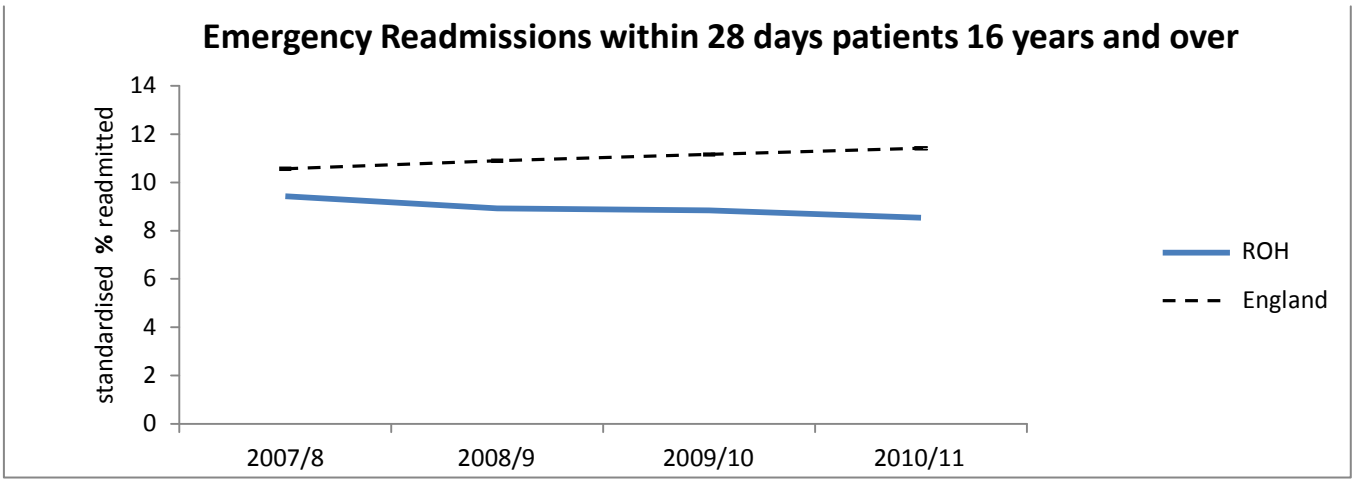
## *2.3.7* Mandatory outcome indicators

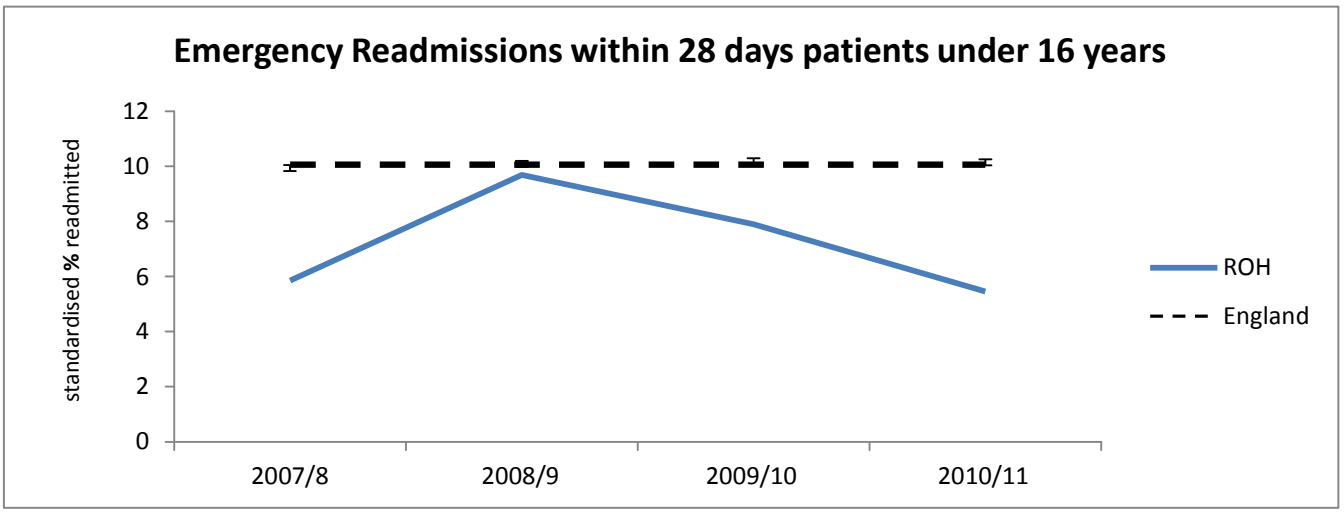
### Patients readmitted to a hospital within 28 days of being discharged

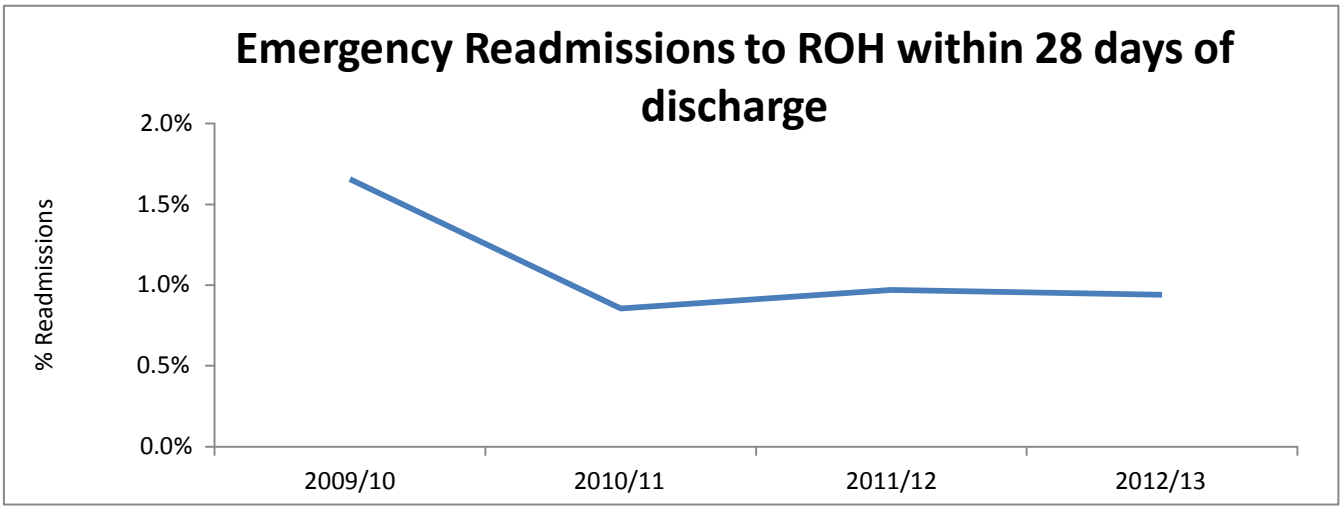
The percentage of emergency admissions to any hospital in England, occurring within 28 days of the last, previous discharge from hospital after admission
(i) patients 0 to 15; and
(ii) patients 16 or over.

The percentage of emergency admissions to a hospital that forms part of the trust, occurring within 28 days of the last, previous discharge from hospital after admission

Results






### Commentary

There are three measures of emergency readmissions, nationally published data that allows comparison with the England average and readmissions to our own hospital which gives more up to date data. Our percentage of emergency readmissions is significantly better than the national figure for both patients under 16 years of age and 16 and over. The percentage of all emergency readmissions has fallen for the last three years reported (to 2010/11). Readmissions to ROH have been less than 1% for the last three years.

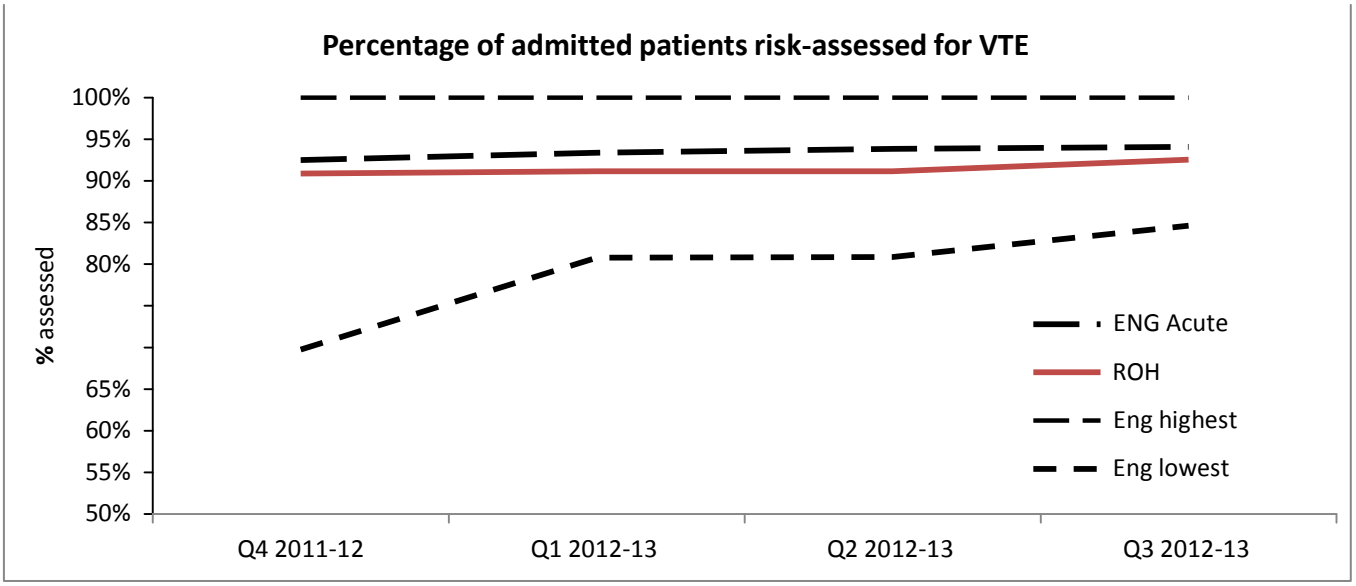
| Emergency Readmissions to ROH within 28 days of discharge | | | |
|---|---|---|---|
| 2009/10 | 2010/11 | 2011/12 | 2012/13 |
| **1.66%** | **0.86%** | **0.97%** | **0.94%** |

Readmission figures form part of the monthly clinical indicators monitoring disseminated to directorates and are being incorporated into the monthly outcomes dashboard.

### Percentage of admitted patients risk-assessed for venous thrombo-embolism

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

## Results




| | Q4 2011-12 | Q1 2012-13 | Q2 2012-13 | Q3 2012-13 |
|---|---|---|---|---|
| **ROH** | **90.9%** | **91.1%** | **91.1%** | **92.5%** |
| All Acute providers England % | 92.5% | 93.4% | 93.8% | 94.1% |
| England lowest | 69.8% | 80.8% | 80.9% | 84.6% |
| England highest | 100.0% | 100.0% | 100.0% | 100.0% |

## Commentary

Our percentage of patients risk assessed for VTE is slightly below the England average however the figure has continued to increase over the last four quarters.

The Trust relies on a paper based data collection system at ward level. This requires staff to manually check that a completed VTE risk assessment form is present and enter this information onto the audit form. Reliance on this method and potential human error factors means that it has proven difficult to gain large increases, however the VTE CQUIN criteria has been met.

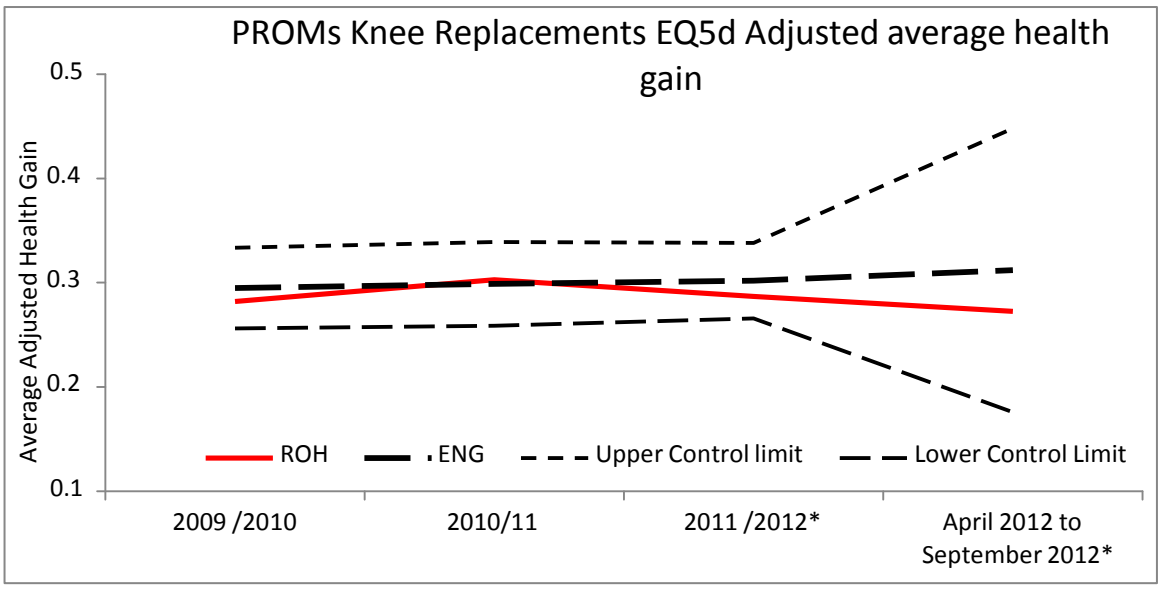
Procedural documents for identification and reporting of VTE risk assessment data were produced following the last external audit and are now in use.

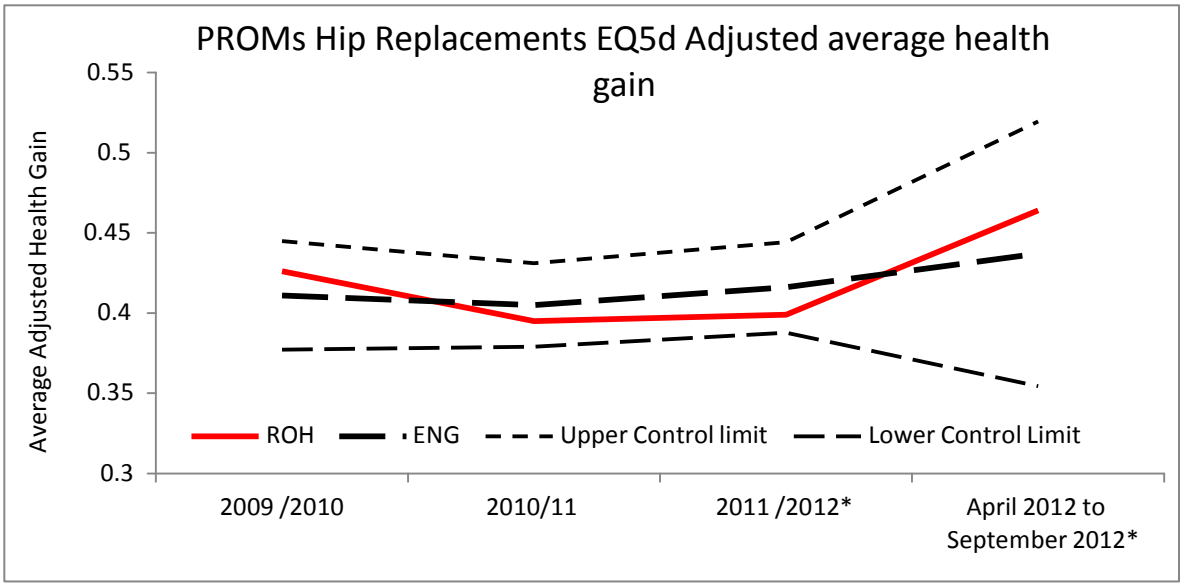
## Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) provide information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. THE EQ5d Index asks patients 5 questions regarding their general health (mobility, self-care, usual activities, pain/discomfort, anxiety/depression) before the operation and six months after the operation.

The adjusted average health gain is used for comparison between providers; this is adjusted for case-mix (age, sex, co-morbidity etc.) and is measured as improvement from the national average pre-operative questionnaire score.

## Results




**** Provisional data only***

**Commentary**

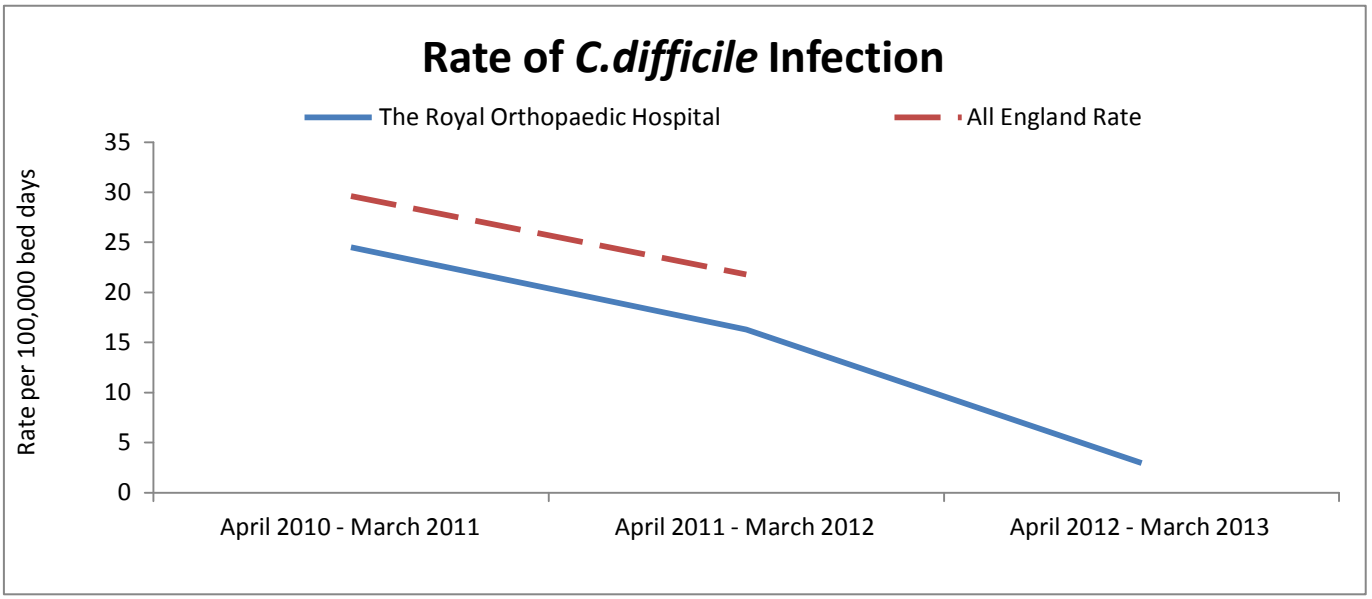
Our position is not significantly different from the England average for both hip replacements and knee replacements.

PROMs data continues to be monitored at our Clinical Outcomes and Effectiveness Committee and our Integrated Governance Committee. We have recently improved our reporting to provide data by individual consultant. The Trust is looking at both individual and overall results to understand these results in more detail and identify areas for action.

### Rate of *C.difficile* Infection

The rate per 100,000 bed days of cases of *C.difficile* infection that have occurred within the trust amongst patients aged 2 or over during the reporting period.

### Results




| | April 2010 - March 2011 | April 2011 - March 2012 | April 2012 - March 2013 |
|---|---|---|---|
| The Royal Orthopaedic Hospital | 24.5 | 16.3 | 3.0 |
| All England Rate | **29.6** | **21.8** | Not published at present |
| Lowest England Rate | 0 | 0 | |
| Highest England Rate | 71.8 | 51.7 | |

### Commentary

The control of infection is of paramount importance for our patients and the Trust has continued to meet its targets with only 1 reportable case of *Clostridium difficile* during 2012-13 against a target of 6 cases with the most recent case being reported in June 2012.

The rate of *C.difficile* infection is lower than the national rate and has continued to reduce over the last three years. Benchmarked against other West Midlands trusts we have one of the lowest rate of *C.difficile* infection and the lowest rate in comparison with other specialist orthopaedic providers.

### Patient Safety incidents with severe harm/death

Patient safety incidents resulting in severe harm or death

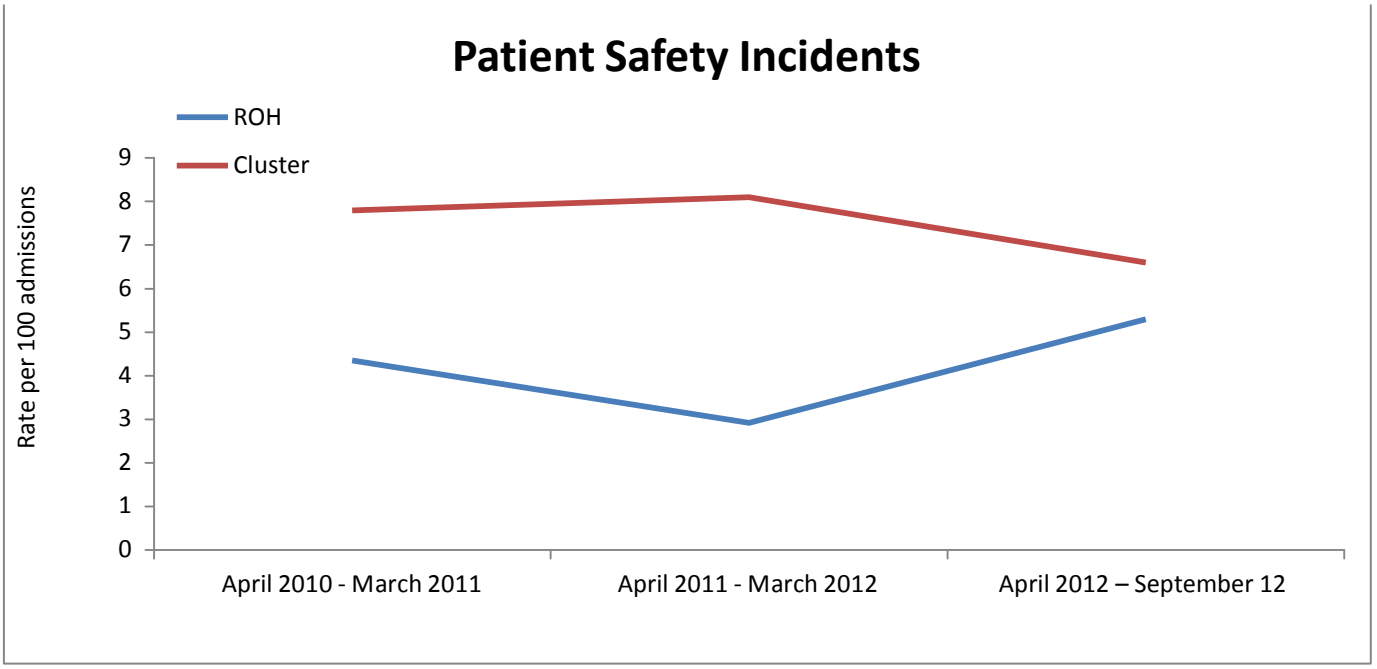
This year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre. The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident

reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to reports patient safety incidents under the NRLS's voluntary arrangements.

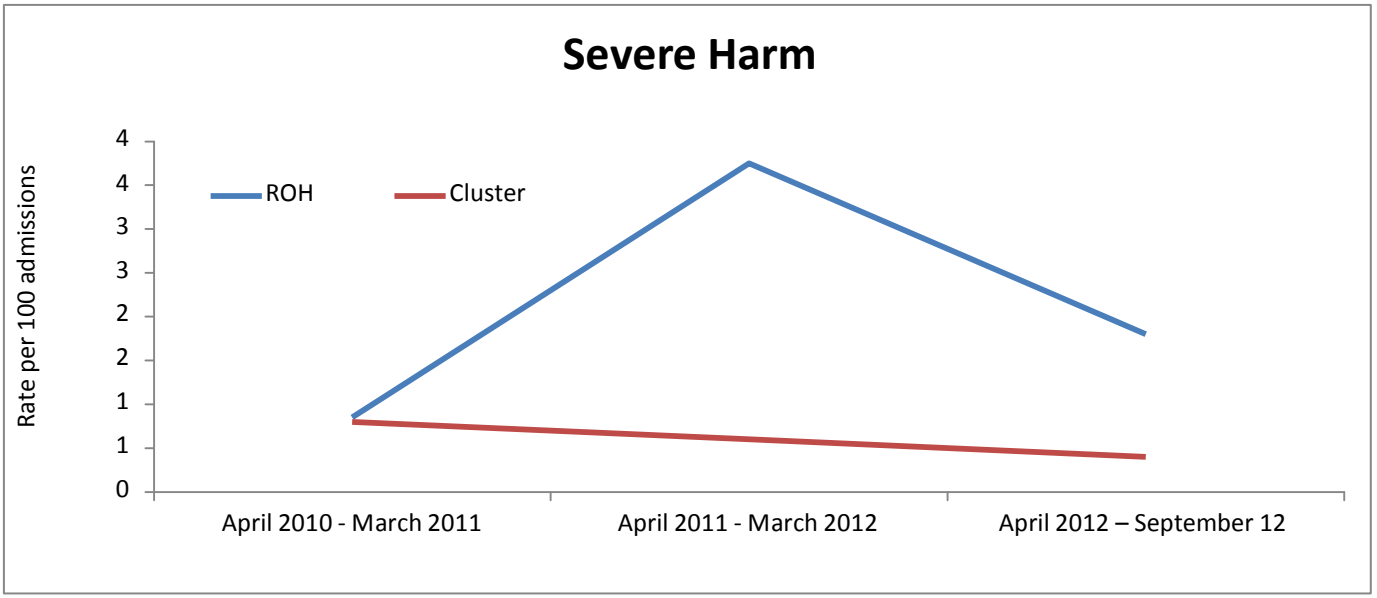
As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the Trusts as this may not be comparable.

*The number and rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death.*

## Results




| Patient Safety Incidents | April 2010 - March 2011 | April 2011 - March 2012 | April 2012 – September 12 |
|---|---|---|---|
| The Royal Orthopaedic Hospital rate (per 100 admissions) | 4.35 | 2.92 | 5.3 |
| Average Cluster Rate (per 100 admissions) | 7.8 | 8.1 | 6.6 |
| Lowest Cluster Rate (per 100 admissions) | 1.67 | 2.7 | 1.37 |
| Highest Cluster Rate (per 100 admissions) | 24.5 | 20.48 | 24.88 |




| | April 2010 - March 2011 | April 2011 - March 2012 | April 2012 – September 12 |
|---|---|---|---|
| The Royal Orthopaedic Hospital rate (per 100 admissions) | 0.85 | 3.75 | 1.8 |
| Average Cluster Rate (per 100 admissions) | 0.8 | 0.6 | 0.4 |
| Lowest Cluster Rate (per 100 admissions) | 0 | 0 | 0 |
| Highest Cluster Rate (per 100 admissions) | 3.1 | 2.9 | 1.8 |

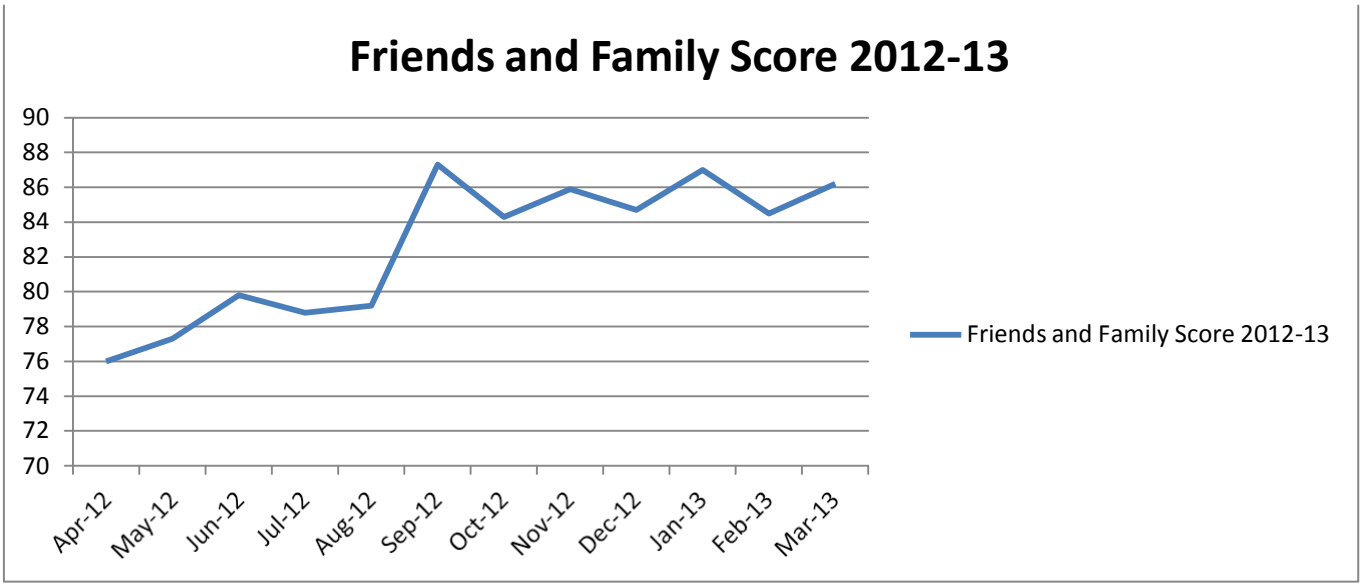
**Commentary and further actions.**

1) These figures are released every 6 months by the National Reporting and Learning System
2) Regular reviews of serious harm incidents are undertaken by the Governance Team and the Quality Committee.
3) The figures submitted to the NRLS are regularly reviewed to ensure all patient safety data has been submitted. There has also been extra care taken this year to ensure these are all sent off by the deadlines set by the NRLS which has led to an encouraging rise in incidents reported, more representative of the cluster group.
4) Staff training to ensure accurate grading of incidents has been started and Governance now features on staff mandatory training and inductions.
5) Random check audit of submitted incidents will commence to check if the actual degree of harm is being recorded accurately (instead of potential level of harm) and is a direct result of the patient safety incident, as an initial review indicates areas where accuracy can be improved.
6) The percentage of patient harm incidents resulting in severe harm or death (as reported on the internal incident system) for 2012/13 as a percentage of overall patient safety incidents is 1.07%

### Indicator

*Net Promoter Score (Friends and Family Test)*

### Results




The Trust has remained in the top quartile of best performing hospitals involved in the pilot project for the last financial year. Return rates steadied at around 17% (requirement was 10%) and the additional information was fed back to wards and departments.

### Commentary

Generally, patients felt that they had a very good experience at the hospital and would have been more than happy to recommend our services. The three main areas identified that would enhance patient experience are:

- Food – including variety, temperature and special diets
- Communication- during access to hospital, whilst in hospital and after discharge. This includes hospital letters, conversations and patient information
- Response times – delays in responding to call bells, obtaining medication and information about what's happening.

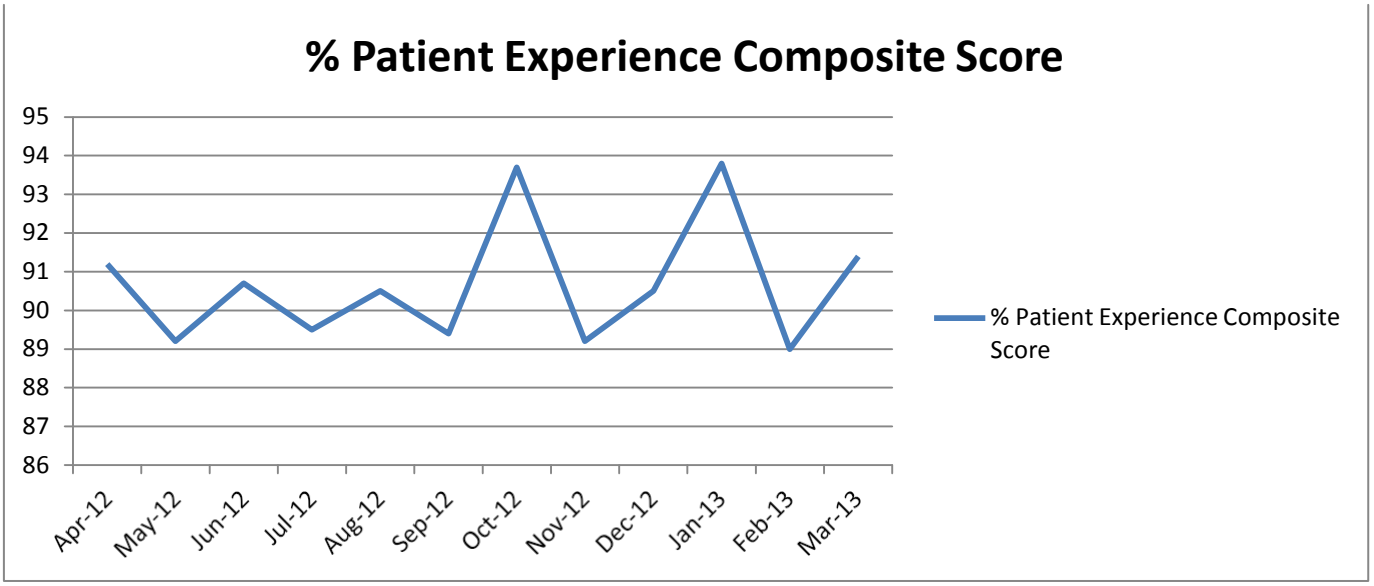
Actions already completed include:

- Altering of Patient information to make it more patient friendly
- Initiated a review of administrative processes to improve patient pathway
- Information about patient perspective has been used in the planning for the new admission and day case unit.
- Wards have discussed Friends and Family results at ward meetings and are taking action at a local level to address these.

### Indicator

The trusts responsiveness to the personal needs of patients

## Results




The composite score for patient experience is a combined total average score from 5 questions on the patient survey. The scoring remains very high (from 89% to 93.8% satisfied) and is used as an indicator of satisfaction in the national CQUIN scheme.

**Commentary**

The five questions asked and evaluated are:

- Were you given enough privacy when discussing your personal details, condition or treatment?
- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Do you know who to contact if you have any concerns or worries after you leave the hospital?
- If you have been prescribed any new medication by the hospital, were you given information about the possible side effects?
- Do you feel that there are staff available to talk to you about any concerns or worries that you may have?

All five questions contain an element of personalising responses to the individual being treated and it can be seen that in the majority, patients feel that we do this very well. Work has continued over the last year to improve the lowest scoring questions (which relate to medication side effects and availability of staff on the ward to discuss concerns).

Actions already completed include:

- Composite scores have been sent to ward managers and matrons for review and action on a quarterly basis
- Anonymous scores have been shared with ward managers and matrons in real time to enable identification of any potential issues

# Part 3 – Other information

## Other information on how the Royal Orthopaedic Hospital NHS Foundation Trust focuses on the delivery of quality services to patients

Part Three of our Quality Account aims to tell the story of how quality underpins everything we do and goes much further than targets alone would suggest.

The focus for 2012/13 has been to embed our culture of continual quality improvement within the new Clinical Directorates ensuring that the triumvirate teams at the head of each – Clinical Director, Matron and Directorate Manager – take ownership of the quality agenda and drive service culture and change.

At Board level we have constantly challenged ourselves, and others, on the decisions that we make ensuring that we have come back every time to underpin our decisions with a view of what is right for the patient. The Board has heard patient stories at every meeting to reflect the experiences of our patients, both good and bad. The Board also met some patients and carers face to face at a Quality Workshop to hear first -hand how the service we provide impacts on our patients and their families.

Over the last year, there has been a real shift in the balance of board focus. Despite the financial and activity challenges, the quality of the service we provide to our patients has remained our key priority.

The Board continues to welcome and recognise the contribution and benefits of Foundation Trust membership, its strong group of volunteers and wider public engagement. The Council of Governors also provides a patient and carer perspective and this too allows the non-executive directors in particular to be held to account for the quality of service.

The Board and Governors have discussed and taken to heart the key themes behind the Francis Inquiry Report. Further work to embed the learning from this report will take place during 2013-14 throughout the hospital.

This section shows how we have really begun to draw these threads together to keep quality and patients at the top of our agenda.

We set a range of priorities for 2012/13 that were agreed by the Board and staff, patient and public stakeholders as important areas to focus on. The following tables show how we have performed against those priorities.

## 3.1 Quality improvement priorities for 2012/13 that were achieved

| Improvement priority | Performance 2012/13 | Performance 2011/12 | Performance 2010/11 | National definition | Data source |
|---|---|---|---|---|---|
| **SAFETY** | | | | | |
| **90% of patients will be assessed for risk of venous thrombo-embolism (blood clots)** | Achieved | Achieved | >90% | Yes - national CQUIN | Unify |
| **Zero never events** | Achieved | Not achieved - 2 | Not measured | Yes | Ulysses |
| **100% of patients whose condition deteriorates and requires transfer to the High Dependency Unit or an Intensive Care Unit will have their case notes reviewed to ensure trends are identified and actioned** | Target 100%<br><br>Achieved 100% | Target 100%<br><br>Achieved 100% | Not measured | No | Monthly review meetings |
| **EFFECTIVENESS** | | | | | |
| **To establish readmission rates of our patients back to us and other hospitals** | Achieved | Achieved with the implementation of the HED information system | No target set | Yes | HED |
| **To reduce length of stay for patients on the enhanced recovery programme** | Achieved<br><br>Primary hip length of stay reduced from 5 to 3 days<br><br>Primary knee length of stay reduced from 5 to 3.5 days | Achieved<br><br>Primary hip length of stay reduced from 5 to 3 days<br><br>Primary knee length of stay reduced from 5 to 3.5 days | 5 days | Yes | Enhanced recovery programme |

| | | | | | |
|---|---|---|---|---|---|
| **To reduce the number of grade 3&4 pressure ulcers by 30%** | Achieved – 50 % reduction | No target | No target | yes | Ulysses |
| **To improve adherence with appropriate chemical VTE prophylaxis in line with CQUIn target** | Achieved | No target | No target | Local CQUIN | CQUIN audit data |
| **EXPERIENCE** | | | | | |
| **To reduce the number of patients cancelled on the day of surgery by the hospital from an average for the year of 1.2% to <1%** | Target <1%<br><br>Achieved 0.6% | Target <1%<br><br>Achieved 0.9% | 1.2% | No | Corporate performance report |
| **To increase the numbers of patients reporting in the national patient survey that they had received written information before admission to >65%** | Achieved<br><br>85% | This question has changed in the national survey this year so a direct comparison is not possible.<br><br>88% of patients reported that they received the right amount of information about their treatment/condition | <65% | National inpatient survey | National inpatient survey |
| **To improve the % of patients reporting in the national survey that they receive information about their medication** | Achieved | No target | No target | Yes | National inpatient survey |
| **Reduce the numbers of patients experiencing delays in the X-ray department** | Achieved | No target | No target | No | Local audit data |

| Not achieved | | | |
|---|---|---|---|
| **Improvement priority** | **Performance** | **National definition** | **Data source** |
| **SAFETY** | | | |
| To ensure actions from SIRIs are completed within agreed timescales | Monitoring via Ulysses has started in March 2013 | No | Ulysses |
| **EXPERIENCE** | | | |
| **To reduce the % of patients who rated hospital food as poor as reported in the national survey to <12%** | Target <12%<br><br>Not achieved -12.8%%<br><br>(2011/12 = 13.6%) | National patient survey | National patient survey |
| **EFFECTIVENESS** | | | |
| **>90% of patient will have on-going falls risk assessments completed and evidence of care plans in place for those at high risk.** | Target >90%<br><br>Not achieved – 73% | No | Quarterly audit data |
| **To reduce the length of time patients are starved before surgery to < 10 hours** | Target < 10 hours<br><br>Not achieved – 13.8hours<br><br>(2010/11 = 13.9 hours) | Yes – standards based on Royal College of Anaesthetists | Audit data |

## 3.3 Excellent Health

The Excellent Health programme is run from a Programme Management Office (PMO) which has increased the number of staff involved in change projects and helped staff from all levels and disciplines work together to create innovative solutions to improving quality whilst reducing cost.

The PMO has been uniquely used to encourage positive culture change within the hospital, promoting staff engagement at all levels.

Although some work had taken place to encourage 'lean' thinking within the hospital, the Excellent Health programme now is encapsulated by the PMO and is used as the primary vehicle to help encourage staff members to achieve the hospital wide transformation, opening up service improvement and Lean techniques to everyone.

Innovation within each of the projects has largely been driven by ideas from frontline staff. Through exploiting the knowledge of front line staff, critical aspects of each project have been modified to incorporate efficiency or service improvements coming from the staff that see real change the most.

Quality has always remained the key aspect of every project. Patient & carer groups are active and are at the heart of the changes being made. ROH has now been operating a PMO for another full financial year. Consequently, it is now clear the results that have been achieved directly from operating the PMO system.

Often efficiency savings regularly go hand in hand with improved patient care.

This has been supported by the continuing high level of hospital wide patient satisfaction seen within the real time patient surveys, and the improved satisfaction levels seen within project areas.

Many of the projects taking place have grown from patient surveys carried out and listening to the voice of the membership. The following are a sample of completed projects as a result of ideas suggested by patients

- Self-arrival terminals in OPD
- Waiting time reduction in x-Ray
- Booked admissions
- Improved Car Parking and flow
- Improving the quality of patient information
- The Bone Infection Unit was driven by the need to improve quality of care for patients undergoing revision surgery for infected joints.

The 'Getting it right programme' has been the focus for the PMO teams this year and has led to a project to map out the patient journey with patient stories fed into the individual projects to force quality and patient experience into the design of new processes – an initiative that has provided key information for improvement projects that will be taken forward over the coming three years.

With strong backing from the Board, the PMO has grown, incorporating more projects and creating time for further projects to be undertaken.

Other organisations have expressed an interest in setting up their own PMO having seen the success at ROH. These include both public and private organisations.

## 3.3 Building for the Future

*"We have been planning our new and exciting Admissions and Day Case facility and we are pleased to report the building is due to open in the summer 2013. This facility will bring together our Admissions and Day Case facilities right next to our current Theatres in a pleasant environment and will greatly improve the service delivery to our patients. We are now planning for the future development of a new theatre complex and improved inpatient services"*

**Stuart Lovack – Head of Estates & Facilities**

Our new restaurant, Café Royale which is located in the foyer of the Treatment Centre opened in July 2012. The facility provides a state-of-the-art servery, a restaurant for 40 people, a small coffee area and a dedicated staff coffee room. There is also a patio area for those who wish to dine 'alfresco' in the summer.

We are currently on-site with our major development which involves the Trust providing a new Admissions and Day Case facility.

This project combines our current Admissions facility with our Day Case Unit.

The unit will accommodate 20 patients in chairs or on a trolley. Phase One was completed in June 2012 and Phase Two continues. The construction works includes works to the original main outpatients department and will use the building known as the Octagon as its main entrance where all patients will be welcomed and received. The new department is located right next to our existing Theatre complex so patients requiring an operation only have to travel a short distance to Theatres. Work will be completed on this project in the summer 2013.

## 3.4 Putting Patients First

The Board continues to be committed to putting patients first. We continued to listen to what patients and the public told us rather than making assumptions about what we thought they'd say. At every public Board meeting, two anonymised patient stories have been discussed to provide a reference point and reality check. This has set the tone for the meeting and prompted much debate about how to improve processes and process design such that earlier mistakes are learnt from and mitigated.

PALS and Complaints, Patient Experience and Patient Information are part of Public and Patient Services Department. This allows the Trust to identify areas of good practice in real time and share this quickly across all areas. In an effort to continually improve its service to patients the Trust asks complainants to comment on their experience of complaint handling and in 2012/13 this showed substantial improvement in the satisfaction with complaint responses and the quality of the service provided, including an increase from 63.6% to 96.6% of respondents feeling that complaints staff were helpful and professional and 90% of complainants reporting that they would feel confident in complaining again if they felt the need to do so.

Disappointingly there has been a 13% increase in the number of formal Complaints compared to the previous year and a 48% increase in the number of informal complaints. Work has been undertaken to identify the reasons for these increases and it is felt that the Trust has made real progress in ensuring that people know how and who to complain to. The department is continuing to work on improving the internal processes for complaint handling to ensure that the quality improvements made are sustained and continue.

The Department has been involved in the pilot project for the Friends and Family Test that will be implemented nationally in the coming year. Data from this pilot has been collected all year and has proved to be a valuable source of informal data (from the additional questions). The Trust has remained within the top quartile in comparison with the other pilot Trusts and expects this to continue.

The hospital continues to perform well in the National Inpatient Survey and monitors continuously via action plans and real time surveys any areas for improvement. This year's survey has indicated that staff need to be more visible to patients and families. Further work on identifying issues and improving communication across departments and areas has begun.

The outpatient survey demonstrated a number of areas for improvement including appointment arrangements, waiting times and patient information. This survey is conducted bi-annually and work has continued to ensure improvements in this area.

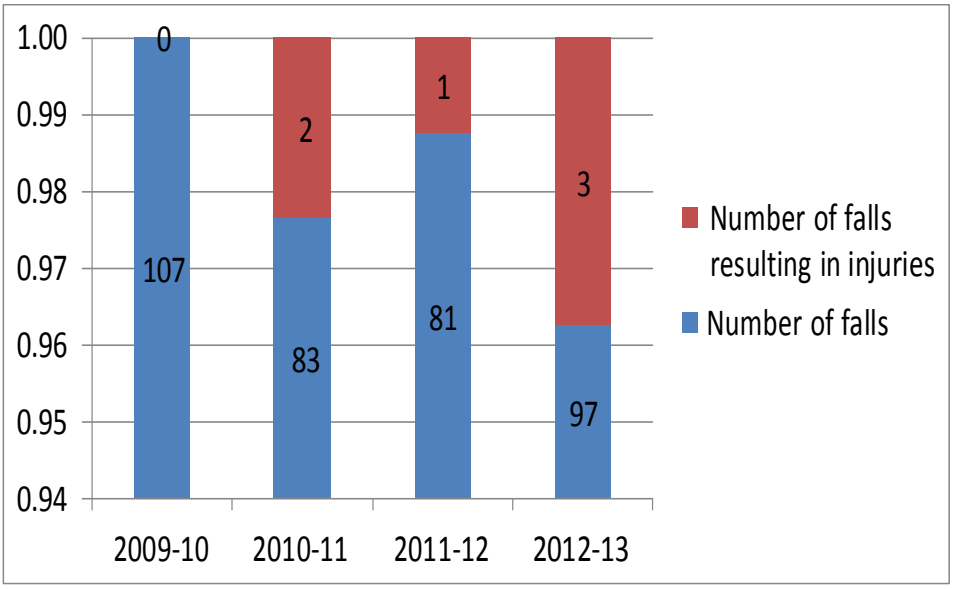
## 3.5 Patient falls

As an organisation, we continue to develop strategies to reduce potential harm to patients who may fall during their stay in hospital.

Over the last year we have continued to develop our falls working group which now includes representation from all members of the multi-disciplinary team as well as a patient representative. We have also reviewed the Royal College of Physicians report on the 2011 inpatient falls pilot audit by the Health Quality Improvement Partnership which outlined recommendations that hospital's should take on board for local improvement. We are currently working through these recommendations and a subsequent assurance framework will be developed to evidence compliance. As part of this work, one of the areas we are reviewing is our local documentation including risk assessments, This is being carried out to improve the level of risk assessment that we undertake and implement all necessary preventative measures.

This year we have had 97 falls which is an increase of 15% from last year. We are mindful that within an organisation that encourages patients to regain mobility and independence as soon as possible this will result in some patients sustaining a fall. However, from the Trust Board to the frontline staff delivering care, we are all committed to ensuring that strategies are in place to reduce the risk and to ensure that all falls are reported and monitored. This year we have also introduced a falls questionnaire, which is part of our incident reporting system. The aim of this initiative is to ensure we have accurate and more detailed data that will enable us to drill down into themes or patterns which need to be addressed.

Figure 1- Shows the Number of inpatient falls and those that resulted in injuries.




Quarterly falls audit results 2012-13

Our quarterly audits in this area have demonstrated for assessment undertaken on admission that we have achieved an average score of 91.5% an improvement from 90.5% last year (see table below). However, whilst we have seen a quarter on quarter increase in the review of risk assessments we have not improved our average score from last year (74%)

Over the next twelve months we aim to continue to improve our completion rates of risk assessments and reviews and ensure that we continue to implement strategies which ensure that our patients are kept safe while in our care.

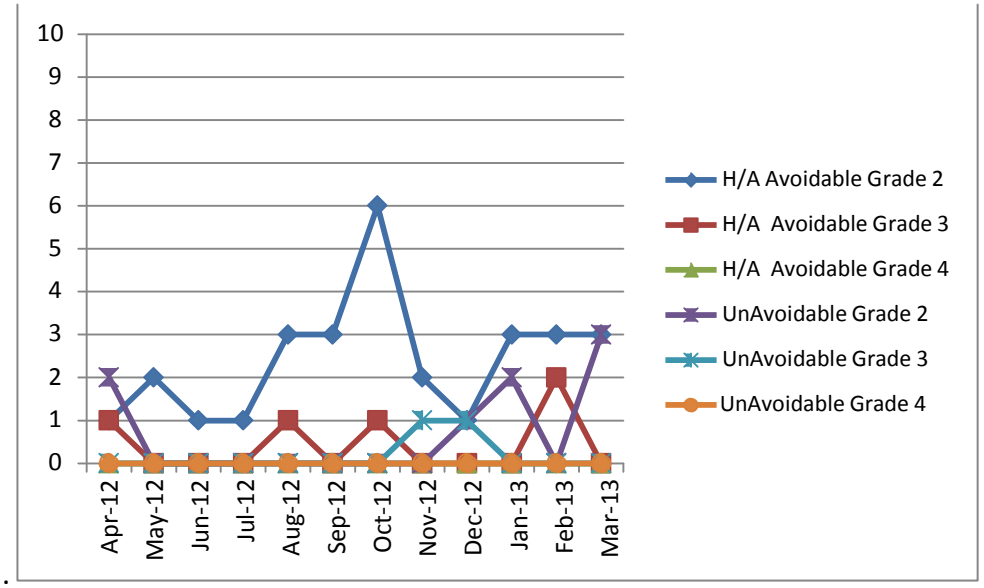
| | | Q1 | Q2 | Q3 | Q4 | Overall performance over 12 months |
|---|---|---|---|---|---|---|
| Q1. | Has the falls assessment been completed on admission? | 86% | 97% | 95% | 88% | 91.5% |
| Q2. | Has the falls assessment been reviewed as per assessment? | 58% | 78% | 72% | 83% | 73% |

## 3.6 Pressure ulcer prevention

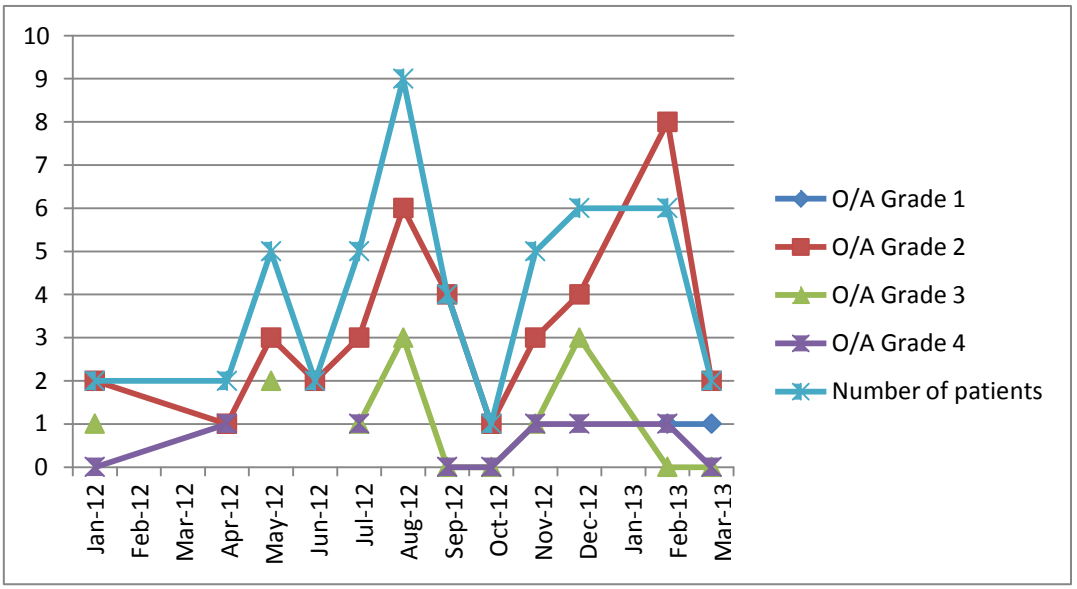
2012-13 has seen a significant reduction in avoidable hospital acquired pressure ulcers. The Tissue Viability team have worked very hard to procure new equipment and to provide training across all areas in order to assist with prevention. The 43.3% reduction in pressure ulcers achieved this year is evidence that the current programme is effective. The work undertaken by the team and all clinical staff involved has ensured we have reduced the harm caused to patients from pressure ulcers however there is more work to do.

A total of 34 avoidable pressure ulcers occurred this year. A further 10 pressure ulcers occurred which were deemed unavoidable. This categorisation is decided following a review of each case – the 10 pressure ulcers were due either to the general poor condition of the patient and/or non-compliance with preventative strategies/equipment. If a pressure ulcer developed despite all preventative strategies being put in place, this is deemed unavoidable. In addition there was also a reduction from 14 to 7 in the number of pressure ulcers that cause the most harm, the grade 3&4 pressure ulcers.

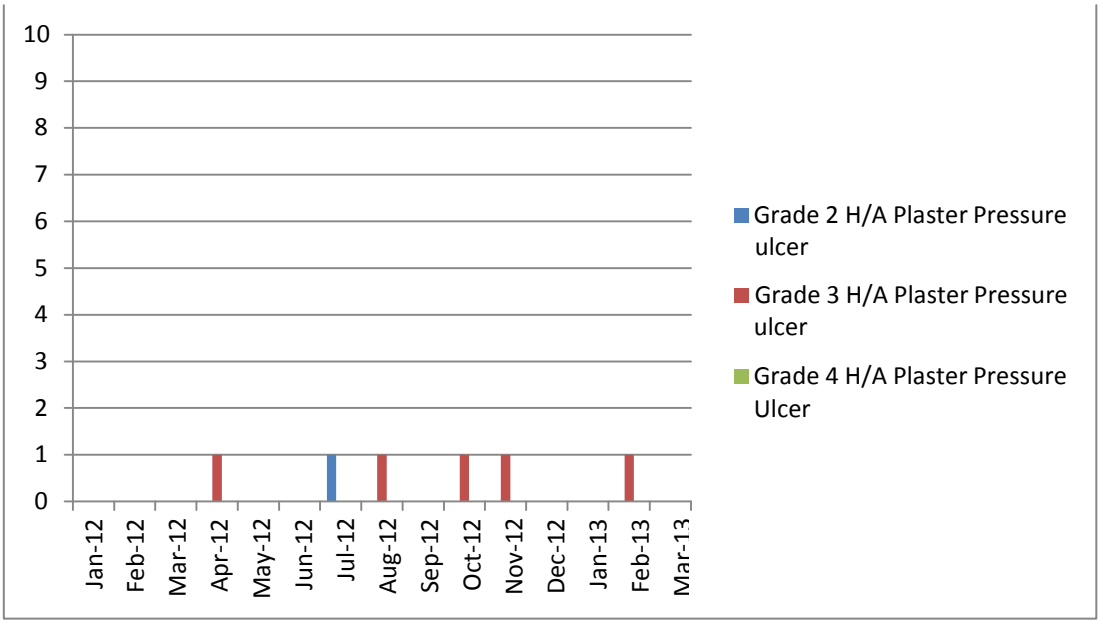
The graph below, shows the incidence of all hospital acquired pressure ulcers (avoidable and unavoidable), and categories of these ulcers.




The second graph demonstrates numbers of patient admitted with existing pressure ulcers. A total of 56 pressure ulcers were present on admission either from home or other Trusts.




A total of 6 patients developed plaster pressure ulcers whilst an inpatient, which are reflected in the figures in the first graph. Of these one was an unavoidable grade 3. These device related pressure ulcers are a particular focus for 2013-14. There are complex issues surrounding these cases as the device is often required to maintain the safety of the limb, and there are few, if any alternatives.

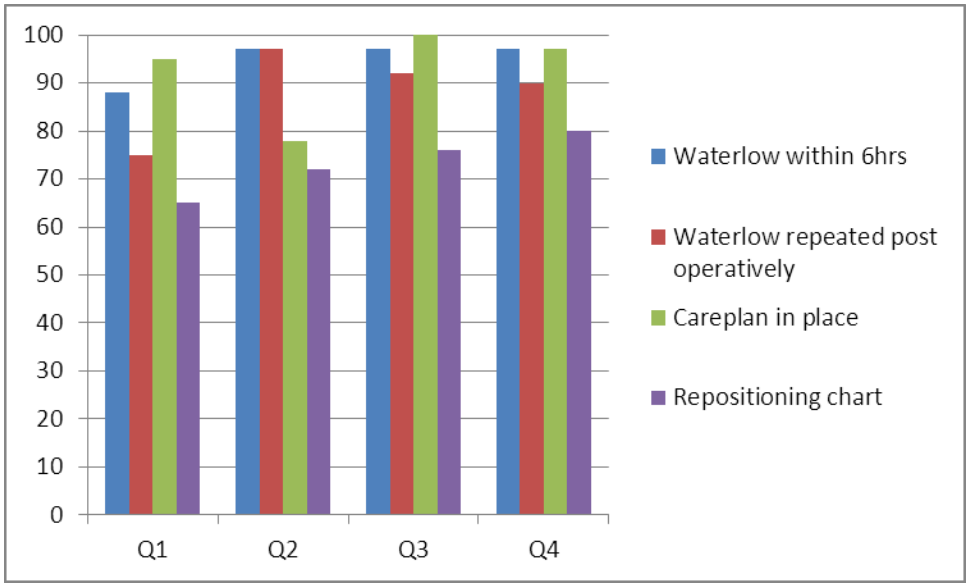



Mandatory training on pressure ulcer prevention is available monthly for all staff. In addition to this all nursing staff groups receive in depth training in the prevention and management of pressure ulcers. The healthcare assistants also receive extra training with a practical session in the prevention and management of pressure ulcers to compliment the theoretical session.

All nurses are completing pressure ulcer competencies, with the aid of a pressure ulcer prevention and management, ward based competency document. Assessment is provided by Tissue viability link nurses and the Tissue Viability Nurses. The competency documents are monitored by ward managers, and reported to matrons for their areas.

The Tissue viability link nurses audit their own ward area every quarter and from this data they can then identify areas they need to improve upon. Findings demonstrated that 97% of patients had a Waterlow score within 6hrs of

admission. We have added an adapted version of the SKIN tool to the pressure ulcer prevention careplan in order to improve recognition of problems and help prevent them. Below is the data collected for the year.



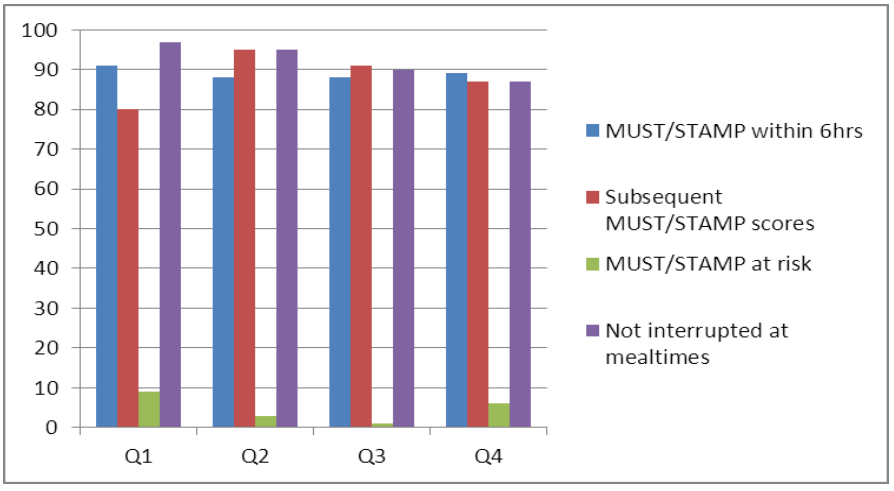

The Tissue viability team carry out monthly documentation audits on wards to ensure all wards are using the correct paperwork, this is fedback to ward managers and matrons. The findings demonstrate documentation has improved over the year.

## 3.7 Nutrition

Nutrition is a vital element of patient care that impacts on various outcomes for our patients, not least their experience of their time at the hospital.

Quarterly audits are undertaken by our team of link nurses to ensure that we are maintaining and improving our standards. The most recent audit this year was undertaken in Feb 2013. 87% of patients audited were not interrupted at mealtimes. 89% had a MUST/STAMP (nutritional) assessment completed within 6hrs of admission; with 87% of patients who needed a subsequent MUST score completing being done. Of this "AT RISK" group, 6% were referred to the dietician and 4% had a 'nutritionally at risk' care plan in place, Other concerns identified included assistance needed with diet, and dietary advice, or concerns regarding wound healing.

The graph below shows this years results:



All grades of nursing staff including student nurses attend training on the clinical skills days run every month. The risk and potential consequences of poor nutrition and hydration are covered on this day along with training regarding when and how to complete MUST and the importance of this.

In addition to the above training the HCA's have a practical training day which also covers MUST and nutritional needs of our patients.

Mandatory training sessions once a month for both clinical and non-clinical staff also cover fasting guidance and recent audit results. This commenced July 2012, in addition to this local GP's receive training into pressure ulcers and wound care twice a year. Physio and OT also received two additional training sessions in April 2012 and Oct 2012 into pressure ulcer prevention and care.

A training event was organised in October 2012 which covered aspects of nutrition in relation to wound healing and infection along with information about the prevention of pressure ulcers. The staff that attended the teaching sessions and additional staff received information/education on dressings available.

Patients who are identified as being nutritionally "AT RISK" are now having this stamped in red on their admission documentation, and pre-operative checklist, in order to highlight the cause for concern and for extra care to be taken throughout the patients' journey. This is commenced in the pre op assessment clinic and followed through to admission.

A nil by mouth audit was carried out in February 2013. The audit was undertaken over a period of 5 days to capture as many patients as possible.

- A total of 61 patients had recorded fluid fasting time, a mean average of **7.17hrs** which is a slight improvement on February 2012 with a mean average of 7.34hrs.
- A total of 61 patients had a recorded diet fasting time, a mean average of **13.53hrs** compared to February 2012 with a mean average of 13.9hrs, again a slight improvement.

| | Dec 2011 | Feb 2011 | Feb 2012 | Feb 2013 |
|---|---|---|---|---|
| Fluid Mean | 10.3hrs | 8.43hrs | 7.3hrs | 7.17hrs |
| Diet Mean | 13.4hrs | 13.4hrs | 13.9hrs | 13.53hrs |

Although we have improved with respect to fluid fasting year upon year, there are improvements still to be made especially with respect to diet.

A considerable amount of work is being undertaken to stop theatre lists being changed which can lead to excess starvation times. A full review of the menus and kitchen practice also took place as part of a project with the TV Chef James Martin. The kitchen staff have made significant improvements to the menus and content of the meals; food delivery and ordering processes have also been reviewed and changed in order to improve the patient experience relating to food.

## 3.8 Healthcare acquired infections

Infection Prevention and Control is an intrinsic part of our everyday function with the safety of our patients at the forefront of what we do. We have a zero tolerance approach to avoidable infections and our proactive team are always looking for ways to improve.

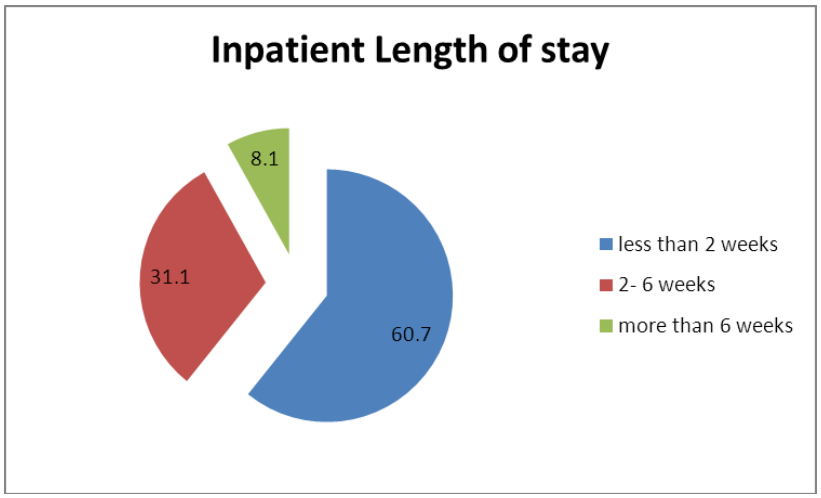
We have not had any hospital acquired MRSA bloodstream infection since May 2008, and continue to see a decrease in the number of cases of *Clostridium difficile* which remain in single figures for the 5th year running. This year we have reported 1 case against a target of 6. Each case is closely scrutinised and lessons learned.

Antimicrobial prescribing and hand hygiene standards remain under the spotlight with the Trusts overall hand hygiene compliance remaining above 90% throughout the year.

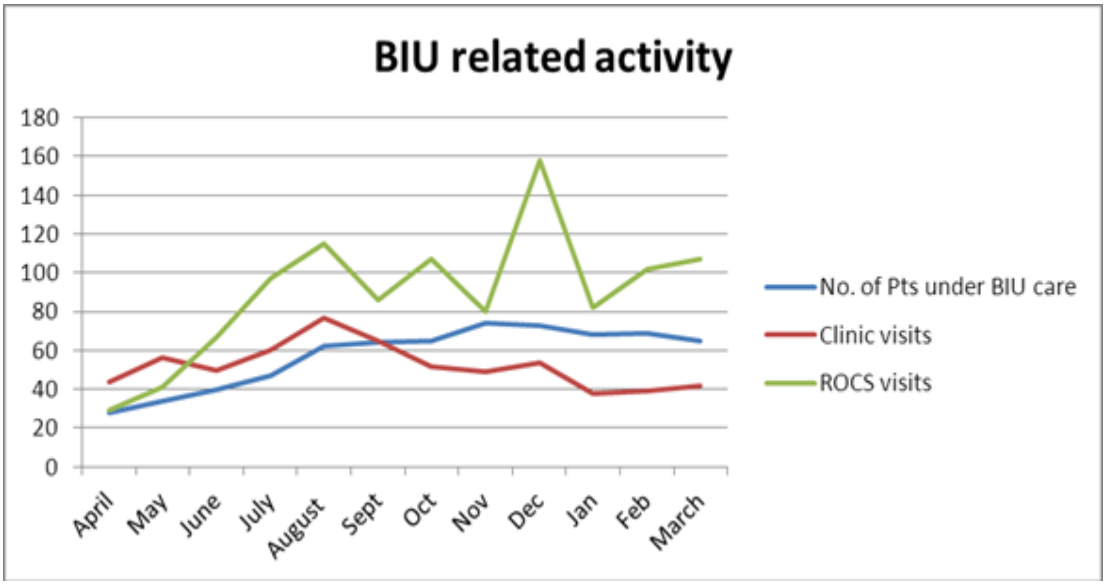
The wound helpline set up in 2011 continues to offer a post discharge service to all ROH patients and is very well utilised. Rather than visit their GP who may not be as familiar with post-operative wounds as we are, we are able to give advice or review patients in person, often on the same day should they have a worry about their wound following surgery.

### 3.8.1 Bone Infection Unit

The implementation of a permanent Bone Infection Unit (BIU) in March 2012 has provided an excellent platform for us to offer close monitoring and supervision to a group of patients with complex needs.. They have often already undergone several or even many years of treatment in other hospitals before eventually being referred to us. In the past these patients would have required an inpatient stay of many weeks but are now able to go home much earlier and receive care on an outpatient basis.




Our multi-disciplinary team includes tissue viability, consultant microbiologist, consultant orthopaedic surgeon, infection control specialist nurses and pharmacists. The patients have open access to the team and we also utilise the Royal Orthopaedic Community Scheme (ROCS) to undertake nursing and physiotherapy in the patient's own home. The BIU has cared for over 150 patients this year.




Antimicrobial prescribing is closely monitored and any complex requirements are now managed via our Bone Infection Unit so patients receive close supervision and support throughout their course of therapy.

Awards:

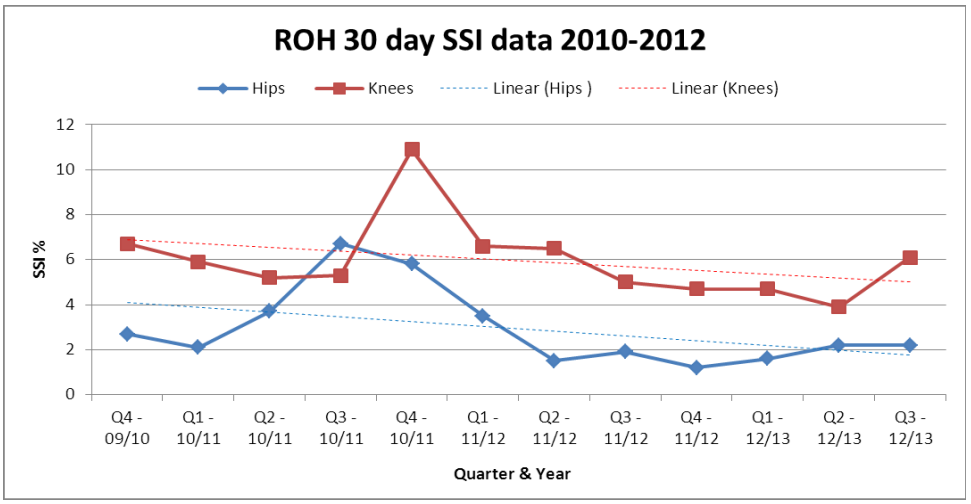
The team were delighted to win a Highly Commended award from the Nursing Times in November 2012.

A poster was presented at the Hospital Infection Society conference in Liverpool in December and 2 more posters were presented at the Oxford Bone Infection Conference in February 2013.

### 3.8.2 Surgical site Infection

Surgical Site Infection (SSI) surveillance is an intrinsic part of our everyday work and we collect and analyse vast quantities of data regarding our patient's outcome constantly. All joint replacements are monitored for 30 days as a minimum.

The graph below shows how we are delivering an overall decrease in rates of surgical site infection rates.




The most successful way to reduce infection is to use a 'bundle' approach; this means changing several things at the same time all of which are shown to be effective individually but together seem to offer even greater benefits. With this approach in mind we have now agreed to standardise some of the critical parts of the surgical pathway for our patients. We anticipate a significant reduction in the rate of surgical site infection following the implementation of this bundle.

## 3.9 Ensuring the privacy and dignity of our patients

As a Trust we have continued to develop staff skills and practice to ensure that we do the best we possibly can, providing feedback to staff and praise to help improve morale for individuals and the teams and when concerns are raised.

We held a celebration event during the year to continue to engage with all staff in the Trust and highlight the areas of good practice and demonstrate how small changes made can make a big difference to our patients care experience. We used a 'Future Tree' where staff and the general public were asked to write up what they want to see in the Trust in the future regarding privacy and dignity

We have been successful in delivering our commitment to same sex accommodation and have not had any breaches, for non-clinical reasons, of this standard.

We have continued to use feedback received from mystery shopper patients providing another voice. Patients are supported to provide feedback to help us then take action to look at some of the following areas: facilities, sign posting to information, help and advice, staff interactions

Our 7 P's for Privacy and Dignity has been launched via staff training and the celebration event - process, people, place, polite , professional , patient, prepared.

Our real time survey scores demonstrate high scores for privacy and dignity and we are using these along with ward self-assessments to identify further areas for improvement in the forthcoming year.

*"As a champion I try to ensure that I keep in mind at all times the importance of seeing the person in the patient and that patient centred care is a human right"*

*"Providing good care matters to us as staff and our everyday interactions with patients are very important"*

***Privacy and dignity champions***

## 3.10 Safeguarding

During the year there has been further additional resource allocated to Safeguarding (adult) to strengthen training, provide better links with external agencies and to deliver the recommendations from the peer review. We have also combined the Paediatrics and Adult Safeguarding committees for continuity and efficacy

Documentation packs for supplementary records, formulated for roll out in the Trust following staff education and training is being undertaken. Staff have also attended financial abuse training.

Level 2 Adult Safeguarding training has been provided for senior staff / bleep holders and on-call managers to support staff with support of external agencies. Level 3 serious case review training has been undertaken by the lead and named nurse for the Trust.

The Trust was represented at the launch of the Pan West Midlands Safeguarding Policy and Procedures and in developed partnership working with Birmingham Safeguarding Board with operational delivery for this.

Partnership working with Birmingham Institute for the deaf, with champion and staff awareness and information for improving care has been undertaken.

The Trust aims to work with Midland Mencap in the forthcoming year on raising staff awareness and signposting and support for patients and carers.

A service level agreement with Birmingham and Solihull Mental Health Trust was introduced to ensure that the hospital has access to staff with experience of patients with mental health needs and can access this service for our patients.

## 3.11Chaplaincy services

Our chaplaincy team offers religious and spiritual guidance and support to patients, visitors and staff. The Trust employs two part time chaplains and has a regular voluntary chaplain; we also have contacts for religious leaders of a variety of faiths.

The Chaplaincy aims to be welcoming and inclusive, respecting people of all faiths or none and responding to individuals at their point of need. An important part of their role is to enable people to practice their particular faith whilst in hospital. The Chaplaincy Team regularly visit wards and can be called to visit individuals at any time. The Chaplaincy also offers support to staff regardless of religious denomination; contact is made via the Hospital Bleep Holder for Chaplaincy services outside of visiting hours.

The Prayer, Meditation & Contemplation Room is available for anyone who might need some time away from the busy and sometimes noisy hospital. It is open and lit day and night.

Religious Calendar Events are held throughout the year and are displayed on the noticeboard outside the Prayer, Contemplation and Meditation Room and on the Trust Intranet. Leaflets about the chaplaincy service are available via the Trust's internet site under patient information.

## 3.12 Our workforce

As part of our work to improve the quality of care delivered for patients. We have changed the organisational structure during the year to create clinical directorates. These teams are led by a Clinical Director, supported by a Matron and Directorate Manager who are responsible for the quality of care for patients in their area of responsibility. To enable these teams in their new roles, a development programme has taken place during the year with a focus on multi-disciplinary working and individual development. This will continue into 2013/14.

We have continued to focus on the Care Quality Commissions requirements for the workforce, with particular focus this year on improving life support training for clinical staff and appraisal of medical staff. The Trust met the Commission's requirements with respect to staffing during their routine, unannounced inspection. Inspectors observed our staff working in a friendly and professional way with patients and they reported no concerns about staffing levels in the areas they visited.

The Revalidation of doctors by the General Medical Council started in December 2012 and the Trust is making good progress to enable all doctors to be revalidated by March 2016. We are monitoring our own progress using the national audit tool.

Levels of sickness absence deteriorated in the period April to September 2012 but have subsequently improved in the second half of the year. This improvement has been achieved as a result of more effective management and support of staff who are absent, together with a focus on prevention of ill-health and improved well-being. We have

focused on encouraging our workforce to improve their physical fitness with on-site exercise classes and running events, as well as improving their mental well-being through activities such as meditation and Tai-Chi.

In January 2012 those staff members who made a unique contribution to quality were congratulated at our annual Staff Awards Ceremony. Those responsible for making improvements in the quality of patient food and child protection arrangements were recognised for their achievements.

In December 2012 there was a significant fire at the Trust which affected two wards. Due to the dedication of our workforce both on the day and in the weeks following, the impact on patients was minimised with no patient having their treatment postponed as a result.

As part of the national changes to workforce education and learning, we are an active participant in the Local Education and Training Council who have responsibility for ensuring the health workforce in Birmingham and Solihull is fit for the future.

In response to the Academy of Medical Royal Colleges recommendations, we have begun work to review our medical workforce to ensure our patients benefit from consultant-delivered care across the whole week, when this is clinically required. We envisage this will require changes to our medical workforce to ensure continued excellence in patient care.

## 3.12 Staff Survey

This year our response rate in the national staff survey was 51%, a decrease of 10% on last year .

Our top five ranking scores were:

| Key Factor | This Year's Score | National Average |
|---|---|---|
| Percentage of staff appraised in the last 12 months | 87% | 83% |
| Percentage of staff having a well-structured appraisal in the last 12 months | 42% | 36% |
| Percentage of staff receiving health and safety training | 84% | 76% |
| Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months | 4% | 6% |
| Percentage of staff suffering work-related stress in the last 12 months | 29% | 32% |

Our bottom five ranking scores were:

| Key Factor | This Year's Score | National Average |
|---|---|---|
| Percentage of staff experiencing physical violence from staff in the last 12 months | 4% | 2% |

| | | |
|---|---|---|
| Percentage of staff saying hand washing materials are always available | 52% | 61% |
| Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month | 33% | 30% |
| Percentage of staff believing the trust provides equal opportunities for career progression or promotion | 86% | 88% |
| Percentage of staff reporting good communication between senior management and staff | 26% | 33% |

Disappointingly the number of staff who recommend the Trust as a place to work or receive treatment has remained unchanged and is worse than average, compared to other acute specialist trusts.

In order to understand these results better and to identify the priorities for action with staff, a series of focus groups were held with staff in the final three months of the year. Staff engagement will be a significant piece of work undertaken during 13/14.

### 3.13 Public engagement

Public Engagement in 2012/13 continued to be key to the Trust's work with the number of patients, members and the general public being given the opportunity to provide feedback increasing continually.

During the year, the Public and Patient Services team have become involved in a number of specific feedback opportunities, such as collecting data from oncology patients about services and from members about the development of new day service facilities. A new 'virtual' patient and carers council has also been set up, specifically for the review of patient information electronically to allow greater scrutiny of these leaflets for readability.

Volunteers have been involved in the delivery of the new Friends and Family Pilot as well as the real time survey and this has proved of great benefit to the patients and Trust alike.

The Trust has produced marketing material for use on a larger scale than previously, culminating in the production of a GP directory which was launched at a West Midlands conference for Practice Managers. This work will continue to be developed in the coming year to include information for Clinical Commissioning Groups and other emerging organisations,

The Trust has held workshops for its Members' Council to prepare for the introduction of the new legislative framework for the NHS and this has helped frame governance intentions for the coming year. The role of membership as a large and segmented customer panel will be maintained and the Trust will consider the benefits of liaison with the new Health Watch bodies as their role emerges in 2013/14.

The Trust has worked consistently with its Governors to ensure that they are aware of all the key patient focused activities in the organisation. The Patient Experience Group in particular has worked on a range of clinical issues and on the design of the new Ambulatory Day Care facility (due to open in summer 2013). This group has provided assurance to full Council on issues such as infection control, developments such as the bone infection unit and has reviewed the experience of individual patients as case studies. This group will continue to work on this vital agenda

and will liaise with the reconstituted group of Governors responsible for communicating with and representing the views of wider trust membership.

## 3.14 Maintaining standards across the board - national targets and regulatory requirements

Every publicly funded organisation is expected to meet standards and achieve targets and the table below shows the key indicators used to assess the overall quality of our performance.

Infection rates are a crucial indicator of care and our patients tell us how important these are in maintaining a high reputation and securing personal recommendations to others.

Cancer targets are essential to help individuals have the best possible chance of surviving this threatening disease. These can be a real challenge for us as some of our cancer patients are referred from other hospitals which have not had the benefit of our breadth of specialist diagnostic skill, so they come to us quite late in the process.

Many members of the public are familiar with the 18 week target and this gives patients the right to expect that from their initial referral to the necessary treatment (such as an operation or physiotherapy), they have to wait no more than 18 weeks.

There will always be exceptions – sometimes for clinical reasons and sometimes because of the sheer level of demand on the surgeons and the absence of colleagues elsewhere with the skills to offer treatment. For us, this is particularly true in spinal deformity surgery and in general orthopaedic paediatric surgery, both of which have been challenged in 2012/13 and are expected to continue to be so in 2013/14. This is due to the high level of long term consultant sickness and the sad death of a surgeon in November 12, which, in both specialties, has led to an increase in patients waiting to have their surgery or treatment. In addition, as we treat more patients in spinal deformity, so the pool of patients requiring ongoing care increases as patients are required to have frequent surgery as they grow. To support this growth, we have appointed 2 spinal deformity surgeons one of which will commence in May 2013 and the second in August 2013. This will help put the service into a more sustainable position and enable us to treat patients in a timely manner.

In the short term and in conjunction with colleagues in the Specialist Commissioning Group, we are offering patients the choice of being treated at other centres in Sheffield, London and Manchester that offer this complex surgery.

In general paediatric surgery we have recently appointed a new consultant who will specialise in treating young adult patients with hip problems and in additional we are actively recruiting to the vacancy created with the death of one of our highly experienced and well established surgeons. Interim measures are in place to manage this cohort of patients, but due to their complexity and a lack of similar national expertise, this too remains a challenge for us.

In 2012/13 in addition to the 90% admitted and 95% non-admitted referral to treatment time targets, a new target was introduced, the 92% Incomplete Pathway target. This target measures the number of patients that are waiting more than 18 weeks for their surgery or treatment. Due to the reasons outlined above, between November 2012 and February 2013 we failed to achieve this target due to the long wait times for spinal deformity and general paediatric surgery. This was achieved in March 2013 and we are confident that we will continue to achieve this during 2013/14.

The table below shows our track record against these targets. When we benchmark ourselves against other orthopaedic departments we continue to find that our achievements are better than most.

| National target | 08/9 | 09/10 | 10/11 | 11/12 | 12/13 | Target |
|---|---|---|---|---|---|---|
| MRSA | Achieved<br>2 cases | Achieved – 0 cases | Achieved – 0 cases | Achieved – 0 cases | Achieved – 0 cases | |
| C diff | Achieved<br>7 cases | National target - achieved<br>Local target – not achieved<br>9 cases | National target –achieved<br>Local target – not achieved<br>8 cases | Achieved<br>6 cases | Achieved<br>1 case | Local target of 7 since 09/10<br>2012/13 target of 6 |
| 31 day subsequent treatment all cancers | NA | Achieved – 100% | Achieved – 100% | Achieved – 99% | Achieved-<br>100% | 94% standard |
| 31 diagnosis to treatment all cancers | Achieved-<br>100% | Achieved – 100% | Achieved –<br>99.3% | Achieved – 100% | Achieved – 100% | 96% standard |
| 62 day referral to treatment of all cancers | Achieved-<br>92% | Not applicable due to low number of patients | Achieved-<br>98.3% | Achieved – 94.7% | Achieved – 95.3% | 85% standard |
| 2 week cancer wait | Achieved-<br>100% | Achieved –<br>99% | Achieved – 99.5% | Achieved – 99% | Achieved – 100% | 93% standard |
| 18 week referral to treatment admitted | Achieved-<br>88% | Achieved – 91.6% | Achieved – 90.5% | Achieved<br>90.2% | Achieved<br>>90% | Target since 09/10 is >90% |
| 18week referral to treatment non admitted | Achieved-<br>87% | Achieved – 95.2% | Achieved – 95.2% | Achieved<br>95.1% | Achieved .95% | Target since 09/10 is 95% |
| 92% incomplete pathway | Not applicable | Not applicable | Not applicable | Not applicable | Not achieved full year (achieved March 2013 ) | 92% |
| Access to healthcare for people with learning disabilities | NA | Achieved | Achieved | Achieved | Achieved | |

## 3.15 Measuring quality as we move forward

The Trust has achieved good performance in its data quality and measures against all national targets. It is recognised, however, that the measurement of quality requires more than quantitative data sets, it requires data analysis and the accumulation of qualitative data.

The Board have agreed to a move towards a system developed by the University Hospital Birmingham NHS Foundation Trust, known as the Health Evaluation Data tool. This system in development allows us to have much closer collaboration with the system designers, so that reporting on a unit level is planned across the major outcome domains. A new post has been created within the Information Technology department. This emphasises the importance the Trust intends to give to outcomes and should to allow the best possible integration and the coordinated use of our information to measure performance.

The Trust uses data at many levels in the organisation, from the highest level key performance indicators submitted to the Board to the very detailed service line reporting used by the operations and finance teams. As always it is the senior middle management level that relies most on data and so service information packs are prepared for the Clinical Service Managers and Clinical Directors. These packs use visual identification by colour coding to highlight areas of concern and allow teams to prioritise key issues. These same teams are involved in data validation so that there should be no inexplicable surprises by the time information is submitted to the board or externally.

*Never a day passes that I or any of my colleagues lose sight of the importance of quality at our hospital and it is central to the way we go about our business. We set ourselves very high standards and we are never satisfied with mediocre performance. We constantly look at ways in which we can improve quality and we have made many improvements throughout the hospital over the past year. We are committed to being open when we don't get things right and to learn from such events for the future.*

*At the Board quality is a topic that is dealt with in an informed and challenging manner. We have comprehensive measures to inform us of our performance against key safety measures and these are supplemented by first-hand accounts gained by non-executive directors undertaking regular organised and informal visits to all parts of the hospital. It is an approach that ensures that quality is always top of our agenda and dealt with comprehensively.*

*We are eager to be the best and in doing so strengthen our reputation as a specialist orthopaedic centre. In a world where patients are having greater influence over their healthcare provision we want to be the first choice for patients based upon our reputation for excellent care and superior outcomes. We are lucky that we have such a loyal group of staff and proud members to support us in this challenge and it is through them that we shall further our ambition.*

*Everyone within the Trust has a passion and commitment for quality and whatever their role they recognise that individually and collectively they are key to our success.*

*Chris Monk, Acting Chairman*

# Statements from Local Involvement Networks, Overview and Scrutiny Committees and clinical commissioning groups

## 4.1 Statement of Birmingham Healthwatch

Birmingham Healthwatch have confirmed they will not be providing a statement

## 4.2 Overview and Scrutiny Committee

The Birmingham Overview and Scrutiny Committee have confirmed they will not be providing a statement

## 4.3 Statement of Birmingham Cross City Clinical Commissioning Group

Birmingham CrossCity CCG as the lead commissioner for the Royal Orthopaedic Hospital (ROH) NHS Foundation Trust welcomes the opportunity to provide this statement for the Trust's Quality Account 2012/13. The Quality Account has been reviewed in accordance with the Department of Health guidance and Monitor's requirements. The statement has been developed in consultation with neighbouring CCGs and the Area Team for NHS England.

With responsibility for the quality of services it commissions from the Trust over the past year the CCG as a newly formed commissioning organisation has developed challenging but constructive relationships with the Trust's clinicians and managers, reviewing performance through monthly Clinical Quality Review Group meetings and addressing any issues around the quality and safety of patient care with the Trust.

The Quality Account for 2012/13 is a balanced and comprehensive report reflecting the improvements the Trust has made within the year. We acknowledge the achievements and progress the Trust has made across most of its priorities and its revised targets for 2013/14. The Commissioning for Quality and Innovation (CQUIN) scheme for 2012/13 reflects the ethos of the Trust to improve patient safety, clinical effectiveness and patient experience as priorities for both the organisation and commissioners. The section on pressure ulcer prevention provides a good account of all the work the Trust has been undertaking to reduce pressure ulcers through staff training and the procurement of more pressure relieving equipment and the reduction in grade 3 and 4 pressure ulcers is very positive.

Reducing patient falls, pressure sores and meeting infection control targets are important priorities and we note the achievements that ROH has made in reducing C. Difficile infections. These priorities continue to challenge all our local health organisations for the coming year and we are pleased that ROH is committed to continue making significant improvements in all these areas in 2013/14. Further information around the Trust's plans to meet infection control targets and reduce patient risk of falls would have been helpful. It is noted that the Trust's target for patient falls risk assessment was not achieved and more information about the reason for this and how this will be improved in 2012/13 is suggested.

The work of the Bone Infection Unit is to be commended and its impact in enabling patients to continue their treatment at home under the expert supervision of a multi-disciplinary team.

We are encouraged to see the work the Trust has been undertaking around patient nutrition and although the target for improving the rating of hospital food was not achieved this area is a priority for the Trust in 2013/14.

There is no mention of the WHO safer surgical checklist performance as the Trust has not yet met the required target of 95% compliance with completion. We know that ROH is actively working with theatre staff to make the changes needed to meet this important target and we anticipate that this target will be met early in 2013/14.

The CCG undertook an unannounced visit in March on the concerns raised around WHO safer surgical checklist and the serious incidents reported. The areas visited were theatres and many of the ward areas and the outpatient department. We observed good standards of care being delivered to patients in all areas. Patients who we spoke to all said that they would recommend the hospital to family and friends. In outpatients, although patients were happy with the care they received some patients waited over an hour to see a consultant and the Trust is reviewing this.

We are pleased to see the work the Trust is undertaking to improve patient experience and the changes it has made in response to patient feedback including self-arrival terminals in outpatients and improvements to patient information. We note the increase in complaints and it will be helpful to see the reasons for this

Overall, this Quality Account is comprehensive and a balanced description of the quality of the services the Trust delivers to its patients and the work it has been undertaking over the past year to improve the quality and safety of patient care. We will continue to work in partnership with ROH and will support the Trust in delivering its priorities and objectives in 2013/14.

Catherine Griffiths

Interim Chief Accountable Officer

Birmingham CrossCity Clinical Commissioning Group.

## Feedback

The Royal Orthopaedic Hospital NHS Foundation Trust would welcome feedback and comments on this Quality Account and would welcome any suggestions for future reports.

If you would like to contribute please contact Lindsey Webb, Director of Nursing and Governance either by email, in writing or by telephone using the details provided below.

Email:Lindseywebb@nhs.net.com
Telephone: 0121 685 4233
The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Birmingham B15 2TH

## Appendix I – List of Research Publications

1: Nakamura T, Abudu A, Murata H, Grimer RJ, Carter SR, Tillman RM, Jeys L. Oncological outcome of patients with deeply located soft tissue sarcoma of thepelvis: A follow up study at minimum 5 years after diagnosis. Eur J Surg Oncol.2013 Jan 21. doi:pii: S0748-7983(12)01378-9. 10.1016/j.ejso.2012.12.019. [Epub ahead of print] PubMed PMID: 23347778.

2: Grimer RJ, Chandrasekar CR, Carter SR, Abudu A, Tillman RM, Jeys L. Hindquarter amputation: is it still needed and what are the outcomes? Bone Joint J. 2013 Jan;95-B(1):127-31. doi: 10.1302/0301-620X.95B1.29131. PubMed PMID: 23307686.

3: Gardner A. Loss of apical vertebral derotation in adolescent idiopathic scoliosis: 2-year follow-up using multi-planar reconstruction computed tomography' [by G. Cui, K. Watanabe, Y. Nishiwaki, N. Hosogane, T. Tsuji, K. Ishii, M. Nakamura, Y. Toyama, K. Chiba, M. Matsumoto; Eur Spine J (2012) Jun;21(6):1111- 20]. Eur Spine J. 2013 Jan 4. [Epub ahead of print] PubMed PMID: 23288454.

4: Nakamura T, Abudu A, Grimer RJ, Carter SR, Jeys L, Tillman RM. The clinical outcomes of extracorporeal irradiated and re-implanted cemented autologous bone graft of femoral diaphysis after tumour resection. Int Orthop. 2012 Dec 28. [Epub ahead of print] PubMed PMID: 23271688.

5: Matharu GS, Revell MP, Pynsent PB, Treacy RB. A review of hip resurfacings revised for unexplained pain. Hip Int. 2012 Nov-Dec;22(6):633-40. doi: 10.5301/HIP.2012.10368. PubMed PMID: 23250717.

6: Robb CA, El-Sayed C, Matharu GS, Baloch K, Pynsent P. Survival of autologous osteochondral grafts in the knee and factors influencing outcome. Acta Orthop Belg. 2012 Oct;78(5):643-51. PubMed PMID: 23162961.

7: Matharu GS, Pynsent PB, Dunlop DJ, Revell MP. Clinical outcome following surgical intervention for periprosthetic hip fractures at a tertiary referral centre. Hip Int. 2012 Sep-Oct;22(5):494-9. doi: 10.5301/HIP.2012.9760. PubMed PMID: 23112076.

8: Pailhé R, Sharma A, Reina N, Cavaignac E, Chiron P, Laffosse JM. Hip resurfacing: a systematic review of literature. Int Orthop. 2012 Dec;36(12):2399-410. doi: 10.1007/s00264-012-1686-3. Epub 2012 Oct 26. PubMed PMID: 23100124; PubMed Central PMCID: PMC3508060.

9: Nakamura T, Grimer R, Gaston C, Francis M, Charman J, Graunt P, Uchida A, Sudo A, Jeys L. The value of C-reactive protein and comorbidity in predicting survival of patients with high grade soft tissue sarcoma. Eur J Cancer. 2013 Jan;49(2):377-85. doi: 10.1016/j.ejca.2012.09.004. Epub 2012 Oct 8. PubMed PMID:

23058786.

10: Gardner A. Paraparesis caused by a cyst in the spinal canal from a pseudarthrosis 22 years following Harrington rod procedure for scoliosis: a case report. J Med Case Rep. 2012 Oct 3;6(1):337. doi: 10.1186/1752-1947-6-337. PubMed PMID: 23034101; PubMed Central PMCID: PMC3470989.

11: Gaston CL, Sumathi VP, Grimer RJ. Is it ever safe to discharge a chondrosarcoma of pelvis? Report of a local recurrence after 10 years. Musculoskelet Surg. 2012 Sep 19. [Epub ahead of print] PubMed PMID: 22990984.

12: Malhas AM, Sumathi VP, James SL, Menna C, Carter SR, Tillman RM, Jeys L, Grimer RJ. Low-grade central osteosarcoma: a difficult condition to diagnose. Sarcoma. 2012;2012:764796. doi: 10.1155/2012/764796. Epub 2012 Jul 16. PubMed PMID: 22851905; PubMed Central PMCID: PMC3407619.

13: Matharu GS, McBryde CW, Revell MP, Pynsent PB. Femoral neck fracture after Birmingham Hip Resurfacing Arthroplasty: prevalence, time to fracture, and outcome after revision. J Arthroplasty. 2013 Jan;28(1):147-53. doi: 10.1016/j.arth.2012.04.035. Epub 2012 Jul 21. PubMed PMID: 22819379.

14: Davis ET, Olsen M, Zdero R, Smith GM, Waddell JP, Schemitsch EH. Predictors of femoral neck fracture following hip resurfacing: a cadaveric study. J Arthroplasty. 2013 Jan;28(1):110-6. doi: 10.1016/j.arth.2012.05.015. Epub 2012 Jul 5. PubMed PMID: 22770857.

15: Matharu G, Robb C, Baloch K, Pynsent P. The Oxford medial unicompartmental knee replacement: survival and the affect of age and gender. Knee. 2012 Dec;19(6):913-7. doi: 10.1016/j.knee.2012.03.004. Epub 2012 Apr 4. PubMed PMID: 22480781.

16: Brewer P, Riddell Z, Grimer RJ, Jeys L. Perioperative mortality following above-knee amputations indicated for bone and soft tissue tumours. Eur J Surg Oncol. 2012 Aug;38(8):706-10. doi: 10.1016/j.ejso.2012.03.004. Epub 2012 Mar 30. PubMed PMID: 22465587.

17: Douis H, Dunlop DJ, Pearson AM, O'Hara JN, James SL. The role of ultrasound in the assessment of post-operative complications following hip arthroplasty. Skeletal Radiol. 2012 Sep;41(9):1035-46. doi: 10.1007/s00256-012-1390-9. Epub 2012 Mar 17. Review. PubMed PMID: 22426776.

18: Douis H, Davies AM, James SL, Kindblom LG, Grimer RJ, Johnson KJ. Can MR imaging challenge the commonly accepted theory of the pathogenesis of solitary enchondroma of long bone? Skeletal Radiol. 2012 Dec;41(12):1537-42. doi: 10.1007/s00256-012-1387-4. Epub 2012 Mar 17. PubMed PMID: 22422023.

19: Thomas MS, O'Hara JN, Davies AM, James SL. Profunda femoris pseudoaneurysm following Birmingham hip resurfacing: an important differential diagnosis for a periarticular cystic mass. Skeletal Radiol. 2012 Jul;41(7):853-6. doi: 10.1007/s00256-011-1341-x. Epub 2011 Dec 24. PubMed PMID: 22197889.

20: Douis H, James SL, Grimer RJ, Davies MA. Is bone scintigraphy necessary in the initial surgical staging of chondrosarcoma of bone? Skeletal Radiol. 2012 Apr;41(4):429-36. doi: 10.1007/s00256-011-1252-x. Epub 2011 Sep 3. PubMed PMID:21892729.

**Independent Auditor's Assurance Report to the Members Council of the Royal Orthopaedic Hospital NHS Foundation Trust on the Annual Quality Report**

We have been engaged by the Members Council of the Royal Orthopaedic Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of the Royal Orthopaedic Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

**Scope and subject matter**

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 28 day readmissions
- 62 day cancer waits

We refer to these national priority indicators collectively as the "indicators".

**Respective responsibilities of the Directors and auditors**

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified below:
    - Board minutes for the period April 2012 to March 2013;
    - Papers relating to Quality reported to the Board over the period April 2012 to March 2013;
    - Feedback from the Commissioners, received 24 May 2013;
    - The Trust's 2012/13 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2013;
    - The national patient survey dated 2012;
    - The national staff survey dated 2012;
    - Care Quality Commission quality and risk profiles dated March 2013; and
    - The Head of Internal Audit's annual opinion over the Trust's control environment for the year ending 31/03/2013.
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance for external assurance on Quality Reports.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Members Council of the Royal Orthopaedic Hospital NHS Foundation Trust as a body, to assist the Members Council in reporting the Royal Orthopaedic Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Members Council to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members Council as a body and the Royal Orthopaedic Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

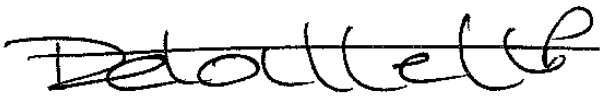
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by the Royal Orthopaedic Hospital NHS Foundation Trust.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in the detailed guidance for external assurance on Quality Reports; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*



Deloitte LLP
Chartered Accountants
Birmingham, United Kingdom
29 May 2013

**5. Sustainability/Climate Change Report 2012/13**

The ROH carries out Sustainability reporting to meet the Government's target of reducing its carbon footprint by 10% by the year 2015.

The ROH endeavours to reduce its carbon footprint in all the areas considered appropriate, such as energy, gas, electricity, water usage, waste and travel. Not only does benefit derive from reducing and contributing to the carbon footprint but hopefully also in a reduction in costs to the Trust. The strategy is to encourage our staff to participate in all aspects of good housekeeping which we consider will make a major contribution in the drive to reducing our carbon footprint. Engagement and encouragement will hopefully also enable staff to be more carbon efficient in their own personal lives.

We continue to invest in saving greenhouse gas emissions through modification and replacement of directly identified gas consuming plant. With indirect electrical usage, we continue with our programme of replacing our controls and luminaires and, where appropriate, applying meters and energy saving devices to electrical usage.

The Trust endeavours to reduce waste wherever possible and has met its gas and water consumption targets. The Trust continues to develop its travel strategy and reduce its carbon footprint in staff travel. Contracts with non-emergency ambulance services are reviewed on a regular basis.

Governance processes involve an Annual Report to the Trust Board on which there is a designated carbon champion (one of our Non-executive Directors). Executive Directors receive updates on carbon reduction and the Good Corporate Citizen Group in the Trust ensures its carbon footprint reduction is managed on a daily and weekly basis.

The Carbon Reduction Strategy Annual Report is presented to the Trust Board.

<u>Greenhouse Gas Emissions – direct gas boilers</u>

The target for 2012/13 was 1,270 tonnes. The ROH did not achieve this for 2012/13 using 1,471 tonnes of gas; this is due to infrastructure upgrades on our incoming meters and generally a colder year. The 2015 target of 1,278 tonnes is challenging and will be further explored through the Trust's site rationalisation and development programme.

| **Area:** | **Greenhouse Gas Emissions** | | | | | |
|---|---|---|---|---|---|---|
| **Type:** | **Direct Gas Boilers** | | | | | |
| **2006/7** | **2007/8** | **2008/9** | **2009/10** | **2010/11** | **2011/12** | **2012/13** |
| **Tonnes** | | | | | | |
| 1,420 | 1,546 | 1,406 | 1,366 | 1,368 | 1,170 | 1,471 |
| **Financial ((£)** | | | | | | |
| 165,000 | 172,000 | 243,000 | 181,000 | 192,000 | 175,000 | 260,841 |

Greenhouse Gas Emissions – indirect Electricity

The target for 2012/13 was 1,450 tonnes; the ROH met its yearly target by using 1,427 tonnes. The target for 2015 is 1,385 tonnes which will be achieved by:

- Replacing further controls and luminaires with energy efficient units.
- Installing further voltage controlling devices.
- Installing further inverters to our electric motors.
- Good housekeeping.

| **Area:** | **Greenhouse Gas Emissions** | | | | | |
|---|---|---|---|---|---|---|
| **Type:** | **Indirect Electricity** | | | | | |
| **2006/7** | **2007/8** | **2008/9** | **2009/10** | **2010/11** | **2011/12** | **2012/13** |
| **Tonnes** | | | | | | |
| 1,539 | 1,629 | 1,714 | 1,585 | 1,570 | 1,512 | 1,427 |
| **Financial ((£)** | | | | | | |
| 266,000 | 256,000 | 422,000 | 358,000 | 314,000 | 326,000 | 389,994 |

Staff Travel to Work

The target for 2012/13 was 900 tonnes; the ROH has met its 2012/13 target achieving 845 tonnes for staff travel to work. The Trust is below the 2015 target of 990 tonnes.

| **Area:** | **Travel** | | | | | |
|---|---|---|---|---|---|---|
| **Type:** | **Staff Travel** | | | | | |
| **2006/7** | **2007/8** | **2008/9** | **2009/10** | **2010/11** | **2011/12** | **2012/13** |
| **Tonnes** | | | | | | |
| - | - | - | - | 1,180 | 900 | 845 |

Waste

The Trust continues to endeavour to reduce its waste and, wherever possible, recycles waste itself. The Trust does recycle aluminium cans, cardboard, printer cartridges and batteries. The Trust has invested in additional recycling containers and from 1 April 2013 will be undertaking recycling collections throughout the Trust. We continue to improve our data collection to distinguish between landfill (general), clinical, recycling, confidential waste and skip waste. The Trust is endeavouring to reduce its clinical and landfill waste, moving towards recycled (which includes confidential) waste.

The Trust's target for landfill waste in 2012/13 was 135 tonnes; the Trust met its target achieving 115 tonnes; the ROH is working towards the 2015 target of 125 tonnes.

| **Area** | **Waste** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2006/7** | **2007/8** | **2008/9** | **2009/10** | **2010/11** | **2011/12** | **2012/13** |
| | **Tonnes** | | | | | | |
| Landfill / general waste | - | - | 139 | 152 | 148 | 125 | 115 |
| Recycled waste | - | - | - | - | - | 4 | 27 |
| Confidential waste | - | - | - | - | - | 171 (includes clinical waste) | 40 |
| Skip waste | - | - | - | - | - | 27 | 26 |
| Clinical waste | - | - | - | - | - | - | 135 |

| **Area** | **Waste** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **2006/7** | **2007/8** | **2008/9** | **2009/10** | **2010/11** | **2011/12** | **2012/13** |
| | **Financial (£)** | | | | | | |
| Landfill / general waste | - | - | 12,764 | 15,830 | 18,381 | 23,000 | 27,841 |
| Recycled waste | - | - | - | - | - | - | - |
| Confidential waste | - | - | - | - | - | 37,000 | 9,530 |
| Skip waste | - | - | - | - | - | - | 6,531 |
| Clinical waste | - | - | - | - | - | - | 59,780 |

Finite Resources – water consumption

The Trust has already taken action in reducing its water consumption through maintenance and refurbishment programmes by introducing energy efficient devices. The target for 2015 is 26,392 cubic metres of water used and consumed within the Hospital.

The Trust has achieved this target and continues to monitor usage. In 2012/13 we set a target of 21,000 cubic metres of water. The ROH did not achieve its stretch target and used 22,000 m3 of water however it is still within the 2015 national target.

| **Area:** | **Finite Resources** | | | | | |
|---|---|---|---|---|---|---|
| **Type:** | **Water Consumption** | | | | | |
| **2006/7** | **2007/8** | **2008/9** | **2009/10** | **2010/11** | **2011/12** | **2012/13** |
| **Cubic Metres** | | | | | | |
| 29,374 | 24,737 | 26,950 | 23,039 | 22,967 | 20,424 | 22,314 |
| **Financial ((£)** | | | | | | |
| 43,484 | 41,310 | 46,861 | 44,348 | 45,210 | 41,000 | 43,715 |

Green Apple Award

The Trust benefits from being sited in a semi-wooded area of South West Birmingham and wanted to continue the tradition maintained by the Cadbury family of keeping tree planting a vibrant part of the environment. The NHS was encouraged to take up the challenge of greening its sites and so ROH did this by encouraging staff and the local community.

## 6. Valuing People, Diversity and Staff Engagement Report 2012/13

### Staff Engagement

Feedback from staff during late 2012/13 indicated improvement is needed in the engagement of staff on issues that matter to them. As a result we have increased opportunities for staff to meet the Acting Chief Executive and other Executive Directors to discuss and address both patient safety and staff issues.

Monthly briefings for all staff by the Acting Chief Executive are proving both popular and effective in ensuring staff hear about key issues and developments as they happen. Changes to the organisations structure and the creation of directorate teams has enabled more opportunity for multi-disciplinary teams to meet, discuss and resolve matters of concern to them and improvements in patient care.

An increasing number of staff are participating in change projects managed through our Programme Management Office with clear improvements seen in care of patients and use of Trust resources.

Our staff took part in the national staff opinion survey. This year our response rate decreased to 51% but this remains above average for acute specialist trusts.

Our top five ranking scores were:

| Key Factor | This Year's Score | National Average | Comparison to last year |
|---|---|---|---|
| Percentage of staff appraised in the last 12 months | 87% | 83% | Improvement |
| Percentage of staff having a well-structured appraisal in the last 12 months | 42% | 36% | No change |
| Percentage of staff receiving health and safety training | 84% | 76% | Deterioration |
| Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months | 4% | 6% | Comparison to previous year not possible due to changes in the survey |
| Percentage of staff suffering work-related stress in the last 12 months | 29% | 32% | No change |

Our bottom five ranking scores were:

| Key Factor | This Year's Score | National Average | Comparison to last year |
|---|---|---|---|
| Percentage of staff experiencing physical violence from staff in the last 12 months | 4% | 2% | Comparison to previous year not possible due to changes in the survey |
| Percentage of staff saying hand washing materials are always available | 52% | 61% | Deterioration |
| Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month | 33% | 30% | No change |
| Percentage of staff believing the trust provides equal opportunities for career progression or promotion | 86% | 88% | No change |
| Percentage of staff reporting good communication between senior management and staff | 26% | 33% | Comparison to previous year not possible due to changes in the survey |

Disappointingly the number of staff who recommend the Trust as a place to work or receive treatment has remained unchanged and is worse than average, compared to other acute specialist trusts.

In order to understand these results better and to identify the priorities for action with staff, a series of focus groups were held with staff in the final three months of the year. These indicated the priority areas for action are communication, incident reporting particularly providing feedback to staff, raising awareness of bullying and harassment and wider improvement in staff engagement.

**Consultation with Staff**

The Trust continues to comply with the Information and Consultation of Employees Regulation 2004. Our excellent and active working relationships with recognised trade union representatives continue through day-to-day work and the Trust Consultative Committee (TCC) and Joint Negotiation and Consultation Committee (JLNC). The TCC meets regularly and is chaired by the Director of Workforce and Organisational Development and involves a number of Executive Directors.

The Trust has undertaken a number of change programmes during the year including the closure of the facility at BMI Edgbaston. All staff from the BMI facility were retained in alternative roles within the Trust.

## Equality and Diversity

Our Equality Objectives set out the way the Trust is meeting its Public Sector Equality Duties in the next four years. We have made some progress during 2012/13 but there are still priorities for action.

The Trust has a commitment to openness and transparency. We have therefore published information on our workforce and reported the progress made in the delivery of the action plans within this document, using language appropriate to the intended audience.

Full details of the Trust's Equality Objectives and progress can be found on the Trust's website.

### Sickness Absence

Achieving improvements in sickness absence have proven to be a challenge during the year with the overall level of absence increasing by 0.31 %. Achieving improvements in this area including implementing approaches to improve the overall health and well-being of staff have already commenced and will continue during 2013/14.

### Workforce Statistics

| | Staff 2011/12 | % | Staff 2012/13 | % | Membership 2011/12 | % | Membership 2012/13 | % |
|---|---|---|---|---|---|---|---|---|
| **Age** | | | | | | | | |
| 0-16 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| 17-21 | 18 | 2.02 | 27 | 3.09 | 18 | 2.02 | 27 | 3.09 |
| 22+ | 872 | 97.98 | 848 | 96.91 | 872 | 97.98 | 848 | 96.91 |
| **Ethnicity** | | | | | | | | |
| White | 684 | 76.85 | 678 | 77.48 | 684 | 76.85 | 678 | 77.48 |
| Mixed | 27 | 3.03 | 16 | 1.82 | 27 | 3.03 | 16 | 1.82 |
| Asian or Asian British | 109 | 12.25 | 104 | 11.88 | 109 | 12.25 | 104 | 11.88 |
| Black or Black British | 33 | 3.71 | 33 | 3.77 | 33 | 3.71 | 33 | 3.77 |
| Other | 37 | 4.16 | 44 | 5.05 | 37 | 4.16 | 44 | 5.05 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Gender** | | | | | | | | |
| Not Stated | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 | 0 | 0.00 |
| Male | 261 | 29.33 | 256 | 29.26 | 261 | 29.33 | 256 | 29.26 |
| Female | 629 | 70.67 | 619 | 70.74 | 629 | 70.67 | 619 | 70.74 |
| **Recorded Disability** | | | | | | | | |
| Not Declared | 131 | 14.97 | 67 | 7.8 | 90 | 10.00 | | |
| Undefined | 630 | 72 | 581 | 66.5 | | | | |
| Yes | 2 | 0.23 | 6 | 0.7 | 799 | 89.78 | | |
| No | 112 | 12.8 | 221 | 25 | 1 | 0.11 | | |

## 7. The Board of Directors' Report on Activity and Obligations 2012/13

This part of the report complements the description of the Trust's activity in the operating and financial review (chapter 3). It describes the governance and conduct of the Board and seeks to assure that the Board effectively discharges its responsibility under the law. It gives evidence of the commitments of the Chairman and each Director and allows the organisation to be viewed against the applicable codes of governance.

The Royal Orthopaedic Hospital was established as an NHS Trust in 1995 and founded under the National Health Services Act 2006 as the Royal Orthopaedic Hospital NHS Foundation Trust on the 1 February 2007. The Trust is located within what was previously the South Birmingham Primary Care Trust health economy area. 2012/13 was a transitionary year from the PCT to the new Clinical Commissioning Group arrangements which will be responsible for purchasing Trust services from 2013/14. The main hospital location is 5 miles from Birmingham City Centre and 2 miles from the University of Birmingham. It is one of a number of acute trusts in Birmingham and primarily serves patients from the West Midlands. The Trust operates no branches outside the UK.

It is a single specialty orthopaedic hospital offering routine elective and specialist treatment. It offers spinal services to the region and soft tissue and bone tumour service to the Midlands, the North of England and Wales.

### The work of the Trust in delivering high quality patient care

The Trust has used the quality governance framework to assess its own performance with regard to quality oversight. In 2012/13 this resulted in a major internal restructuring of the way in which the Trust delivered its services. Clinical directors were appointed to lead sub specialty services. Each is supported by a Matron/Senior Nurse and Directorate Service Manager and these triumvirates are responsible for performance across the dimensions of finance and quality. There are regularly programmed Directorate review meetings and Trust Business and Learning days have been introduced on a regular basis where all staff can come together to discuss issues and be briefed face to face by the CEO.

The Trust was visited (unannounced) in-year by the Care Quality Commission (CQC) and by its local commissioners. These visits are reported on in Chapter 4 of the report.

The Board receives case studies on patients and learns of patient stories on a regular basis and this brings life by example to the patient safety report which is a major monthly Board agenda item.

During 2012/13 the Trust has developed a single house style for patient information and has updated over 100 core pieces of information for patients using a patient panel to review the wording, readability and content of the material. This is now produced in-house and can be updated as often as necessary and printed on site. Key material has also been translated into the key languages used by our patient population.

During the year the Trust has also built stronger relations with Birmingham Children's Hospital NHS Foundation Trust and with Birmingham and Solihull Mental Health NHS Foundation Trust. This has allowed better continuity of care for both children and adults with mental health issues who need to access our services.

## The Board of Directors' activity 2012/13

The Board of Directors is a unitary body accountable for decisions on the running of the organisation, its direction and fiduciary control. The Board regularly reviews its governance role and capability and the Council of Governors considered the Board composition adequate throughout the year.

The Board of Directors was chaired by Mr Laurence James until early November 2012, when he tendered his resignation prior to the expiry of his term of office scheduled for the end of October 2014. The Vice Chairman, Chris Monk, was asked to assume the role pending a substantive appointment and he served as Chairman for the remainder of the 2012/13 financial year.

The Chief Executive, Mr Donal O'Donoghue, was absent from the trust on sick leave for the second half of the year and the role was assumed on an acting basis by the recently retired former Deputy Chief Executive, Mr Graham Bragg.

Other than the Chairman, at the end of March 2012 there were six Executive Directors and six Non-Executive Directors. The Directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business, with The Royal Orthopaedic Hospital NHS Foundation Trust.

Access to the register of directors' interests is available on application by writing to:
Company Secretary
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham, B31 2AP

Following consultation in February 2006, Monitor issued a final version of the NHS Foundation Trust Code of Governance in October 2006 for implementation. The Code applies with effect from 1st April 2006. The Code is issued as best practice advice and is not mandatory; however, the Code imposes disclosure requirements on NHS Foundation Trusts. The Board of Directors considers that throughout the year 2012/13 it was fully compliant with the Principles of the NHS Foundation Trust Code of Governance.

The Board has adopted a scheme of reservation and delegation which makes clear the powers delegated to management. The Board retains full responsibility for setting the strategic development of the Trust (in consultation with the Council of Governors); for approving all items of major capital expenditure; for overseeing and reviewing the Board Assurance Framework in order to safely manage major corporate risks and for appointing Executive Directors to the Board.

The Council of Governors supported the appointment of Mr Chris Monk as Senior Independent Director (SID and Vice Chairman). Upon appointment as Chairman, the role of SID was assigned to Professor Tauny Southwood until the end of March 2013. He also became Vice Chairman. The SID has held one meeting with Non-Executive Directors without the Chairman during the period covered by this report. Non-Executive Directors have met with the Chairman prior to each board meeting during this period.

NEDs have attended seminars organised by regional and national bodies together with a range of workshops organised by the Trust bringing in external speakers

Members and Governors have direct access to all members of the Board. In addition to having direct access on request, all the members of the Board are invited to attend every Council of Governors meeting and participate fully in discussion with members of the Council. Members of the Board or Trust Senior Managers who might have issues, where contact through the normal channels with Chairman, Chief Executive or Finance Director is inappropriate, have right of direct access to the Chairman of the Audit Committee and the Vice Chairman. In addition, the

Board designates two Board meetings per annum as joint meetings with the full Council of Governors. In 2012/13 the Board met 9 times and ad hoc as necessary.

A formal schedule of matters specifically reserved for decision by the Board of Directors was adopted by the Board in May 2008. This schedule is available on the Trust's website. The Board delegates other matters to the Executive Directors and other senior management. The directors are given accurate, timely and clear information so that they can maintain full and effective control over strategic, patient safety, financial, operational, compliance and governance issues. The directors have a range of skills and experience and each brings independent judgment and considerable knowledge to the Board's discussions and determinations. This range of skills and experience ensures balance, completeness and appropriateness to the requirements of the Trust. The attendance of directors at Board and Committee meetings is set out later in this report.

Information made available to the Board and its committees has been reviewed during the year to ensure appropriate levels of assurance are available within each element of the governance structure.

The Board considers that all Non-Executive Directors (with the exception of the Trust Chairman, to whose office Provision A.3.1 of the Foundation Trust Code of Governance does not apply) are independent in character and judgment and there are no relationships or circumstances which are likely to affect, or appear to affect, their judgment.

**Directors holding office during 2012/13**

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

Mr Laurence James – Resigned November 2012
Professor Taunton Southwood – Non-Executive Director (1st term of office expires 31/01/2014)
Dr Elizabeth Hensel - Non-Executive Director (2nd term of office expired 31/12/2012)
Mr Robert Millinship - Non-Executive Director (2nd term of office expires 04/10/2013)
Mr Chris Monk - Non-Executive Director (2nd term of office expired 31/12/2012 – became Acting Chairman in November 2012 with term of office extended by the Council of Governors to May 2013)
Mr Roger Otto - Non-Executive Director (2nd term of office expired 31/12/2012; retained as an associate, non-voting NED until end March 2013)
Mrs Frances Kirkham – Non-Executive Director (1st term of office expires 10/02/2014)
Mr Andrew Meehan – Non-Executive Director (appointed 01/01/2013, 1st term of office expires 31/12/2015)
Miss Elizabeth Mountford– Non-Executive Director (appointed 01/01/2013, 1st term of office expires 31/12/2015)
Mr Timothy Pile– Non-Executive Director (appointed 01/01/2013, 1st term of office expires 31/12/2015)
Mr Donal O'Donoghue – Chief Executive Officer, (absent on sick leave 31/10/2012)
Mr Graham Bragg - (Acting CEO from 01/11/2012 to 31/03/2013) (Deputy CEO from July to November 2012)
Mr Stephen Bloomer – Director of Finance (resigned 07/12/2012)
Mr Paul Taylor – Interim Director of Finance (from December 2012)
Mrs Valerie Doyle - Director of Operations (resigned 31/03/2012)
Mr Michael Woods – Interim Director of Operations (to 08/07/2012)
Mrs Amanda Markall – Director of Operations (appointed with effect from 09/07/2012)
Mr Andrew Thomas - Medical Director (resigned 10/03/2013)
Mr Andrew Pearson – Medical Director (with effect 11/03/2013)
Mrs Lindsey Webb - Director of Nursing and Governance

**The Five Board Committees**

The Board has five committees – Audit as the key scrutinising committee; Integrated Governance as its progress review committee; Nominations and Remuneration Committee to address Board capability, terms of employment for executive directors and staff pay awards; and Charitable Funds of which the Trust Board is a corporate trustee. The Investment Committee considers major strategic investments that have major corporate, reputational or financial implications for the Trust.

The role and function of each committee is under regular review in order to support the Board in its declarations of compliance. In particular, the Board has continued to revise its Assurance Framework and Corporate Risk Register and Board members take an active role in the assessment of evidence of compliance with standards.

**Audit Committee**

Membership:
Mr R Otto (Chair to December 2012, then Mr Andy Meehan)
Mr C Monk (until November 2012)
Dr E Hensel (Until December 2012, then Ms Elizabeth Mountford)
Mr R Millinship
Mr T Pile
Mr S Bloomer as Finance Director attended until December 2012. Mr Paul Taylor assumed this role from December 2012)

**Purpose**

The work of the Audit Committee is to provide a means of independent and objective review of financial and corporate governance and risk management. To do this the committee:

- Ensures that there is an effective internal audit function established by management that provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- Receives reports on counter-fraud work within the Trust.
- 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 to oversee the relationship with the External Auditor.
- Monitors the integrity of the financial statements of the Trust, reviewing significant financial reporting issues and judgments which they contain.

The Audit Committee provides an annual report of its work to the Trust Board and a note of each meeting proceeding are prepared by the Chairman and presented at every Trust Board meeting. The Committee has an annual work plan that ensures it embraces the necessary range of internal and external audit activities. Where work is undertaken by Auditors that is not of an audit nature, this is separately commissioned against a clear brief and is undertaken by someone who is not engaged in independently auditing the Trust. Where possible, this is scheduled into the work plan and therefore included in the information presented to the Council of Governors. This work plan is made available to the Council of Governors and the Chair of Audit is available to update Council on any matters of interest.

**Integrated Governance Committee**

Membership:
Professor Taunton Southwood (Chair)
Mr L James (until November 2012, then Mr Chris Monk)
Dr E Hensel (until December 2012, then Ms Elizabeth Mountford)
Mrs F Kirkham (absent January to March 2013 due to professional commitments)
Mr Donal O'Donoghue (until November 2012, then Mr G Bragg)
Mrs L Webb
Mr A Thomas until 10/03/13

**Purpose**

The work of the Committee is primarily to:

- Provide a monitoring and scrutinies function on behalf of the Trust Board that provides assurance on issues of corporate governance, patient safety, risk and clinical governance.
- Report to the Trust Board any significant areas of concern regarding quality of care, clinical outcomes, or any other aspects of performance.
- Satisfy it that national and local targets are being met and that recognised guidance/ best practice such as the National Institute for Clinical Excellence (NICE) Guidance is being adhered to.
- Oversee and review the governance processes within the Trust including corporate governance, information governance and research governance in the organisation
- Ensure the Trust is fulfilling its requirements under its Terms of Authorisation with Monitor.

The Committee has an annual work plan that ensures it receives effective reporting from appropriate executive sub-groups. A note of each meetings proceeding are prepared by the Chairman and presented at the next available Trust Board.

**Nominations and Remuneration Committee**

Membership:

Mr L James (Chair until November 2012)
Mr C Monk (member until November 2012, Chair from November 2012 to March 2013)
Mr R Otto (until December 2012)
Mrs F Kirkham (absent January to March 2013 due to professional commitments)

(Any NED may attend this committee as a full member and between January and March 2013, this meeting was also attended by Ms E Mountford, Mr T Pile, Mr A Meehan and Mr T Southwood)

Professional advice was provided from time to time by the Trust's Director of Workforce and Organisation Development, Mrs Anne Gynane. Financial guidance was provided by Mr Steve Bloomer as Finance Director and Mr Paul Taylor as Interim FD from December 2012).

**Purpose**

The Remuneration and Nominations Committee of the Board undertakes to:

- Review the structure, size and composition of the Board and make recommendations with regard to any changes.
- Give full consideration to succession planning.

- Evaluate the balance of skills, knowledge and experience in relation to the appointment of both executive and non-executive directors.
- Identify and nominate suitable candidates to fill executive director vacancies.
- Agrees Executive Directors' remuneration, terms and conditions.
- (Executive Director salary levels are informed by benchmark salary information derived from established national NHS pay surveys. All Executive Directors are employed on permanent contracts of employment with a six month notice period. No Executive Directors have provision for other payments over and above their statutory entitlement, to be made on termination of employment. In determining whether or not to agree an annual uplift of salary for Executive Directors, the Committee had due regard to the national pay awards made to other staff groups).

In the case of Non-Executive Director vacancies including the Chair, the relevant information is passed to the Remuneration and Nominations Committee of the Council of Governors so that it can then incorporate the information into its deliberations. The Remuneration and Nominations Committee of the Council of Governors is then responsible for the identification and nomination of Non-Executive Directors, including the Chairman, and for making recommendations to the Council of Governors as to their terms and conditions of employment and appointment.

In the case of Executive Director vacancies, the Remuneration and Nominations Committee draws up the job description and person specification, and undertakes the recruitment process and then makes a recommendation to the Trust Board which may accept or reject the recommendation. The committee benchmarks remuneration annually.

The Committee addressed the need to fill the post of Director of Operations during spring 2012 with the support of external head hunters, and made an appointment in July 2012.
The committee also began the recruitment process for a substantive Finance Director at the end of 2012/13.

From November to the end of the financial year, the committee has regularly considered the structure and composition of the senior management team in order to safeguard the performance of the organisation.

It is for the Non-Executive Directors to appoint and remove the Chief Executive and such an appointment requires the approval of the Council of Governors.

**Investment Committee**

Membership:
Mr C Monk (Chair)
Mr R Millinship
Mr L James (until November 2012)
Mr S Bloomer (until December 2012, then Mr Paul Taylor)
Mr G Bragg (until July 2012 as Deputy CEO and Director of Strategy. As Acting CEO from November 2012 to end March 2013)

**Purpose**

The work of the committee is to:

- Review and evaluate proposals for major investment or significant reputational impact that may present substantial risk to the trust.
- Work with executives to consider projects from inception through business case for these then to become reviewed as part of Trust business in the usual way.

**Charitable Funds Committee**

The Trust Board is a corporate trustee for the charitable funds of the hospital. Charitable funds are examined separately from exchequer funds and trustees discharge their responsibilities in this regard in independence from the Foundation Trust itself.

**Evaluation of Board Performance**

Each Board committee prepares an annual work plan and evaluates its performance against this. The Audit Committee takes lead responsibility for developing and refining this process for later adoption by all other board committees as appropriate.

Board evaluation is further supported by the appraisal process which is conducted towards the end of the financial year and results in feedback to the Council of Governors in readiness for their recording of satisfaction with NED performance.

In 2012/13 the Board did not undertake any external evaluation of its performance in light of the known and significant changes in the Board itself.
The Trust does not have a formal process for evaluating the performance of the Council of Governors or its members.

**Non-Executive Directors' attendance at meetings**

Brief synopsis of major areas of responsibility of the Board and its committees:

| **Trust Board**<br><br>**9 meetings** | **Audit Committee**<br><br>**6 meetings** | **Integrated Governance Committee**<br><br>**9 meetings** | **Remuneration and Nomination Committee**<br><br>**5 meetings** | **Charitable Funds Committee**<br><br>**4 meetings** | **Investment committee meetings** |
|---|---|---|---|---|---|
| Development of long term strategy; monthly performance review; key national target review; strategic planning; capital project development. | Review of overall assurance with internal and external auditors; major project reviews. | On-going review of Assurance Framework; Clinical Governance; Policy review | Approval of pay awards; agreement of external advertising and specification for Non-Executive Director (with Council of Governors Nominations & Remuneration Committee); HR Review. | Review of investment strategy; Prioritisation of fund allocation | Considers early stage investment proposals and then makes recommendations to trust board about major strategic investments of corporate, financial or reputational risk. |

| **Laurence James Chairman (To November 2012)** | Trust Board | Integrated Governance Committee | Remuneration & Nomination Committee | Charitable Funds | Investment committee |
|---|---|---|---|---|---|
| | Chairman 6/9 | 6/9 | Chairman 1/5 | Chairman 2/4 | 4/5 |

| **Professor Taunton Southwood** | **Trust Board** | **Integrated Governance Committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** |
|---|---|---|---|---|
| **Mr Southwood is a professor at Birmingham University and also works at Birmingham Children's Hospital** | 7/9<br>Undertaking chair appraisal and feedback to Council of Governors | Chairman 9/9<br><br>Chairman<br>Focus on clinical guidance and outcomes | 3/5 | 4/4 |

| **Chris Monk (Chairman from November 2012)** | **Trust Board** | **Integrated Governance Committee** | **Audit Committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** | **Investment committee** |
|---|---|---|---|---|---|---|
| **Mr Monk is retired as a Partner in King Sturge, a firm of property agents and also serves on Advantage West Midlands and several other bodies.<br>He was both SID and Vice Chair during the period of this report.** | 7/9<br><br>Leading on capital development and estates | 2/9 | 2<br><br>Particular focus on best practice HR & OD | 4/5 | 3/4 | Chairman 5/5 |

| **Roger Otto (until end December 2012)** | **Trust Board** | **Audit Committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** |
|---|---|---|---|---|
| **Mr Otto is a qualified accountant and was a partner with Baker Tilly. He has also served as a** | 7/9<br><br>Reporting on work of audit and annual report to Council of Governors | Chairman 5/6<br><br>Acts independently of Trust Chairman in holding the organisation to | 1/5 | 3/4 |

| | | | | |
|---|---|---|---|---|
| **non-executive director on a PCT** | | account. | | |

| **Dr Elizabeth Hensel (until end December 2012)** | **Trust Board** | **Audit Committee** | **Integrated Governance Committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** |
|---|---|---|---|---|---|
| **Dr Hensel is a clinical psychologist and has been a non-executive director of an NHS ambulance trust.** | 7/9<br><br>Leading on information systems and patient flows | 4/5<br>Acts as link person with integrated governance | (Deputy Chairman)<br>6/9<br>Acts as link person with audit; particular focus on governance structures | 1/5 | 1/4 |

| **Robert Millinship** | **Trust Board** | **Audit Committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** | **Investment committee** |
|---|---|---|---|---|---|
| **Mr Millinship has a background in manufacturing and production businesses and acts as an interim director or consultant.** | 12/12<br><br>Leading on 18 weeks project delivery | 5/6<br><br>Key focus on performance criteria | | 2/4 | 5/5 |

| **Mrs Frances Kirkham**(absent January to March 2013 due to professional commitments) | **Trust Board** | **Integrated Governance committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** | **Investment committee** |
|---|---|---|---|---|---|
| **Mrs Kirkham is a retired judge.** | 4/9<br>Leading on legal issues and complaints/PALs | 5/9<br>Key focus on reputational awareness of performance | 1/5 | 2/4 | 0 |

| **Ms Elizabeth Mountford** (from January 2013) | **Trust Board** | **Audit Committee** | **Integrated Governance committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** | **Investment committee** |
|---|---|---|---|---|---|---|
| **Ms Mountford is an independent HR consultant** | 2/2 | 1 | 1/2 | 3/3 | 2/4 | 1/1 |

| **Mr Tim Pile** (from January 2013) | **Trust Board** | **Audit Committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** | **Investment committee** |
|---|---|---|---|---|---|
| **Mr Pile is a Director of a marketing and media company** | 1/2 | 0 | 1/3 | 1/4 | 0 |

| **Mr Andrew Meehan** (from January 2013) | **Trust Board** | **Audit Committee** | **Remuneration and Nomination Committee** | **Charitable Funds Committee** | **Investment committee** |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| **Mr Meehan is a Board member of a major retailer and the chair of a hospice.** | 2/2 | 0 | 3/3 | 2/4 | 0 |

Executive Director attendance at Board and Committee meetings.

| | **Trust Board** | **Audit Committee** | **Integrated Governance Committee** | **Investment Committee** | **Remuneration Committee** | **Charitable Funds Committee** |
|---|---|---|---|---|---|---|
| | 9 meetings | 4 meetings | 9 meetings | 1 meetings | 5 meetings | 4 meetings |
| Donal O'Donoghue ( to November 2012) | 6 | | 4 | | | 2 |
| Graham Bragg (from November 2012) | 2 | | 1 | | 1 | 1 |
| Graham Bragg (April 2012 to July 2012) | 4 | | | 5/5 | | |
| Steve Bloomer (to December 2012) | 6 | 4/4 | | 5/5 | | 2 |
| Andrew Thomas (to February 2013) | 6 | | 6 | | | 1 |
| Lindsey Webb | 9 | | 9 | | | 4/4 |
| Michael Woods from April to June 2012 | 3 | | 1 | | | 1 |
| Amanda Markall (from July 2012 | 7 | | | | | 2 |
| Paul Taylor from Dec 2012 | 3 | 2/2 | | 1 | | 2 |
| Andrew Pearson (from March 2013) | 1 | | | | | 1 |

**Board of Directors' Discharge of Obligations 2012/13**

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

The directors confirm that the above requirements have been complied with in the financial statements.

In addition, the directors are responsible for maintaining adequate accounting records and sufficient internal controls to safeguard the assets of the Trust and to prevent and detect fraud or any other irregularities, as described further in the Statement of Accounting Officer's Responsibilities.

**Trust Contractual Arrangements**

The Trust entered into contractual arrangements with Primary Care Trusts for the provision of health services. The Trust maintained one major capital construction contract for the building of its outpatients department and all other contracts were entered into in line with trust policies on procurement.

**Audit arrangements**

The Trust's external auditor is

Mr Gus Miah
Deloitte, 4 Brindley Place, B1 2HZ

The external auditors' remuneration for 2012/13 was £44,000.

The directors confirm that, so far as they are aware, having taken all steps to review information available to them, there is no relevant audit information of which the auditors are unaware and that each director has taken all reasonable steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

**Valuation of fixed assets**

During 2012/13 the Trust completed its annual revaluation of property. This has resulted in an overall revaluation loss of £0.3m being reported in the statement of comprehensive income for the year. The main contributor to this loss is the on-going building works relating to the old outpatients building which has reduced in value while the building is in a state of re-build.

**Political and Charitable Donations**

There were no political or charitable donations made by the Trust during the year under review.

**Post Balance Sheet Events**

There were no post balance sheet events during the year under review.

**Consultation with staff**

The Trust continued to meet the requirements of the Information and Consultation of Employees Regulation 2004. Details of this are contained in Chapter 6 of this Annual Report.

**Equal Opportunities**

The Trust continued to comply with legislation and details of the trust's equality and diversity activity can be found in Chapter 6 of this Annual Report.

**Health and Safety at Work**

The Trust takes its responsibilities for the health and safety of its staff and patients very seriously. During 2012/13, the Director of Operations has the responsibility for health and safety at board level.

The Governance department has gone through a restructure and changes in staff, since April 2012 there have been 3 staff changes to the Health and Safety Advisors post and to the Risk Managers posts. Both substantive posts have now been filled.

Risk Assessment Training

A new Risk Assessment training course has been developed and run by the Trust's Health and Safety Advisor and a training schedule for 2013/14 has been developed in order to deliver the training during the next year.

Audits and Inspections

A new audit and inspection procedure is being implemented and a schedule of audits and inspections has been developed for 2013/14. It is proposed that further inspections will be carried out on a quarterly basis by department and ward managers as an on-going assurance and compliance process.

Policies

Policies have been updated, including the Health and Safety Policy, Control of Substances Hazardous to Health Policy, Personal Protection Equipment Policy, Manual Handling Policy and Risk Assessment Policy.

Mandatory Training

Annual mandatory training for all non-clinical trust staff continues to be provided by the Health and Safety Advisor on the Mandatory Training days, this includes health and safety policies and issues, general awareness, incidents and accidents and access to information. Health and Safety training for clinical staff was delivered by external trainers ARC during the load patient handling course. The new external providers Darby will be delivering a higher quality level of training and will only be delivering patient handling information and techniques which will make the trust none compliant with health and safety legislation. To mitigate this risk the health and safety session will need to be put on the clinical mandatory training days for 2013/14.

Central Alerting System (CAS)

The Health & Safety Advisor continues to monitor the Medicine Healthcare Regulatory Authority (MHRA) alerts the Trust receives and disseminates information to relevant staff/departments. The status of all CAS alerts are reported at Quality Committee meetings and escalated to the Board where necessary.

**External Consultations**

The Trust has actively contributed responses to a range of consultations from the Department of Health, Monitor and the Care Quality Commission (CQC). In most cases the Trust makes

comment to the Foundation Trust Network and NHS Confederation (for inclusion in their aggregate response) and in its own right so that the specific impact of any proposals on a specialist orthopaedic service can be registered. The Trust has keenly assessed any governance and legal implications of changes and endeavoured to prepare for the implementation of changes well in advance.

The Trust has not undertaken any formal external consultations on its own services during 2012/13.

**Emergency Planning**

The Trust is classified as a Category 1 Responder under the Civil Contingencies Act 2004. The Major Incident plan was reviewed in January 2013 following recent local and regional health economy changes and a major onsite fire in December 2012.

Training of executives, junior clinical managers and bleep holders has been ongoing throughout the year.

An extensive flu vaccination programme was undertaken during winter and vaccination rate targets were increased by 7% compared to the previous year and 20% to two years ago.

Trust Business Continuity plans have been robustly tested during the response and recovery following the fire in December 2012.

The Royal Orthopaedic Hospital takes part in the local resilience partnership for the economy and the Chief Executive takes part in the regional emergency response rota to fulfil responsibilities of partnership working under the Civil Contingencies Act.

**Environment**

The Trust recognises its responsibilities with respect to the environment and focuses on reducing its environmental impact by using less, recycling more and disposing of waste sensitively and remains committed to reducing its carbon footprint. Full detail can be found in Chapter 5 of this Annual Report.

**Better Payment Practice**

The Trust paid 99.2% of invoices within 30 days against the target of 95%. The Trust did not incur any late payment penalties during 2012/13 under the Late Payment of Commercial Debts (Interest) Act 1998.

**Compliance with the cost allocation and charging requirements**

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

**Freedom of Information (FOI) Act**

The Trust continued to meet the requirements of the act and responded to requests in a compliant fashion.

**Use of Information Technology**

The Trust firmly believes that the intelligent use of Information technology, focused towards clinical needs, is essential in providing the excellent patient care which continues to be the focus of the Trust's work. During 2012/2013 the Trust improved its information reporting to enhance outcome measurement and Theatre utilisation. The Trust also commissioned a complete refresh

of its IT Strategy. This work has resulted in a number of projects that will be started to enhance the systems in use by the Trust so that clinical information can be provided where it is need, at the point of care, whilst reducing the amount of time required for staff to maintain those systems. A key area that the Trust will be focusing on will be secure electronic transfer of referrals and inpatient discharge and outpatient information between the Trust and patient General Practitioners. This will greatly reduce the time taken for information to reach the patient and the patient's GP. Keeping the patient informed at all stages of care remains a key focus for the Trust.

With regards to security and confidentiality of information and IT systems the Trust achieved the mandated level 2 in all 45 criteria of the Information Governance Toolkit.

**Serious untoward incidents relating to data loss and breaches of confidentiality**

During 2012/13 the Trust had 2 serious incidents relating to Information Governance. One involved the loss of 2 patient tapes containing patient information, one with 24 patients the other with 17 patients. The tapes were left in transcribers that went missing; it could not be established if the equipment was stolen or relocated. Patient data was re-dictated and there was no impact on patient care. Following the incident staff were instructed to always remove patient tapes from transcribers when the machines are unattended. The tapes have not been found. The other incident was a handover sheet containing details of 21 patients being dropped by a doctor and recovered by a member of staff. The doctor was aware of the error and had made efforts to retrieve the document. This example is used at mandatory Information Governance training to remind staff to take care of paper documentation.

**Policies and procedures relating to counter-fraud**

The Trust engages the services of its local counter-fraud specialist. Regular audits of counter-fraud activities are undertaken, and the Trust is active in promoting the work of the counter-fraud team to all staff. A joint communication strategy and action plan has been developed to ensure that all staff are aware of their responsibilities and where they can seek help. Regular updates are provided to the Audit Committee on the work of the local counter fraud specialist and the Board has received a presentation on the work of counter-fraud.

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

Executive Director Salaries are determined by the Nominations and Remuneration Committee of the Trust Board, informed by benchmark salary derived from established national NHS pay surveys. All Executive Directors are employed on permanent contracts of employment with a six month notice period. No Executive Directors have provision for other payments over and above their statutory entitlement, to be made on termination of employment. In determining whether or not to agree an annual uplift of salary for Executive Directors, the Committee had due regard to the national pay awards made to other staff groups.

**Remuneration Report Summary and explanation of policy on duration of contracts, and notice periods and termination payments for chairs and non-executive members of The Royal Orthopaedic Hospital NHS Foundation Trust**

**Terms and Conditions**

1. **Statutory Basis for Appointment**
   Chairs and non-executive members of Foundation Trusts hold a statutory office under the National Health Service Act 1977. Their appointment does not create any contract of service or contract for services between them and the Secretary of State or between them and the Trust. The appointment and tenure of office of chairs and members of The Royal Orthopaedic Hospital NHS Foundation Trust are governed by the Trusts regulations.

2. **Employment Law**
   The appointments are not within the jurisdiction of Employment Tribunals. Neither is there any entitlement for compensation for loss of office through employment law.

3. **Reappointments**
   Chairs and non-executive members are eligible for reappointment at the end of their period of office, but they have no right to be reappointed. The Governors will usually consider afresh the question of who should be appointed to the office. However, it is likely to consider favourably a second term of appointment without competition for people whose performance has been appraised as consistently good during their first term. If reappointed, further terms will only be considered after open competition, subject to a maximum service of ten years with the same organisation and in the same role.

4. **Termination of appointment**
   There is no provision in the Trust's annual accounts for the early termination of any non-executive's appointment.

5. **Remuneration**
   The chair and non-executive members are entitled under the Act 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.

6. **Current rate for chair and nonexecutives**
   The rate (2012/13) of remuneration payable to the chair of the Trust is £35,700 pa for up to 2 days a week. The current rate of remuneration payable to members is £10,200 pa for approximately 3 days per month.

7. **Tax and National Insurance**
   Remuneration is taxable under Schedule E, and subject to Class I National Insurance contributions where appropriate. Any queries on these arrangements should be taken up with the Inspector of Taxes or the Contributions Agency respectively.

**8. Allowances**

Chairs and non-executive members are also eligible to claim allowances, at rates set centrally, for travel and subsistence costs necessarily incurred on Trust business.

**9. Conflict of interest**

NHS boards are required to adopt the Codes of Conduct and Accountability, published in April 1994. The Codes require chairs and board members to declare on appointment any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. These must be entered into a register which is available to the public at public Board meetings.

**10. Indemnity**

The Trust is empowered to indemnify the chair and non-executive members against personal liability which they may incur in certain circumstances whilst carrying out their duties.

The Trust has taken out a policy of Directors and Officers liability insurance in consultation with the NHS Litigation Authority having regard to the NHS England and international nature of its work.

**For executive directors of The Royal Orthopaedic Hospital NHS Foundation Trust**

**Terms and Conditions**

**1. Basis for appointment**

Executive directors are appointed on a permanent basis under a contract of service at an agreed salary, eligibility to claim allowances for travel and subsistence costs, at rates set by the Trust for expenses incurred necessarily on its behalf. Executive directors acting in an interim capacity are normally appointed on the basis of a fixed term agreement. They are not entitled to a performance related award but would be entitled to all other allowances and benefits.

**2. Termination of appointment**

The notice period for any executive director is 6 months. During the year one payment was made to terminate a director's contract of employment. This reflected their contracted entitlement on termination and was not a compensation payment.

**Salaries and allowances**

| **A) Salaries*** | | | | | | |
|---|---|---|---|---|---|---|
| | **2012-13 (12 months to 31st March 2013)** | | | **2011-12 (12 months to 31st March 2012)** | | |
| **Name and Title** | **Salary (bands of £5,000) £000** | **Other Remuneration (bands of £5,000) £000** | **Benefits in Kind Rounded to the nearest £100** | **Salary (bands of £5,000) £000** | **Other Remuneration (bands of £5,000) £000** | **Benefits in Kind Rounded to the nearest £100** |
| Mr. L. James - Chairman (Left 14.11.2012) | 20-25 | 0 | 300 | 35-40 | 0 | 0 |
| Mr. C. Monk – Non Executive Director and Acting Chairman (from 15.11.2012) | 15-20 | 0 | 0 | 10-15 | 0 | 0 |
| Mr. D. O'Donoghue – Chief Executive ***note 1*** | 160-165 | 0 | 0 | 5-10 | 0 | 0 |
| Mr. G. Bragg - Director of Strategic and Business Development and Acting Chief Executive (from 13.09.2012) | 65-70 | 0 | 0 | 105-110 | 0 | 0 |
| Mrs. P Venables – Chief Executive (left 30.12.2011) | 0 | 0 | 0 | 90-95 | 0 | 0 |
| Mrs. L. Webb – Director of Nursing and Governance, and Deputy Chief Executive | 95-100 | 0 | 0 | 80-85 | 0 | 0 |
| Mr. A. Thomas - Medical Director (stepped down 08.03.2013) | 20-25 | 120-125 | 0 | 20-25 | 115-120 | 0 |

**Salaries and Allowances (cont'd)**

| A) Salaries* | | | | | | |
|---|---|---|---|---|---|---|
| | 2012-13 (12 months to 31st March 2013) | | | 2011-12 (12 months to 31st March 2012) | | |
| Name and Title | Salary (bands of £5000) £000 | Other Remuneration (bands of £5000) £000 | Benefits in Kind Rounded to the nearest £100 | Salary (bands of £5000) £000 | Other Remuneration (bands of £5000) £000 | Benefits in Kind Rounded to the nearest £100 |
| Dr. A. Okubadejo – Medical Director ***note 3*** | 0 | 20-25 | 0 | 0 | 0 | 0 |
| Mr. A. Pearson – Medical Director (from 11th March 2013) | 0-5 | 0 | 0 | 0 | 0 | 0 |
| Mrs. V. Doyle – Director of Operations (left 31st March 2012) | 0 | 0 | 0 | 85-90 | 0 | 0 |
| Mr. M Woods – Interim Director of Operations (to 8th July 2012) | 25-30 | 0 | 0 | 0 | 0 | 0 |
| Mrs. A. Markall – Director of Operations (from 9th July 2012) | 65-70 | 0 | 0 | 0 | 0 | 0 |
| Mr. S. Bloomer – Director of Finance and IM&T (left 9th December 2012) | 70-75 | 0 | 100 | 85-90 | 0 | 0 |
| Mr. P. Taylor – Interim Director of Finance (from 3rd December 2012) ***note 2*** | 45-50 | 0 | 0 | 0 | 0 | 0 |
| Dr. E. Hensel - Non Executive Director (left 31st December 2012) | 5-10 | 0 | 0 | 10-15 | 0 | 0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Mr. R. Otto - Non Executive Director (left 31st December 2012) | 10-15 | 0 | 100 | 10-15 | 0 | 0 |
| Mr. R. Millinship - Non Executive Director | 10-15 | 0 | 0 | 10-15 | 0 | 0 |

**Salaries and Allowances (cont'd)**

**A) Salaries***

| Name and Title | 2012-13 (12 months to 31st March 2013) | | | 2011-12 (12 months to 31st March 2012) | | |
|---|---|---|---|---|---|---|
| | Salary (bands of £5000) £000 | Other Remuneration (bands of £5000) £000 | Benefits in Kind Rounded to the nearest £100 | Salary (bands of £5000) £000 | Other Remuneration (bands of £5000) £000 | Benefits in Kind Rounded to the nearest £100 |
| Mrs. F. Kirkham – Non Executive Director | 5-10 | 0 | 0 | 5-10 | 0 | 0 |
| Mr. T. Southwood – Non Executive Director | 10-15 | 0 | 0 | 10-15 | 0 | 0 |
| Miss. E. Mountford – Non Executive Director (from 1st January 2013) | 0-5 | 0 | 0 | 0 | 0 | 0 |
| Mr. T. Pile – Non Executive Director (from 1st January 2013) | 0-5 | 0 | 0 | 0 | 0 | 0 |
| Mr. A. Meehan – Non Executive Director and Audit Committee Chair (from 1st January 2013) | 0-5 | 0 | 0 | 0 | 0 | 0 |

*This element of the annual report has been audited.

**Notes**

1. Mr. D O'Donoghue is currently on long term sick leave which commenced in November 2012. In the interim Mr. G Bragg has stepped into the role as the Trusts Acting Chief Executive with Mrs. L Webb as the Deputy Chief Executive.
2. Mr. P Taylor commenced his post on 3 December 2012 and was remunerated for two days a week through contract arrangements with Taylor Moore Associates Ltd.

3. There has been one instance of a termination of employment payment relating to the appointment of a new Medical Director due to changed circumstances within the Trust. This payment related to a contractual obligation.

**Salary and Pension Entitlements of Senior Managers**

**B) Pension Benefits***

| 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 2013 (bands of £5000) £000 | Cash Equivalent Transfer Value at 31 March 2013 £000 | Cash Equivalent Transfer Value at 31 March 2012 £000 | Real Increase/ (decrease) in Cash Equivalent Transfer Value £000 | Employers Contribution to Stakeholder Pension To nearest £100 |
|---|---|---|---|---|---|---|
| Mr. D. O'Donoghue – Chief Executive | (14.5-17) | 240-250 | 1,173 | 1,183 | (38) | 0 |
| Mrs. P Venables – Chief Executive (left 31.12.2011) | 0 | 0 | 0 | 886 | 0 | 0 |
| Mr. G. Bragg - Director of Strategic and Business Development and Acting Chief Executive (from 13.09.2012) | (2.5-5) | 185-190 | 0 ***note 1*** | 1,077 | 0 ***note 1*** | 0 |
| Mrs. L. Webb – Director of Nursing and Governance, and Deputy Chief Executive | 15-17.5 | 100-105 | 419 | 337 | 74 | 0 |
| Mr. A. Thomas - Medical Director (stepped down 08.03.2013) | 12-14.5 | 235-240 | 1,344 | 1,210 | 106 | 0 |
| Mr. A. Pearson – Medical Director (from 11.03.2013) | 0-2.5 | 125-130 | 572 | 478 | 4 | 0 |
| Mrs. V. Doyle – Director of Operations (left 31.03.2012) | 0 | 0 | 0 | 563 | 0 | 0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Mr. M Woods - Mr. M Woods – Interim Director of Operations (to 8th July 2012) | 0 ***note 2*** | 100-105 | 377 | 0 ***note 2*** | 0 ***note 2*** | 0 |
| Mrs. A. Markall – Director of Operations (from 1st April 2012) | 0 ***note 3*** | 105-110 | 411 | 0 ***note 3*** | 0 ***note 3*** | 0 |
| Mr. S. Bloomer - Director of Finance and IM&T | 10-12.5 | 100-105 | 374 | 303 | 47 | 0 |

*This element of the annual report has been audited

**Note**

1. Mr. G Bragg had previously retired but has since returned to work
2. Mr. M Woods did not hold an executive position prior to 1 April 2012 and so no comparative numbers have been provided in this report.
3. Mrs. A Markall did not hold an executive position prior to 1 April 2012 and so no comparative numbers have been provided in this report.

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.

**Highest paid director ratio**

The HM Treasury FreM requires disclosure of the ratio between the highest paid director and the median remuneration of the reporting entity's staff. The calculation is based on the full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Agency staff have not been included in this calculation as this would not give a true view of the Trust's remuneration.

The Trust ratio for this calculation is 6.2:1 for the year ending 31 March 2013 with the highest paid director salary being £165k and a median salary £27k, (2011/12 6.1:1). No individual receives remuneration in excess of the highest paid director, (2011/12 nil).

**Directors and Governors expense claims**

*This information is not subject to audit*

For 2012/13 the Trust is required to disclose information relating to expense claims processed in relation to the Trusts directors and governors:

| Name | Title | £ |
|---|---|---|
| Mr S Bloomer | Director of Finance | 259 |
| Mr G Bragg | Director of Strategic Business Development and Acting Chief Executive | 630 |
| Mr L James | Chairman | 5,653 |
| Mrs L Webb | Director of Nursing and Governance, and Deputy Chief Executive | 78 |
| Mr R Otto | Non-Executive Director | 546 |
| Mr R Talboys | Governor | 187 |

**Reporting related to the Review of Tax Arrangements of Public Sector Appointees**

*This information is not subject to audit*

As part of the *Review of Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012, the Trust is required to publish information in relation to the number of off payroll engagements – at a cost of over £58,200 per annum – that were in place on
31 January 2012 and for off payroll engagements entered into between 22 August 2012 and 31 March
2013 where the daily rate is greater than £220 and the contract exceeds a 6 month period.

**Off payroll engagements at a cost of over £58,000 per annum that were in place as of 31 January 2012:**

| Description | WTE |
|---|---|
| No. In place on 31 January 2012 | 0 |
| No. that have since come onto the organisations payroll | 0 |
| No. that have since been re-negotiated/re-engaged to include contractual clauses allowing the Trust to seek assurance as to their taxobligations | 0 |
| No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the Trust to seek assurance as to their tax obligations | 0 |
| No. that have come to an end | 0 |

**Off-payroll engagements between 23 August 2012 and 31 March 2013 for more than £220 per day and more than 6 months:**

| Description | WTE |
|---|---|
| No. of new engagements | 2 |
| No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and national insurance | 1 |
| No. for whom assurance has been accepted and received | 2 |
| No. for whom assurance has been accepted and not received | 0 |
| No. that have been terminated as a result of not receiving assurance. | 0 |

**Graham Bragg**
Acting Accounting Officer
The Royal Orthopaedic Hospital NHS Foundation Trust
29 May 2013

## 8. The Council of Governors report on its work, elections and membership

### The work of the Council of Governors 2012/13

The Council of Governors is responsible for representing the interests of the Trust's members and partners, for advising on strategy, for appointing the auditors and for appointing the Chairman and non-executive directors of the Trust. The Council has three committees – Nominations and Remuneration, Patient Experience and Member Engagement.

The 25 representatives on our Council of Governors are elected or appointed by our constituency members to represent their interests and help shape the Trust's work. Their role is a key part of the Trust's governance structure as they hold the Board of Directors to account and have direct responsibility for appointing the Chairman and Non-Executive Directors as well as the Trust's Auditors.

There are three categories of representatives (public and patient, staff and partner nominated members) on the Council of Governors. The Chairman of the Board of Directors is also Chair of the Council of Governors. This ensures a continuity of communication between the two forums. Council committees are attended by executive directors and non-executive directors and in this way, the Council can ask directly for supplementary information. The Council of Governors meets quarterly in public and attends two Board meetings each year at which it is fully engaged in discussions, although any decisions taken remain the sole responsibility of the Board.

The Council of Governors appointed Mr Neil Hart as their Lead Governor. He resigned during 2012 and Mr Alan Last was elected to serve in this role. Neither has had cause to exercise this role during the year in regard to dialogue with Monitor regarding performance of non-executive directors. Mr Last may be contacted through the Trust's Company Secretary, The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, B31 2AP.

### Doing its job – as a whole Council

The Council of Governors fully discussed the Trust's Annual Plan and also worked closely with the Board on the continued development of its strategy for the Trust. This strategy was discussed at its AGM and at the joint meetings with the Board.

### Council of Governors involvement in strategy

The Council approves the Annual Plan prior to submission each year at one of its public meetings. This is underpinned by a mixture of workshops and formal meetings. Council members attend two Board meetings each year and these focus on performance and future direction.

In this way the Council can be seen to be actively engaged in the work of the Trust, directly able to assess the work of the Board and observe the work of the Chairman in a context other than as Chairman of the Council of Governors.

### In committees

The Patient Experience Committee has responsibility for ensuring that the Trust keeps patient needs at the heart of its work and responds to issues identified by patients and service users through the Patient Council, from survey feedback or through patient and carer membership. The committee is attended by the Director of Nursing and Governance and the Director of Operations, giving direct access to executive action and also by a designated NED who can

maintain a strong link with the board. This alleviates any potential problems of disconnection and ignorance of customer issues.

The Member Engagement committee has responsibility for identifying ways in which the membership can become involved in the work of the Trust through consultations and surveys as well as by outreach. This committee also has a designated NED and is supported by the Director of Strategy and Business Development and the Public Engagement Manager.

The Nominations and Remuneration Committee is supported by the Director of Workforce and Organisation Development and Company Secretary and reviews NED remuneration based on available benchmark data and also considers the appointment of additional NEDs on behalf of the full council prior to making recommendations for appointment.

**Constituencies**
The Trust has several classes of member. Stakeholder members of Council are appointed from an agreed range of partner and interested local organisations.

Public members come from identified constituencies across England and Wales and staff members from clinical and non-clinical staff groups. Elections to council are held from each public constituency when terms of office expire or vacancies occur. Stakeholder representatives are nominated by their host organisation to serve for an open ended or fixed terms at their discretion.

There are five public constituencies within Public membership:

- South Birmingham
- Heart of Birmingham
- Northern & Eastern Birmingham
- Rest of West Midlands
- Rest of England & Wales

There are two constituencies within Staff membership:

- Clinical
- Non-clinical

All election boundaries for public members (including patients) are co-terminus with either PCT or local authority boundaries. Public membership eligibility is restricted to those persons living within the relevant boundary and being over 16 years of age. In addition to those representatives on the Council of Governors elected by the public, patient and staff members, a number of key organisations that work closely with the Trust appoint representatives for the Council of Governors.

Any individual of the age of 16 or over who resides in England or Wales is eligible to become a public member of the Trust. Staff membership is open to those individuals who have a permanent or 12 month fixed term contract with the Trust for employment.

**Elections**
**There was 1 set of elections results to report during 2012/13**

As terms of office came to an end for several Governors in this period, an election was called to fill seats in the following constituencies:

South Birmingham: 2 seats

| | |
|---|---|
| Rest of West Midlands: | 1 seat |
| Heart of Birmingham: | 1 seat |
| Northern & Eastern Birmingham: | 2 seats |
| Staff Clinical: | 2 seats |

In the two smallest constituencies, only one person nominated themselves for election. Therefore 1 seat in Birmingham East & North was filled (uncontested) and the remaining seat, with the seat within Heart of Birmingham remained unfilled. The remainder of the seats in the three other constituencies were contested.

Results

Elections to our Council of Governors for vacancies arising in 2012/13 have been overseen by the Electoral Reform Society.

**Public: South Birmingham July 2012**

| | |
|---|---|
| Number of eligible voters: | **2817** |
| Total number of votes cast: | **547** |
| Turnout: | **19.4%** |
| Number of votes found to be invalid: | **9** |
| Blank or Spoilt<br>Declaration form received | |
| Total number of valid votes to be counted: | **538** |

**Result (two to elect):**

The following candidates were elected:
ARNOLD, Peter
BETTERIDGE, Marion Ruth

In addition, the resignation of Mr. Gary Roskell in July 2012 created a third vacancy on the Board of Governors for South Birmingham. As there were more candidates within this constituency, a third person was appointed from this election.

MARTIN, Dia

**Public: Rest of West Midlands July 2012**

| | |
|---|---|
| Number of eligible voters: | **1755** |
| Total number of votes cast: | **381** |
| Turnout: | **21.7%** |
| Number of votes found to be invalid: | **4** |
| Blank or Spoilt<br>Declaration form received | **2** |
| Total number of valid votes to be counted: | **379** |

**Result (one to elect):**

The following candidate was elected:
SCOTT, Yvonne

**Staff: Clinical July 2012**

| | |
|---|---|
| Number of eligible voters: | **494** |
| Total number of votes cast: | **127** |
| Turnout: | **25.7%** |
| Number of votes found to be invalid: | **0** |
| Blank or Spoilt<br>Declaration form received | |
| Total number of valid votes to be counted: | **127** |

**Result (two to elect):**

The following candidates were elected:
HUGHES, Karen
PEARSON, Andrew

**Public: Northern & Eastern Birmingham**

Uncontested Election

BAHRA, Kulwant

**Elected Members serving during the year 2012/13 meeting attendance**

South Birmingham (5 seats)

**1. BLACKLEDGE, Joseph** – appointed for 3 years until end January 2014.
(attended 4 out of 4 council meetings)
**2. BETTERIDGE, Marion** – appointed for 3 years until end July 2015
(attended 2 out of 2 council meetings)
**3. ARNOLD, Peter** – appointed for 3 years until end July 2015
(attended 0 out of 4 council meetings)
**4. MARTIN, Dia –** appointed for 3 years until end July 2015
(attended 2 out of 2 council meetings)
**5. VACANT SEAT** currently out for election

**ROSKELL, Gary** - appointed March 08 until end January 2010 and re-elected for 3 years until end January 2013. Resigned July 2012
**HART, Neil** - appointed for 3 years until end January 2010, re-elected for 3 years until end January 2013. Term of Office ended January 2013
**RICHMOND**, **Isobel Ingrid** – re-elected for 3 years until 15th April 2012. Term of Office ended April 2012

Heart of Birmingham (1 seat)
**1. VACANT SEAT** (failure to secure nominations from a very small constituency membership)

Rest of the West Midlands (4 seats)
**1. SCOTT, Yvonne** - appointed on re-election, for 3 years until 15th April 2012, re-elected for 3 years until July 2015
(attended 4 out of 4 council meetings and serves on the Patient Experience Committee)
**2. LAST Alan**, appointed for 3 years until end January 2014.
(attended 4 out of 4 council meetings and serves on the Membership Engagement Committee)

**3. WILLIAMS, Kenneth** – appointed for 3 years until end January 2014.
(attended 1 out of 4 council meetings)
4. **VACANT SEAT** currently out for election

**NOON, Stella** - appointed for 3 years until end January 2010, re-elected for 3 years until end January 2013. Term of office ended January 2013

East and North Birmingham (2 seats)
**1. BHARA, Kulwant –** appointed for 3 years until end July 2015
(attended 1 out of 2 council meetings)
**2. VACANT SEAT** (failure to secure nominations from a very small constituency membership)

Rest of England (1 seat)
**1. VACANT SEAT** currently out for election

**TALBOYS, Robert** – appointed for 3 years until end January 2013. Term of office ended January 2013

**Clinical Staff Representatives**
**1. HUGHES, Karen –** appointed for 3 years until end July 2015
(attended 2 out of 2 council meetings)
**2. PEARSON, Andrew –** appointed for 3 years until end July 2015
(attended 1 out of 2 council meetings)

**CHURCHMAN, John** re-elected for 3 years until end March 2012. Term of Office ended March 2012
**GRIMER Robert** – appointed for 3 years until end March 2012. Term of Office ended March 2012

Non-Clinical Staff Representatives
**1. WALSHAW, Janet,** elected for 3 years until end of May 2013.
(attended 4 out of 4 council meetings and serves on the Patient Experience and Member Engagement Committees)

**Partner Nominees**
The following organisations make nominations to the Council of Governors and the following individuals held posts during the period of this report:

**South Birmingham PCT** - no nominee in year

**Heart of Birmingham PCT -** no nominee in year

**Birmingham City Council-** no nominee in year

**University of Birmingham** - no nominee in year

**Birmingham City University**
**Marion Thompson** Attended 2 Council meetings (of 4) and serves on the Remuneration Committee

**Bournville Village Trust**
**Paul Sabapathy** from February 2012 to June 2012 Attended 1 of 1 Council meetings

**Patient Support Groups**
**Sue Arnott** Attended 4 Council meetings (of 4) and serves on the Patient Experience Committee

**Member of Parliament**
**Richard Burden MP** Attended 0 Council meetings (of 4)

**Birmingham Council of Faiths**
**Parwez Hussain**
Attended no Council meetings (of 4).

**The Council of Governors Register of Interests**
This is available for inspection on application to the Trust's Company Secretary, The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham, B31 2AP. No member declared a material conflict of interest during the year and all interests were registered and available for inspection.

Members of Council receive no remuneration, but are entitled to claim expenses at an agreed rate.

**Engaging Our Membership**

As agreed, the focus of membership activity in the last year has been to create more opportunities for members to engage directly with the Trust, rather than on growth of numbers.

Over the past year, the Trust has continued to look at ways in which members can engage meaningfully with the Trust. As a number of the existing initiatives focussed on members who wished to engage in person, the department has worked on finding more opportunities to engage from home. This has been particularly successful when asking members for feedback on new initiatives and planning services. Examples of this include:

- Surveying members regarding preferences on time of admission for surgery (night before or on the morning) and the reasons to assist in planning services in the new ambulatory care unit.
- Asking for feedback on the quality account and areas for focusing on improvement.
- Increase in the use of the virtual patient and carers' council for proof-reading patient information and papers to ensure readability.

In addition members have become involved in more projects on site, in addition to the existing opportunities. These include:

- Providing patient and carer input into efficiency saving projects in the Project Management Office to ensure that the patient view is represented.
- Becoming involved in the planning group for the implementation of the new Ambulatory Care Unit.
- Assisting in the production of patient experience materials such as videos to provide insight for staff, create promotional material and increase understanding of the issues that people may face when coming into contact with the NHS.

Members continue to:

- Be involved in the Simulated patient Programme
- Help conduct the real-time Patient Survey and Friends and Family survey
- Become Mystery shoppers
- Assisting with outcomes data collection
- Be Involved with the Research and Development Department in delivering trials and collecting information.

Any member may contact the Trust's Company Secretary at the Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Birmingham B31 2AP. 0121 685 5000

**Membership size and movements**

| **Public constituency** | **2012 - 13** | **2013 - 14 (estimated)** |
|---|---|---|
| At year start (April 1) | 6,004 | 5,912 |
| New members | 43 | 150 |
| Members leaving | 133 | 120 |
| At year end (March 31) | 5,912 | 5,942 |
| | | |
| **Staff constituency** | | |
| At year start (April 1) | 875 | 848 |
| New members | 56 | 30 |
| Members leaving | 83 | 28 |
| At year end (March 31) | 848 | 850 |

**Analysis of current membership**

At the end of 2012/13 the Trust had maintained an approximate membership of 6,000. The Trust will continue to develop its membership base in 2013/14 but again, will not seek significant growth and continue to focus on more varied opportunities for engagement with existing members. However, in the coming year, we will review the mix of the membership in light of revised census information and use of facilities to ensure that it remains a credible source of information whose views and opinions are reflective of users of our services.

| **Public constituency** | **Number of members** | **Eligible membership** |
|---|---|---|
| **Age (years):** | | |
| 0-16 | 3 | |
| 17-21 | 142 | 5,690, 271 |
| 22+ | 5,399 | |
| Not stated | 368 | |
| | | |
| **Ethnicity** | | |
| White | 4,130 | 1,138,054 |
| Mixed | 115 | 16,501 |
| Asian or Asian British | 386 | 83,078 |
| Black or Black British | 289 | 44,384 |
| Other | 103 | 4,408,254 |
| Not Stated/Do not wish to state | 889 | |

| **Public constituency** | **Number of members** | **% of membership** |
|---|---|---|
| **Socio-economic Category** | | |
| ABC1 | 3,110 | 53 |
| C2 | 1,102 | 19 |
| D | 1,258 | 21 |

| | | |
|---|---|---|
| E | 407 | 7 |
| Data not available | | |
| **Gender** | | |
| Male | 2,260 | 38 |
| Female | 3,567 | 61 |
| Unspecified | 85 | 1 |

**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 accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial 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; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed

**Graham Bragg**

Acting Chief Executive

Date: 29th May 2013

## Annual Governance Statement

### Scope of responsibility

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

### The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going 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; and
- 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 2013 and up to the date of approval of the Annual Report and Accounts.

### Capacity to handle risk

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

The Audit Committee is chaired by a Non-Executive Director of the Trust, meets at least six times a year and reports directly to the Trust Board. The Audit Committee ensures that effective systems of internal control for all risks are maintained. It receives the Board Assurance Framework at the beginning of the financial year and then at each meeting throughout the year. It robustly challenges mitigation and action plans that deal with key corporate risks. The Audit Committee seeks positive assurance on the overall arrangements for governance and risk management from the Integrated Governance Committee.

The Integrated Governance Committee has designated responsibility for risk management and is chaired by a Non-Executive Director of the Trust; the Chief Executive is a member of this committee. The Integrated Governance Committee provides a performance monitoring and scrutinies function on behalf of the Trust Board and oversee all aspects of integrated governance within the Trust including corporate governance. The Committee meets a minimum of 10 times per year and will review national risk management priorities and delegate responsibility for further analysis/ action and review the Corporate Risk Register.

Sub-Committees reporting to the Integrated Governance Committee also meet regularly and review the risks attributed to their respective committee, scrutinising and ensuring that appropriate ratings have been attributed and appropriate mitigation undertaken. This process includes the evaluation of mitigation actions that have taken place to understand and assess the

outcomes of these actions. The Trust Board also receives the risks attributed to them on a regular basis.

The Trust has purchased a web based risk register that will facilitate both local and Corporate risk registers and Board Assurance Framework. The education and training of all staff in the principles of risk management is an essential element of the Trusts Risk Management Strategy. Risk management update training is provided to new staff as part of the induction programme to the organisation and all existing staff receive annual updates on key elements as per the mandatory training programme identified through the Trust Training Needs Analysis. Enhanced training in root cause analysis, investigations and risk registers is also included.

**The risk and control framework**

A review of the risk management strategy was updated in January 2012 and is due for full review in January 2014. The purpose of the risk management strategy is to:

- define the strategic direction for risk management in the Trust.
- focus upon experiences and learning in order to improve patient care, clinical outcomes and the working environment,
- assess and where possible anticipate risk and also to eliminate or reduce risk of harm to patients, staff, visitors or contractors,
- describe the framework and the method that the Trust will use to identify, manage and reduce the risks (actual or potential) which exist within the organisation and its environment and provides the Trust with clear direction on which to base all future risk management initiatives.

If effectively implemented it will ensure the Trust will be in the best position to deliver corporate objectives both strategic and operational and minimise the Trusts financial liability.

The Trust recognises the importance of collecting meaningful and relevant data in a statistical format so that it can be analysed and trends can be monitored and appropriate action taken. Quarterly reports highlighting trends and pertinent risk issues are made to the Integrated Governance Committee; this committee also receives quarterly summary reports of the combined corporate risk register and board assurance framework including the detail of all red rated risks. The Integrated Governance Committee then provides assurance to the Trust Board. The Quality Governance Framework assesses the combination of structures and processes in place, both at and below Board level, which enables a Trust Board to assess the quality of care it provides.

The Trust Board has reviewed the Quality Governance Framework (QGF) in June 2012 to ensure it reflects a true position. The Integrated Governance Committee review the QGF on a quarterly basis to give assurance to the Trust Board that risks are being monitored and any weaknesses resolved.

Information on serious incidents is shared with key staff. Once completed serious incident investigation reports are anonymised and circulated to key stakeholders including the Virtual Serious Incident Review Investigation Group (VSIRI) for comments and feedback. The VSIRI Group is a multi-disciplinary co-opted group of senior staff who will review clinical reports and provide scrutiny of findings, recommendations and action plans. Meetings are arranged where necessary to discuss the findings of serious incident investigation reports. Monthly reports on new serious incidents and actions resulting from on-going incident investigations are provided to

the Trust Board and Operational management teams via the Patient Safety Report. Key learning points are also shared at the Trust's combined surgical and anaesthetic audit meeting.
Information on clinical and non-clinical incidents and claims is collated and incorporated in the Trust quality governance reports on a quarterly basis. This is discussed at the Quality Committee. Actions and learning are detailed within the quarterly report which is reviewed and approved by the Integrated Governance Committee. Once approved the Trust report is submitted to the local commissioning bodies and scrutinised as part of the contract review process. The Quality Committee is also attended by members of the local commissioning body. Directorates receive localised reports which are discussed as part of Directorate meetings at the Trust Business and Learning day which has occurred monthly since September 2012. In the forthcoming year feedback from these local meetings will be shared at the Quality committee.

Ward Managers and Matrons report monthly against key performance indicators which cover workforce, training, safety, patient experience and effectiveness and are reviewed within directorate meetings and directorate performance review meetings. A RAG rating is assigned which is circulated in order to share areas of good practice and encourage peer support with weaker areas. Improvement targets are set and monitored. The Trust Board and Operational Management Group and our commissioning body receive an overarching RAG rating report as part of the monthly Patient Safety Report.

The Board Assurance Framework 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 Board Assurance Framework draws together the key corporate risks from the Corporate Risk Register and is considered by the Integrated Governance 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 officer, lead executive, action plan and comments on performance to date which assure the Board on progress and management of corporate risks within the organisation.

The key on-going risks, as reported in the Board Assurance Framework are:

- Long waiting times for Spinal Deformity cases
- Failure to deliver contractual KPI targets & Commissioning for Quality and Innovation (CQUIN) schemes, causing financial loss
- Executive Director continuity and corporate memory
- Insufficient assurance around robust implementation of infection prevention strategies in theatres
- Current clinical workforce unable to meet the needs of increasingly complex patients with multiple co-morbidities
- Failure to deliver activity targets, shrinking the organisation
- A low position for health improvement as measured by PROMS

Red risks are managed through the Audit Committee and Integrated Governance Committee throughout the year and they provide assurance to the Trust Board on status and progress.

The organisation highlighted a key risk around medical engagement for 2012/13, and work is on-going to embed the Trust's approach to service line management as a key vehicle for engaging the medical workforce.

The Trust has a detailed action plan aimed at treating all patients waiting over 52 weeks (mainly in Spinal Deformity) by the end of June 2013. The plan is very challenging as the issues relating to its delivery are multifactorial.

The Internal Auditors have undertaken audit work around the current risk management systems including the Trust Board Assurance Framework and risk management. They are able to give reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. Internal Audit did highlight some issues that, if not addressed, increase the likelihood of risk materialising. The key issues raised were:

- The links between risks and Trust objectives
- Timeliness and completeness of risk template updates
- The availability and audit trail behind some risk assurance documents

The Trust reviews external reports produced by various bodies and is currently considering how to review the Francis report to ensure full engagement of operational and management staff and to adopt where appropriate the recommendations. The Trust Board will consider this issue shortly with the intention of agreeing an action plan which will be completed by December 2013.

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

The main control for Information governance is the IG Toolkit and the IG Group monitors compliance with the Toolkit via its quarterly meetings. Other specific controls include:

- Trust portable devices i.e. laptops, tablets, data sticks and PDAs, have encryption software installed and no personal devices can operate on the Trust network.
- Information flows containing personal/sensitive data in and out of the Trust have been identified, reviewed and risk assessed, and transfer methods changed where required.
- Information assets (IT systems and papers) have been risk assessed to ensure that data is held securely and have appropriate access controls.
- All staff receive annual IG training via mandatory training supplemented by the e-learning IG Training Toolkit to ensure up to date knowledge about the importance of the confidentiality and security of information.

The Trust is committed to involving stakeholders as appropriate in all areas of the Trust's activities. This includes informing and consulting on the management of any significant risks. Key stakeholders included NHS Midlands and East, lead commissioners at Birmingham Cross City Clinical Commissioning Group, subcontractors, voluntary groups, the Council of Governors, patient groups (including the statutory LINKS), patients, the local community and the Local Authority Overview and Scrutiny Committee.

General public awareness of the Trust's Strategy is achieved through its presentation to the Council of Governors, explicit references within the Trust's Annual Plan and Annual Report and by ensuring the general availability of the strategy on the Trust's website. Annual plans and annual reports are also made available via the website of Monitor the Foundation Trust Independent Regulator.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission but has some "Minor" issues identified for outcome 4, Care and Welfare of people

who use services, and outcome 9 management of medicines. This follows an unannounced routine inspection in December 2012.

Due to the issues being identified as “minor”, regulatory action was not taken by either the CQC or Monitor.

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 in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with. This is overseen by the Workforce and Organisational Development Committee.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has an active Good Corporate Citizen Group who are overseeing progress on carbon reduction.

**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, Directorate performance meetings and regular reports to the Executive Management Team and the Trust Board. The budgetary control system is complemented by a clear scheme of delegation and financial approval limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis.

In August 2012, the Trust restructured into Clinical Directorates, with 5 surgical and 2 clinical support Directorates introduced in line with clinical sub-specialties. This new structure is aimed at developing greater involvement and integration with clinical managers, putting the responsibility and control of resources into the hands of the people who use them. Each Directorate is subject to formal quarterly reviews with Executive Directors. These reviews combine outcomes with efficiency, effectiveness, use of resources, quality and governance to ensure a holistic view of performance is taken.

The Trust has developed, within its Corporate Performance Report, a scorecard which monitors both national and local targets together with efficiency indicators which are reported on a monthly basis. More detailed monitoring, with a particular emphasis on financial controls, is reported on a quarterly basis. This report has been adapted to provide Directorate-specific performance data to each Clinical Directorate on a monthly basis.

A component of the Trust's financial planning is the implementation and delivery of a cost improvement programme which is monitored by the Trust Board monthly and supported by the Trust’s Programme Management Office.

The Trust regularly benchmarks its reference costs with national tariffs to highlight the areas of potential inefficiency and compares its use of resources with other specialist orthopaedic centres. As a member of the Specialist Orthopaedic Alliance both formal and informal reviews of services and their cost effectiveness are carried out.

The Trust benefits from the data produced by the Patient Level Information and Costing System, which has enabled the Trust to increase the understanding of where efficiencies can be targeted and has focused discussions with the Department of Health around issues with the national Payment by Results tariff system. Information from the Patient Level Information and Costing System has been used to develop Service Line Reporting, which is circulated to management and clinical directors on a quarterly basis. This has further developed the understanding of the link between income and costs and has provided clinical management with a greater depth of information to support their decision making. Financial contribution from Service Line Reporting is reported quarterly to Directorates within their performance reports.

The Board receive regular updates from its Audit Committee on the reviews carried out by both Internal Audit and External Audit. They receive and consider the Internal Auditors opinion and the Annual Management Letter by the External Auditors which comments on the economy, efficiency and effectiveness of the use of resources. The Audit Committee or Integrated Governance Committee consider the recommendation of all audits carried out and ensure corrective action is undertaken where necessary.

The Council of Governors approve the Trust's Annual Plan, and review and challenge planned and actual corporate performance throughout the year.

The financial risk rating of 5 awarded by Monitor, the independent regulator represents a strong and robust financial performance in 2012/13.

The governance rating of Amber-Green awarded by the independent regulator represents full achievement of all Monitor governance indicators in 2012/13 with the exception of the 18 Week RTT target requiring 92% of incomplete pathways to be less than 18 weeks long. The Trust failed to meet this target in November, and has been working with Monitor and the Intensive Support Team from the Department of Health to increase performance back above the 92% target. The Trust achieved the 92% target in March.

**Annual Quality Report**

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

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

The metrics included within the Annual Quality Report and Account are regularly reported to the Trust Board within the monthly and quarterly Corporate Performance Reports and the monthly Patient Safety Report, where they are subject to review and challenge.

Consultation took place with the Integrated Governance Committee, The Trust Board and the Council of Governors prior to the completion of the Annual Quality Report and Account.

**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, the Audit Committee and the Integrated Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process in place for maintaining and reviewing the effectiveness of the system of internal control includes:-

- The Board regularly reviewing progress against a number of action plans including the red risks on the Board Assurance Framework to ensure that identified actions are implemented in a timely manner.
- The Audit Committee receiving regular reports on reviews undertaken by the Internal and External Auditors and monitoring the system of financial control.
- The Audit Committee receiving update reports on audit recommendation tracking to ensure that the management team are implementing the agreed improvements to internal control processes within the agreed timeframe or that there are reasonable explanations for variances.
- The Audit Committee receiving updates on prior year audit recommendations from the Trust's Internal Auditors.
- The Integrated Governance Committee monitoring progress and suggesting action to be taken as appropriate in relation to regular reports regarding complaints, incidents, legal claims and other risks identified.
- The Executive Management Team ensuring actions on lapses in the core standards are implemented.
- The Audit Committee reviewing its objectives annually and revising them in the knowledge of the Trust's objectives and the major risks identified on the Assurance Framework. The Audit Committee objectives are designed to monitor the major organisational risks throughout the year as well as the systems of internal control.
- The Integrated Governance Committee having a programme for reviewing clinical audit and outcomes including the use of comparative benchmark data and the National Joint registry.
- Quality rounds undertaken by the Director of Nursing & Governance and her team of matrons.

- Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems.
- Executive and Non-Executive Directors having been allocated specific areas within the Trust to visit and gain feedback on safety and experience issues.
- Staff listening events being hosted by the Chief Executive and the Director of Workforce and Occupational Development to gain direct feedback from staff on a wide variety of issues.
- Staff opinions shared each month at the Trust Business and Learning Day Executive Question Time.

- The Clinical Outcomes and Effectiveness Committee (COEC) provides assurance to the Integrated Governance Committee on Clinical Audit, including agreeing the Clinical Audit Plan and monitoring progress against the plan in year.

**Conclusion**

No significant internal control issues were identified for the Trust during the year.

I can confirm that the accounts have been completed under the "going concern" basis because:

- The Trust holds £21m of cash in the Statement of Financial Position accumulated from several years of favourable financial performance since authorisation
- The Trust has a credible cost reduction plan in 2013-14 which has been compiled by the Clinical Directors and Service leads where there is a high level of confidence of achievement, and ownership of delegated budgets
- The Trust has signed 81% (in value) of its clinical contracts for 2013-14 despite the changed commissioning landscape and has already developed good working relationships with local Clinical Commissioning Groups and the Area Team of NHS England

In addition to the process described above in arriving at my view as to the effectiveness of the control systems I have taken into account the following:

- the views of the Trust's Internal and External Auditors
- review of Theatres by the West Midlands Quality Review Service
- the Care Quality Commission inspection
- the local Counter Fraud Reports
- the National Patient Satisfaction Survey
- The National Joint Register and PROMS data
- Healthcare Evaluation Data (HED) outcome data
- the National Staff Opinion Survey and Patient Survey
- the Clinical Pathology Accreditation (CPA) for the Histopathology Lab
- the Human Tissue Authority (HTA) inspection and licence
- Data Quality Audits
- the Independent Regulator's assessment of the Trust as part of the Compliance Framework
- the Council of Governors meetings
- Health & Safety Executive reviews
- the review meetings held with, and inspections by, the Trust's host commissioner and quarterly meetings with associate Primary Care Trusts / Clinical Commissioning Groups
- The Fire Group and Improvement Action Plan

Signed

**Graham Bragg**

Acting Chief Executive

Date: 29th May 2013

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

We have audited the financial statements of The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Cash Flow Statement, the Statement of Changes in Taxpayers Equity and the related notes 1 to 27. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of The Royal Orthopaedic Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

### Respective responsibilities of the accounting officer and auditor

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. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

### Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

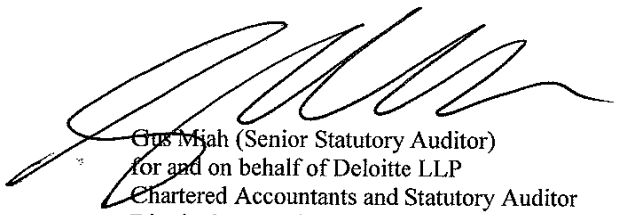
**Matters on which we are required to report by exception**

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us 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 inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

**Certificate**

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts



Gus Mjah (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom

29 May 2013

## FOREWORD TO THE ACCOUNTS

The accounts for the year ended 31 March 2013 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 in the form which Monitor, the independent regulator of NHS Foundation Trusts has, with the approval of the Treasury directed.

**Graham Bragg**

Acting Chief Executive

## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2013

| | Notes | Year Ended 31 March 2013 £000 | Year Ended 31 March 2012 £000 |
|---|---|---|---|
| Operating Income | 3 | 71,008 | 71,242 |
| Operating Expenses | 4 | (67,611) | (68,812) |
| **Operating Surplus** | | **3,397** | **2,430** |
| **Finance Costs** | | | |
| Finance income | 6 | 195 | 142 |
| Finance expense - financial liabilities | 6 | (50) | (46) |
| Finance expense - unwinding of discount on provisions | 16 | (32) | (13) |
| PDC Dividends payable | | (1,280) | (1,268) |
| **Net Finance Costs** | | **(1,167)** | **(1,185)** |
| **SURPLUS / (DEFICIT) FOR THE YEAR** | | **2,230** | **1,245** |
| **Other comprehensive income** | | | |
| Impairments on property, plant and equipment | | 67 | (624) |
| **TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR** | | **2,297** | **621** |

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

The notes on pages 119 to 153 form part of these accounts.

## STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2013

| | Notes | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 8 | 70 | 120 |
| Property, Plant and Equipment | 9 | 40,872 | 39,046 |
| Trade and other receivables | 11 | 0 | 27 |
| **Total non-current assets** | | **40,942** | **39,193** |
| **Current assets** | | | |
| Inventories | 10 | 2,841 | 2,927 |
| Trade and other receivables | 11 | 1,888 | 3,329 |
| Other non-financial assets | 11 | 335 | 456 |
| Other current assets | 11 | 1,085 | 681 |
| Cash and cash equivalents | 13 | 21,448 | 19,711 |
| **Total current assets** | | **27,597** | **27,104** |
| **Current liabilities** | | | |
| Trade and other payables | 14 | (8,840) | (8,306) |
| Borrowings | 14.2 | (148) | (164) |
| Provisions | 16 | (76) | (177) |
| Other liabilities | 14.1 | (780) | (1,122) |
| **Total current liabilities** | | **(9,844)** | **(9,769)** |
| **Total assets less current liabilities** | | **58,695** | **56,528** |
| **Non-current liabilities** | | | |
| Borrowings | 14.2 | (693) | (842) |
| Provisions | 16 | (259) | (240) |
| **Total non-current liabilities** | | **(952)** | **(1,082)** |
| **Total assets employed** | | **57,743** | **55,446** |
| **Financed by taxpayers' equity** | | | |
| Public Dividend Capital | | 38,905 | 38,905 |
| Revaluation reserve | | 2,712 | 2,645 |
| Income and expenditure reserve | | 16,126 | 13,896 |
| **Total taxpayers' equity** | | **57,743** | **55,446** |

The financial statements were approved by the Board of Directors on 29 May 2013 and are signed on its behalf by:

**Graham Bragg**
**Acting Chief Executive**

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2013**

| | Total £000 | Public Dividend Capital £000 | Revaluation Reserve £000 | Income and Expenditure Reserve £000 |
|---|---|---|---|---|
| **Taxpayers' Equity at 1 April 2012** | 55,446 | 38,905 | 2,645 | 13,896 |
| Surplus for the year | 2,230 | 0 | 0 | 2,230 |
| Impairment gains on property, plant and equipment | 67 | 0 | 67 | 0 |
| **Taxpayers' Equity at 31 March 2013** | **57,743** | 38,905 | 2,712 | 16,126 |

| | Total £000 | Public Dividend Capital £000 | Revaluation Reserve £000 | Income and Expenditure Reserve £000 |
|---|---|---|---|---|
| **Taxpayers' Equity at 1 April 2011** | 54,824 | 38,905 | 3,268 | 12,651 |
| Surplus for the year | 1,245 | 0 | 0 | 1,245 |
| Impairment losses on property, plant and equipment | (624) | 0 | (624) | 0 |
| Other reserve movements | 1 | 0 | 1 | 0 |
| **Taxpayers' Equity at 31 March 2012** | **55,446** | 38,905 | 2,645 | 13,896 |

## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2013

| | Year Ended 31 March 2013 £000 | Year Ended 31 March 2012 £000 |
|---|---|---|
| **Cash flows from operating activities** | | |
| Operating surplus | 3,397 | 2,430 |
| **Non-cash income and expense** | | |
| Depreciation and amortisation | 2,361 | 2,380 |
| Impairments | 558 | 922 |
| Reversal of impairments | (267) | (6) |
| Decrease in Trade and Other Receivables | 1,166 | 2,103 |
| Decrease in Inventories | 86 | 228 |
| Increase in Trade and Other Payables | 511 | 1,620 |
| (Decrease) in Other Liabilities | (164) | (166) |
| (Decrease)/Increase in Provisions | (114) | 49 |
| Other movements in operating cash flows | 1 | 1 |
| **NET CASH GENERATED FROM OPERATING ACTIVITIES** | **7,534** | **9,561** |
| | | |
| **Cash flows from investing activities** | | |
| Interest received | 197 | 143 |
| Purchase of intangible assets | (15) | (61) |
| Purchase of Property, Plant and Equipment | (4,497) | (3,216) |
| **NET CASH GENERATED USED IN INVESTING ACTIVITIES** | **(4,315)** | **(3,134)** |
| | | |
| **Cash flows from financing activities** | | |
| Interest element of finance lease | (50) | (46) |
| Capital element of finance lease rental payments | (171) | (171) |
| PDC Dividend paid | (1,261) | (1,302) |
| **NET CASH GENERATED USED IN FINANCING ACTIVITIES** | **(1,482)** | **(1,519)** |
| | | |
| **Increase/(Decrease) in cash and cash equivalents** | **1,737** | **4,908** |
| | | |
| **Cash and Cash equivalents at 1 April** | **19,711** | **14,803** |
| | | |
| **Cash and Cash equivalents at 31 March** | **21,448** | **19,711** |

## NOTES TO THE ACCOUNTS

### 1.1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual (FT ARM)* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2012/13* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual (FREM)* to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

### Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### Significant accounting policies, judgments and sources of estimation uncertainty

Accounting policies that have been selected during the process of applying International Reporting Standards have been considered by management to ensure they assist users in understanding financial performance and financial position. Management is required to make various 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.

The accounting policies that have a significant effect on the amounts recognised in the financial statements are detailed below:

### Leases

Leases have been reclassified from operating leases to finance leases if the lease transfers substantially all the risks and rewards incidental to ownership of an asset. Title may or may not eventually be transferred. An asset and a liability will be recognised on the statement of financial position.

Judgements and sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

### Determination of useful lives for Property, Plant and Equipment

Buildings, dwellings and fittings not scheduled for disposal/demolition are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional valuer.

### Partially completed spells

Once a patient is admitted and treatment begins, income for a treatment or spell is accounted for within the financial statements. The income relating to those spells which are partially completed at the financial year end are apportioned across the financial year on a pro rata basis. This basis may be the expected or actual length of stay or may be based on the costs incurred over the length of the treatment.

**Annual Leave provision**

In accordance with the requirement of IAS 19, the Trust provides for unpaid annual leave carried forward by staff at year end. The total number of annual leave days that each of the Trust's employees has not taken at year end is accounted for within the financial statements. The number of unused days is multiplied by the employees' average salary per day, to give the total cost on individual cost centres.

**1.2 Consolidation**

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

HM Treasury has granted dispensation to the application of IAS 27 by NHS Foundation Trusts in relation to the consolidation of NHS charitable funds for 2011/12 and 2012/13. The disclosure requirements of the standard will, however, apply should the NHS charitable fund be considered to be a subsidiary of the NHS foundation trust.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material.
Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

An associate is an entity which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method.

As at 31 March 2013 the ROH did not have any subsidiaries or associates.

**1.3 Income**

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

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

## 1.4 Expenditure on Employee Benefits

### Short-term Employee Benefits

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

### Pension costs

### NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

### a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013 is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

### b) Full actuarial (funding) valuation

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

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

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

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

**c) Scheme provisions**

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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

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

**1.5 Expenditure on other goods and services**

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

**1.6 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

    - individually have a cost of at least £5,000; or

    - form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

    - form part of the initial setting-up cost of a new building of a refurbishment of a ward or unit, irrespective of their individual or collective cost.

    - Professional fees such as legal costs, design costs, planning fees and feasibility studies incurred in the construction/bringing the asset into use.

**Measurement**

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

Property is measured at fair value. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent asset valuations were undertaken on 31 March 2013 by GVA Grimley international property advisers. The revaluation undertaken at that date has been accounted for in these accounts on 31 March 2013 as follows:

- Land £3,135,060
- Buildings and Dwellings £30,499,513

The valuations are carried out primarily on the basis of market equivalent value for specialised operational property and fair value for non-specialised operational property. The value of land for existing use purposes is assessed at fair value. For non-operational properties including surplus land, the valuations are carried out at open market equivalent value.

All land and buildings are re-valued using professional valuations in accordance with IAS 16.

Assets in the course of construction are valued at cost and are valued on completion by professional valuers as part of the land and buildings revaluation required by IAS 16.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

**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 over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The economic useful lives of the main categories of assets, excluding land on which no depreciation is charged, are as follows:

- Buildings – as per Professional Valuer's estimate
- Plant and Machinery:
    - Engineering Plant and Equipment – short life 5 years
    - Engineering Plant and Equipment – medium life 10 years
    - Engineering Plant and Equipment – long life 15 years
    - Medical Equipment – short life 5 years
    - Medical Equipment – medium life 10 years
    - Medical Equipment – long life 15 years
    - Decontamination Equipment – short life 2 years
- Transport Equipment – 7 years
- Information Technology – 3 years
- Furniture and Fittings:
    - Furniture – short life 3 years
    - Furniture – medium life 5 years
    - Furniture – long life 10 years

**Revaluation gains and losses**

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

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

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

**Impairments**

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. 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.

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

**De-recognition**

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

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

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

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

**1.7 Donated assets**

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

**1.8 Intangible assets**

**Recognition**

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the 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.

**Internally generated intangible assets**

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

**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 licences 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 licence 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.

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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

**Amortisation**

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The Trust deems the expected useful lives of intangible assets to be 3 years.

### 1.9 Government grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

IAS 20 is applied to the accounting treatment of government and other grants with the following interpretations.

- The option to deduct the grant from the carrying value of the asset is not permitted.
- Grant income relating to assets is recognised within income when the foundation trust becomes entitled to it, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed as specified by the grantor and if it is not, the grant must be returned to the grantor.
- Where such a condition exists, the grant is recognised as deferred within liabilities and carried forward to future financial years to the extent that the condition has not yet been met.

### 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out method.

### 1.11 Cash and cash equivalents

Cash and cash equivalents comprise of cash in hand and demand deposits, together with short-term highly liquid investments with maturities of 100 days or less and bank overdrafts. Account balances are only set off where a formal 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, bank overdrafts which are repayable on demand and which form an integral part of an entity's cash management are also included as a component of cash and cash equivalents with the equivalent items reported in the Statement of Financial Position.

### 1.12 Finance income and costs

Interest earned on bank accounts and interest charged on overdrafts is recorded as 'interest receivable' and 'interest payable' in the periods to which they relate, and shown on the Statement of Cash Flows. Bank charges are recorded as operating expenditure in the periods to which they relate.

### 1.13 Financial instruments and financial liabilities

**Recognition**

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

The Trust holds a financial liability in respect of assets acquired or disposed of through a finance lease at 31 March 2013. The Trust has not entered into any regular way purchases or sales in the year to 31 March 2013.

Public Dividend Capital is not considered to be financial instrument and is measured at historical cost.

All other financial assets and liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

**De-recognition**

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

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

**Classification and Measurement**

Financial assets are categorised as 'Loans and receivables'. Financial liabilities are classified as 'Other Financial liabilities'.

**Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'**

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

The Trust does not hold any assets in this category.

**Loans and receivables**

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

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

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

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

**Available-for-sale financial assets**

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

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

The Trust does not hold any assets in this category.

**Other financial liabilities**

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

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

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

**Determination of fair value**

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

**Impairment of financial assets**

At the statement of financial position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

### 1.14 Leases

#### Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

#### Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

#### Leases of land and buildings

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

### 1.15 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 its 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.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It is 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.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

### 1.16 Provisions

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

**Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 16 on page 102 but is not recognised in the NHS Foundation Trust's accounts.

**Non-clinical risk pooling**

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises. The Trust has also taken out additional insurance to cover claims in excess of £1 million.

### 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 19 on page 86 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 19 unless the probability of a transfer of economic benefits is 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.

### 1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash balances held with

the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the 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.

**1.19 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.

**1.20 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.

**1.21 Foreign Exchange**

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**1.22 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. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury *Financial Reporting Manual*.

**1.23 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 in 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.

**1.24 Application of International Financial Reporting Standards**

The following standards and interpretations listed below have been adopted by the European Union but are not required to be followed by the Foundation Trust until a future accounting period. None of them are expected to impact upon the Trust's financial statements. The following standards will be adopted by the Foundation Trust as follows:

- IAS 19 Employee Benefits (Revised 2011)

**1.25 Charitable funds**

The Trust is not required to apply IAS 27 in 2012/13 following dispensation obtained by Monitor. However, this only applies to the consolidation of NHS Charitable Funds. The Trust has therefore not consolidated 'The Royal Orthopaedic Hospital Charitable Fund' into the financial statements for the Trust for the year ending 31 March 2013.

**1.26 Related Party Disclosures**

IAS 24 requires inclusion of commitments with related parties among transactions to be disclosed. It allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures.

**1.27 Accounting standards adopted early**

There are no accounting standards that the Trust has chosen to adopt early.

**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, the production processes are similar, and also the type or class of customer and nature of the regulatory environment are the same. The five operating segments are all active in the same business being the provision of healthcare, thus reporting a single segment of Healthcare is consistent with IFRS 8.

The provision of healthcare is within one main geographical segment being the United Kingdom, and materially from Departments of HM Government in England. Income from within the whole of HM Government is disclosed below:

| | Year Ended 31 March 2013 | | Year Ended 31 March 2012 | |
|---|---|---|---|---|
| | £000 | % | £000 | % |
| Income from whole HM Government | 68,859 | 96.97% | 69,584 | 97.67% |
| Income from non HM Government | 2,149 | 3.03% | 1,658 | 2.33% |
| | **71,008** | 100.00% | **71,242** | 100.00% |

All business activities of the Trust are continually reviewed for material segments.

**3 Income from Activities**

**3.1 Income by type**

| | Year Ended 31 March 2013 | Year Ended 31 March 2012 |
|---|---|---|
| | £000 | £000 |
| Elective income | 39,653 | 40,834 |
| Non elective income | 2,543 | 2,582 |
| Outpatient income | 7,580 | 8,008 |
| Other NHS clinical income | 15,068 | 14,737 |
| Private patient income | 986 | 775 |
| Other non-protected clinical income | 0 | 31 |
| **Total income from activities** | **65,830** | **66,967** |
| **Other operating income** | | |
| Research and development | 426 | 416 |
| Education and training | 2,282 | 2,370 |
| Charitable and other contributions to expenditure | 0 | 0 |
| Reversal of impairments of property, plant and equipment | 267 | 6 |
| Income in respect of staff costs where accounted on gross basis | 1,064 | 1,067 |
| Other | 1,139 | 416 |
| **Total other operating income** | **5,178** | **4,275** |
| **TOTAL OPERATING INCOME** | **71,008** | **71,242** |

Other income includes £128,480.13 from onsite catering services (2011/12 - £93,981); staff accommodation rentals of £74,995 (2011/12 - £75,902); car park income of £61,837 (2011/12 - £37,551); clinical tests of £13,916 (2011/12 - £12,276); private guests accommodation rentals of £26,778 (2011/12 - £28,034) and insurance income of £500,000 in relation to the kitchen fire.

Other NHS clinical income includes £6,131,992 (2011/12 - £6,152,534) for oncology block contract income from the National Specialist Commissioning Team, £2,442,393 (2011/12 - £2,474,745) for critical care bed days and £1,266,092 (2011/12 - £1,468,570) for physiotherapy services.

The Terms of Authorisation set out the mandatory goods and services that the Trust is required to provide (protected services). All of the income from activities before private patient income shown above is derived from the provision of protected services.

### 3.2 Income by Source

| | Year Ended 31 March 2013 £000 | Year Ended 31 March 2012 £000 |
|---|---|---|
| NHS Foundation Trusts | 268 | 268 |
| NHS Trusts | 63 | 20 |
| Strategic Health Authorities | 6,140 | 6,156 |
| Primary Care Trusts | 57,322 | 58,553 |
| Other WGA | 17 | 0 |
| Non NHS Private Patients | 986 | 638 |
| Non NHS Overseas patients | 0 | 137 |
| NHS Injury scheme (RTA) | 40 | 31 |
| Non NHS Other | 994 | 1,164 |
| **TOTAL INCOME FROM ACTIVITIES** | **65,830** | **66,967** |

### 3.3 Private Patient Income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required for 2012/13 and as such have not been reported here.

**4 Operating Expenditure**

| | Year Ended 31 March 2013 £000 | Year Ended 31 March 2012 £000 |
|---|---|---|
| Services from NHS Foundation Trusts | 1 | 1 |
| Services from other NHS Trusts | 498 | 408 |
| Purchase of healthcare from non NHS bodies | 1,078 | 1,154 |
| Employee Expenses - Executive directors | 653 | 617 |
| Employee Expenses - Non-executive directors | 102 | 103 |
| Employee Expenses - Staff | 37,913 | 36,740 |
| Drug costs | 425 | 480 |
| Supplies and services - clinical (excluding drug costs) | 7,924 | 8,524 |
| Supplies and services - general | 994 | 443 |
| Establishment | 742 | 759 |
| Transport | 57 | 138 |
| Premises | 2,970 | 2,196 |
| Increase/(decrease) in bad debt provision | 71 | (229) |
| Inventories write down | 12 | 9 |
| Inventories consumed | 8,907 | 9,208 |
| Depreciation on property, plant and equipment | 2,296 | 2,302 |
| Amortisation on intangible assets | 65 | 78 |
| Impairments of property, plant and equipment | 558 | 922 |
| Audit services - statutory audit | 44 | 41 |
| Other auditor's remuneration - further assurance services | 18 | 12 |
| Clinical negligence | 1,203 | 869 |
| Loss on disposal of other property, plant and equipment | 1 | 53 |
| Legal fees | 87 | 215 |
| Consultancy costs | 206 | 284 |
| Training, courses and conferences | 254 | 256 |
| Patient travel | 15 | 13 |
| Hospitality | 4 | 5 |
| Insurance | 78 | 80 |
| Other services eg external payroll | 216 | 204 |
| Losses, ex gratia & special payments | (31) | 65 |
| Rentals under operating leases | 47 | 2,379 |
| Other | 203 | 483 |
| **TOTAL OPERATING EXPENDITURE** | **67,611** | **68,812** |

Impairment of property, plant and equipment includes an amount of £539,175 which relates to impairment (due to market revaluation) of the old Outpatients buildings situated on the existing premises.

## 5 Operating leases

### 5.1 Payments recognised as an expense

| | Year Ended 31 March 2013 £000 | Year Ended 31 March 2012 £000 |
|---|---|---|
| Minimum lease payments | 47 | 2,379 |
| **TOTAL PAYMENTS** | **47** | **2,379** |

The Trusts operating leases for 2012/13 consists of £11k for the use of an offsite car park and £28k for Histopathology property lease. The remainder relates to a small amount of plant and equipment.

During 2011/12 the Trust was engaged in providing a range of orthopaedic and other procedures to patients via a lease with BMI Healthcare limited for the use of facilities at the BMI Edgbaston Hospital. The lease with BMI Healthcare limited expired on 31 March 2012.

### 5.2 Total future minimum lease payments

| | Land £000 | Buildings £000 | Other £000 | Year Ended 31 March 2013 £000 | Year Ended 31 March 2012 £000 |
|---|---|---|---|---|---|
| - not later than one year; | 1 | 0 | 13 | 14 | 29 |
| - later than one year and not later than five years; | 0 | 0 | 0 | 0 | 12 |
| **TOTAL FUTURE PAYMENTS DUE** | **1** | **0** | **13** | **14** | **41** |

## 6 Finance income and costs

| | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|
| Interest from deposit account investments | 195 | 142 |
| **TOTAL FINANCE INCOME** | **195** | **142** |

| | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|
| Finance lease interest | 50 | 46 |
| **TOTAL FINANCE COSTS** | **50** | **46** |

## 7 Employee costs and numbers

### 7.1 Employee costs

| | 2012/13 | | | 2011/12 | | |
|---|---|---|---|---|---|---|
| | Total | Permanently Employed | Agency | Total | Permanently Employed | Agency |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Salaries and wages | 30,340 | 30,340 | 0 | 29,503 | 29,503 | 0 |
| Social security Costs | 2,615 | 2,615 | 0 | 2,533 | 2,533 | 0 |
| Employers contributions to NHS Pensions | 3,146 | 3,146 | 0 | 3,047 | 3,047 | 0 |
| Agency and contract staff | 2,465 | 0 | 2,465 | 2,274 | 0 | 2,274 |
| **TOTAL EMPLOYEE COSTS** | **38,566** | **36,101** | **2,465** | **37,357** | **35,083** | **2,274** |

The total Employer Pension contribution payable for the period is £3,145,632 (31 March 2012: £3,046,653).

### 7.2 Average number of persons employed

| | Total Number | Permanently Employed Number | Agency Number | Total Number | Permanently Employed Number | Agency Number |
|---|---|---|---|---|---|---|
| Medical and dental | 105 | 99 | 6 | 102 | 98 | 4 |
| Administration and estates | 236 | 230 | 6 | 228 | 227 | 1 |
| Healthcare assistants and other support staff | 82 | 82 | 0 | 77 | 76 | 1 |
| Nursing, midwifery and health visiting staff | 330 | 320 | 10 | 321 | 310 | 11 |
| Nursing, midwifery and health visiting learners | 1 | 1 | 0 | 1 | 1 | 0 |
| Scientific, therapeutic and technical staff | 133 | 125 | 8 | 136 | 126 | 10 |
| Other | 7 | 7 | 0 | 7 | 7 | 0 |
| **TOTAL PERSONS EMPLOYED** | **894** | 864 | 30 | **872** | 845 | 27 |

**7.3 Exit Packages**

| Exit package cost band (including any special payment element) | 2012-13 Number of compulsory redundancies Number | 2012-13 Number of other departures agreed Number | 2012-13 Total number of exit packages by cost band Number | 2011-12 Number of compulsory redundancies Number | 2011-12 Number of other departures agreed Number | 2011-12 Total number of exit packages by cost band Number |
|---|---|---|---|---|---|---|
| <£10,000 | **0** | **0** | **0** | 0 | 3 | 3 |
| £10,001 - £25,000 | **0** | **0** | **0** | 0 | 4 | 4 |
| £25,001 - 50,000 | **0** | **0** | **0** | 0 | 2 | 0 |
| £50,001 - £100,000 | **0** | **0** | **0** | 0 | 0 | 0 |
| £100,001 - £150,000 | **0** | **0** | **0** | 0 | 0 | 0 |
| £150,001 - £200,000 | **0** | **0** | **0** | 0 | 0 | 0 |
| >£200,001 | **0** | **0** | **0** | 0 | 0 | 0 |
| **Total number of exit packages by type** | **0** | **0** | **0** | 0 | 9 | 7 |
| **Total resource cost (£000s)** | **0** | **0** | **0** | 0 | 175 | 175 |

### 7.3 Retirements due to ill health

During the year to 31 March 2013 there were no early retirements from the Trust agreed on the grounds of ill-health (31 March 2012 – £nil).

### 8 Intangible assets

| | Software licences (purchased) £000 | Total £000 |
|---|---|---|
| Gross cost at 1 April 2012 | 337 | 337 |
| Additions - purchased | 15 | 15 |
| **Gross cost at 31 March 2013** | **352** | **352** |
| | | |
| Amortisation at 1 April 2012 | 217 | 217 |
| Provided during the year | 65 | 65 |
| **Amortisation at 31 March 2013** | **282** | **282** |
| | | |
| Net book value | | |
| NBV - Purchased at 31 March 2013 | 70 | 70 |
| NBV - Donated at 31 March 2013 | 0 | 0 |
| **NBV total at 31 March 2013** | **70** | **70** |

| | Software licences (purchased) £000 | Total £000 |
|---|---|---|
| Gross cost at 1 April 2011 | 276 | 276 |
| Additions - purchased | 61 | 61 |
| **Gross cost at 31 March 2012** | **337** | **337** |
| | | |
| Amortisation at 1 April 2011 | 139 | 139 |
| Provided during the year | 78 | 78 |
| **Amortisation at 31 March 2012** | **217** | 217 |
| | | |
| Net book value | | |
| NBV - Purchased at 31 March 2012 | 120 | 120 |
| NBV - Donated at 31 March 2012 | 0 | 0 |
| **NBV total at 31 March 2012** | **120** | 120 |

There is no active market for the Trust's intangible assets and there is no revaluation reserve.

## 9 Property, plant and equipment for year ended 31 March 2013

| | 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 2012 | 45,775 | 3,135 | 30,948 | 989 | 569 | 8,013 | 19 | 1,991 | 111 |
| Additions - purchased | 4,346 | 0 | 517 | 0 | 3,382 | 342 | 20 | 68 | 17 |
| Additions - government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged to revaluation reserve | 67 | 0 | 67 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 24 | 0 | (24) | 0 | 0 | 0 | 0 |
| Revaluations | (1,830) | 0 | (1,800) | (30) | 0 | 0 | 0 | 0 | 0 |
| Disposals | (489) | 0 | 0 | 0 | 0 | (474) | 0 | (15) | 0 |
| **Cost or Valuation at 31 March 2013** | **47,869** | **3,135** | **29,756** | **959** | **3,927** | **7,881** | **39** | **2,044** | **128** |
| | | | | | | | | | |
| Accumulated depreciation at 1 April 2012 | 6,729 | 0 | 35 | 0 | 0 | 4,719 | 11 | 1,853 | 111 |
| Provided during the year | 2,296 | 0 | 1,534 | 40 | 0 | 634 | 4 | 82 | 2 |
| Impairments charged to income and expenditure | 558 | 0 | 568 | (10) | 0 | 0 | 0 | 0 | 0 |
| Reversals of impairments | (267) | 0 | (267) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | (1,830) | 0 | (1,800) | (30) | 0 | 0 | 0 | 0 | 0 |
| Disposals | (489) | 0 | 0 | 0 | 0 | (474) | 0 | (15) | 0 |
| **Accumulated depreciation at 31 March 2013** | **6,997** | **0** | **70** | **0** | **0** | **4,879** | **15** | **1,920** | **113** |
| | | | | | | | | | |
| Net book value | | | | | | | | | |
| NBV - Purchased at 31 March 2013 | 37,518 | 3,135 | 27,282 | 959 | 3,927 | 2,052 | 24 | 124 | 15 |
| NBV - Finance lease at 31 March 2013 | 827 | 0 | 0 | 0 | 0 | 827 | 0 | 0 | 0 |
| NBV - Donated at 31 March 2013 | 2,527 | 0 | 2,404 | 0 | 0 | 123 | 0 | 0 | 0 |
| **NBV total at 31 March 2013** | **40,872** | **3,135** | **29,686** | **959** | **3,927** | **3,002** | **24** | **124** | **15** |
| | | | | | | | | | |
| Analysis of Property, plant and equipment | | | | | | | | | |
| NBV - Protected assets at 31 March 2013 | 40,872 | 3,135 | 29,686 | 959 | 3,927 | 3,002 | 24 | 124 | 15 |
| NBV - Unprotected assets at 31 March 2013 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total at 31 March 2013** | **40,872** | **3,135** | **29,686** | **959** | **3,927** | **3,002** | **24** | **124** | **15** |

**9.1 Property, plant and equipment for year ended 31 March 2012**

| | 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 |
|---|---|---|---|---|---|---|---|---|---|
| Net book value | | | | | | | | | |
| NBV - Purchased at 31 March 2012 | 35,426 | 3,135 | 28,438 | 989 | 569 | 2,149 | 8 | 138 | 0 |
| NBV - Finance lease at 31 March 2012 | 1,001 | 0 | 0 | 0 | 0 | 1,001 | 0 | 0 | 0 |
| NBV - Donated at 31 March 2012 | 2,619 | 0 | 2,475 | 0 | 0 | 144 | 0 | 0 | 0 |
| **NBV total at 31 March 2012** | **39,046** | 3,135 | 30,913 | 989 | 569 | 3,294 | 8 | 138 | 0 |
| | | | | | | | | | |
| Analysis of Property, plant and equipment | | | | | | | | | |
| NBV - Protected assets at 31 March 2012 | 35,037 | 3,135 | 30,913 | 989 | 0 | 0 | 0 | 0 | 0 |
| NBV - Unprotected assets at 31 March 2012 | 4,009 | 0 | 0 | 0 | 569 | 3,294 | 8 | 138 | 0 |
| **Total at 31 March 2012** | **39,046** | 3,135 | 30,913 | 989 | 569 | 3,294 | 8 | 138 | 0 |

**9.2 Impairments**

| | 31 March 2013 £000 | Operating income £000 | Operating expenses £000 | Revaluation reserve £000 |
|---|---|---|---|---|
| Changes in market place | 491 | 0 | 558 | (67) |
| Reversal of impairments | (267) | (267) | 0 | 0 |
| **TOTAL IMPAIRMENTS AT 31 MARCH 2013** | **224** | **(267)** | **558** | **(67)** |

| | 31 March 2012 £000 | Operating income £000 | Operating expenses £000 | Revaluation reserve £000 |
|---|---|---|---|---|
| Changes in market place | 1,546 | 0 | 922 | 624 |
| Reversal of impairments | (6) | (6) | 0 | 0 |
| **TOTAL IMPAIRMENTS AT 31 MARCH 2012** | **1,540** | **(6)** | **922** | **624** |

## 10 Inventories

| | 31 March 2013 | 31 March 2012 |
|---|---|---|
| | £000 | £000 |
| Consumables | 2,841 | 2,927 |
| **TOTAL INVENTORIES** | **2,841** | 2,927 |

| | 31 March 2012 | 31 March 2011 |
|---|---|---|
| | £000 | £000 |
| Inventories recognised in expenses | 8,907 | 9,208 |
| Write-down of inventories recognised as an expense | 12 | 9 |
| **TOTAL** | **8,919** | 9,217 |

## 11 Trade receivables and other receivables

| | Financial Assets | | Non-Financial Assets | |
|---|---|---|---|---|
| | 31 March 2013 | 31 March 2012 | 31 March 2013 | 31 March 2012 |
| | £000 | £000 | £000 | £000 |
| **Current financial assets** | | | | |
| NHS Receivables | 1,860 | 3,206 | 0 | 0 |
| Other receivables with related parties | 121 | 145 | 0 | 0 |
| Provision for impaired receivables | (93) | (22) | 0 | 0 |
| | **1,888** | 3,329 | **0** | 0 |
| Prepayments | 0 | 0 | 227 | 303 |
| Accrued income | 70 | 91 | 0 | 0 |
| Interest receivable | 4 | 2 | 0 | 0 |
| PDC receivable | 26 | 45 | 0 | 0 |
| VAT receivable | 0 | 0 | 108 | 153 |
| Other receivables | 985 | 543 | 0 | 0 |
| | **1,085** | 681 | **335** | 456 |
| Total Current Financial Assets | **2,973** | 4,010 | **335** | 456 |
| **Non-Current financial Assets** | | | | |
| Trade and other receivables | 0 | 27 | 0 | 0 |
| **TOTAL TRADE AND OTHER RECEIVABLES** | **2,973** | 4,037 | **335** | 456 |

### 11.1 Impairment of receivables

The ageing analysis of NHS and Non NHS impaired debts is as follows:

| | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|
| 0 - 30 days | 0 | 22 |
| 30 - 60 days | 0 | 0 |
| 60 - 90 days | 0 | 0 |
| 90 - 180 days | 93 | 0 |
| **TOTAL AGEING OF IMPAIRED RECEIVABLES** | **93** | 22 |

The ageing analysis of NHS and Non NHS non-impaired debts is as follows:

| | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|
| 0 - 30 days | 209 | 232 |
| 30 - 60 days | 296 | 65 |
| 60 - 90 days | 130 | 33 |
| 90 - 180 days | 59 | 103 |
| Over 180 days | 238 | 441 |
| **TOTAL AGEING OF NON IMPAIRED RECEIVABLES** | **932** | 874 |

### 12 Other current assets

### 12.1 Current and Non-Current asset investments

The Trust did not hold any current asset investments or non-current asset investments in the period to 31 March 2013, (31 March 2012, £nil).

### 13 Cash and cash equivalents

| | 31 March 2013 £000 | 31 March 2012 £000 |
|---|---|---|
| Cash and cash equivalents at 1 April | 19,711 | 14,803 |
| Net change in year | 1,737 | 4,908 |
| Cash and cash equivalents at 31 March | 21,448 | 19,711 |
| | | |
| Broken down into: | | |
| Cash at commercial banks and in hand | 51 | 116 |
| Cash with the Government Banking Service | 21,397 | 19,595 |
| **Cash and cash equivalents as in Statement of financial position and Statement of Cash Flows** | **21,448** | **19,711** |

## 14 Trade and other payables

| | Financial liabilities | | Non-financial liabilities | |
|---|---|---|---|---|
| | 31 March 2013 £000 | 31 March 2012 £000 | 31 March 2013 £000 | 31 March 2012 £000 |
| NHS Payables | 2,784 | 3,766 | 0 | 0 |
| Amounts due to other parties | 0 | 15 | 0 | 0 |
| Trade payables - capital | 298 | 446 | 0 | 0 |
| Social security costs | 0 | 0 | 388 | 361 |
| Taxes payable | 0 | 0 | 476 | 447 |
| Other trade payables | 4,149 | 2,764 | 0 | 0 |
| Accruals | 745 | 507 | 0 | 0 |
| **TOTAL TRADE AND OTHER PAYABLES** | **7,976** | 7,498 | **864** | 808 |

Other Trade Payables include £419,977 outstanding pension contributions at 31 March 2013 (31 March 2012: £385,914). There are no payments due in future years under arrangements to buy out the liability for early retirements over five years.

### 14.1 Other liabilities

| | Current | | Non-Current | |
|---|---|---|---|---|
| | 31 March 2013 £000 | 31 March 2012 £000 | 31 March 2013 £000 | 31 March 2012 £000 |
| Deferred income | 780 | 1,122 | 0 | 0 |
| **TOTAL OTHER LIABILITIES** | **780** | 1,122 | **0** | 0 |

### 14.2 Borrowings

| | Current | | Non-Current | |
|---|---|---|---|---|
| | 31 March 2013 £000 | 31 March 2012 £000 | 31 March 2013 £000 | 31 March 2012 £000 |
| Obligations under finance leases | 148 | 164 | 693 | 842 |
| **TOTAL BORROWINGS** | **148** | 164 | **693** | 842 |

### 14.3 Finance lease obligations

| | Net lease liabilities | | Gross lease liabilities | |
|---|---|---|---|---|
| | 31 March 2013 £000 | 31 March 2012 £000 | 31 March 2013 £000 | 31 March 2012 £000 |
| Within one year | 148 | 164 | 172 | 200 |
| Between one and five years | 693 | 787 | 759 | 687 |
| After five years | 0 | 55 | 0 | 172 |
| | **842** | 1,006 | **931** | 1,059 |
| Included in : | | | | |
| Current borrowings | 148 | 164 | 0 | 0 |
| Non-Current borrowings | 693 | 842 | 0 | 0 |
| | **842** | 1,006 | **0** | 0 |

### 15 Prudential Borrowing Limit

NHS foundation trusts are required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and

- the amount of any working capital facility approved by Monitor.

As per Section 46 of the Act, the Trust has a Prudential Borrowing Limit of £15,700,000 in 2012/13 (£17,200,000 in 2011/12). The Trust borrowed/repaid a net £nil in 2012/13 (£nil in 2011/12) and at 31 March 2013 had £nil of outstanding borrowing (£nil at 31 March 2012).

The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £13.9m (£13.2m – 31 March 2012), and
(ii) Approved working capital facility of: not to exceed £4.0m

| Financial Ratio | Actual 2012/13 | Plan 2012/13 | Actual 2012/13 | Plan 2012/13 |
|---|---|---|---|---|
| Minimum Dividend Cover | 2x | 2x | 2x | 2x |
| Minimum Interest Cover | 0% | 0% | 0% | 0% |
| Minimum Debt Service Cover | 0% | 0% | 0% | 0% |
| Maximum Debt Service to Revenue | 0% | 0% | 0% | 0% |

The Trust has an approved working capital facility of £4.0m (£4.0m in 2011/12). The Trust had not utilised any of its working capital facility at 31 March 2013 (£nil at 31 March 2012).

Until the Trust draws down a loan only the minimum dividend cover is relevant. The Trust was within the appropriate limit.

Further information on the NHS foundation trusts Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

**16 Provisions for liabilities and charges**

| | Current | | Non-Current | |
|---|---|---|---|---|
| | **31 March 2013 £000** | **31 March 2012 £000** | **31 March 2013 £000** | **31 March 2012 £000** |
| Legal claims | 64 | 157 | 0 | 0 |
| Other | 12 | 20 | 259 | 240 |
| **TOTAL PROVISIONS** | **76** | 177 | **259** | 240 |

| | **Legal claims £'000** | **Other £'000** | **Total £'000** |
|---|---|---|---|
| At 1 April 2012 | 157 | 260 | 417 |
| Arising during the year | 80 | 0 | 80 |
| Utilised during the year | (14) | (12) | (26) |
| Reversed unused during the year | (160) | (8) | (168) |
| Unwinding of discount | 0 | 32 | 32 |
| **At 31 March 2013** | **64** | **271** | **335** |

| | | | |
|---|---|---|---|
| Expected timing of cash flows: | | | |
| not later than one year | 64 | 12 | 76 |
| later than one year and not later than five years | 0 | 52 | 52 |
| later than five years | 0 | 206 | 206 |
| **Total expected timing of cash flows** | **64** | **271** | **335** |

The provisions included under legal claims are for employee and public liability, and are subject to changes in value and timing by either third party insurers or the NHS Litigation Authority depending on the incident date.

Other claims relate to injury benefit provisions which are discounted using the real discount rate set by HM Treasury. For 2012/13 there has been a change to the calculation for discounting provisions. Rather than using a single rate as in previous years (2.2%) the provisions are discounted according to the expected timing of cash flows (short-term, medium-term and long-term). The below rates have therefore been applied for 2012/13: -

Short-term (less than one year) (1.8%)

Medium-term (one – five years) (1%)

Long-term (later than 5 years) 2.2%

Due to the negative discount rates for the short and medium term categories there has been an increase in the unwinding of the discount for 2012/13 of £17k. No uncertainty relates to this provision as it is being paid by the Trust on a quarterly basis.

The NHS Litigation Authority as at 31 March 2013 has £10,759,926 (£6,286,969 – 31 March 2012) in respect of clinical negligence liabilities of the Trust included in its accounts.

**17 Contractual Capital Commitments**

| | 31 March 2013 | 31 March 2012 |
|---|---|---|
| | £000 | £000 |
| Property, plant and equipment | 902 | 1,073 |
| **TOTAL CONTRACTUAL CAPITAL COMMITMENTS** | **902** | 1,073 |

Capital commitments include £549,944 in relation to the ADCU building and £151,616 in relation to the new theatre scheme.

**18 Revaluation Reserve**

| | Total Revaluation Reserve | Revaluation Reserve - property, plant and equipment |
|---|---|---|
| | **£'000** | **£'000** |
| Revaluation reserve at 1 April 2012 | 2,645 | 2,645 |
| Impairments | 67 | 67 |
| Other reserve movements | 0 | 0 |
| **Revaluation reserve at 31 March 2013** | **2,712** | 2,712 |

| | | |
|---|---|---|
| | **£'000** | **£'000** |
| Revaluation reserve at 1 April 2011 | 3,268 | 3,268 |
| Impairments | (624) | (624) |
| Other reserve movements | 1 | 1 |
| **Revaluation reserve at 31 March 2012** | **2,645** | 2,645 |

| | 31 March 2013 | 31 March 2012 |
|---|---|---|
| | **£000** | **£000** |
| Gross value of contingent liabilities | 0 | 0 |
| **NET VALUE OF CONTINGENT LIABILITIES** | **0** | 0 |

There are no contingent liabilities or contingent assets for the year ending 31 March 2013 (2011/13 £nil).

**20 Post Balance Sheet Events**

The Trust does not have any disclosable post balance sheet events.

## 21 Related party Transactions

The Royal Orthopaedic Hospital NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by the independent regulator for Foundation Trusts Monitor on February 1 2007.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with The Royal Orthopaedic Hospital NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year The Royal Orthopaedic Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. Balances of £100,000 or higher are listed below:

| | Receivables 2012/13 £000 | Payables 2012/13 £000 | Revenue 2012/13 £000 | Expenditure 2012/13 £000 |
|---|---|---|---|---|
| Barnsley PCT | 0 | 175 | 555 | 0 |
| Birmingham Childrens Hospital NHS Foundation Trust | 267 | 602 | 415 | 1,065 |
| Birmingham Community Healthcare NHS Trust | 0 | 0 | 0 | 441 |
| Birmingham East And North PCT | 0 | 0 | 14,070 | 0 |
| Bristol PCT | 0 | 0 | 634 | 0 |
| Coventry Teaching PCT | 0 | 160 | 278 | 0 |
| Department of Health | 0 | 356 | 170 | 0 |
| NHS Supply Chain (Maidstone) | 0 | 161 | 0 | 0 |
| Dept of Work and Pensions | 204 | 0 | 0 | 0 |
| Dudley PCT | 0 | 0 | 3,176 | 0 |
| Heart Of Birmingham Teaching PCT | 0 | 132 | 2,682 | 0 |
| Heart Of England NHS Foundation Trust | 0 | 0 | 0 | 126 |
| Herefordshire PCT | 0 | 0 | 452 | 0 |
| HM Revenue & Customs - Other taxes and duties | 0 | 864 | 0 | 0 |
| HM Revenue & Customs - VAT | 108 | 0 | 0 | 0 |
| Leicestershire County And Rutland PCT | 0 | 0 | 990 | 0 |
| London Strategic Health Authority | 0 | 0 | 6,104 | 0 |
| NHS Blood and Transplant | 0 | 0 | 0 | 186 |
| NHS Litigation Authority | 0 | 0 | 500 | 1,210 |
| North Staffordshire PCT | 0 | 0 | 101 | 0 |
| Sandwell And West Birmingham Hospitals NHS Trust | 0 | 0 | 0 | 139 |
| Sandwell PCT | 0 | 131 | 3,116 | 0 |
| Shropshire County PCT | 0 | 0 | 161 | 0 |
| Solihull PCT | 0 | 0 | 1,826 | 0 |
| South Birmingham PCT | 237 | 0 | 17,996 | 0 |
| South Staffordshire PCT | 0 | 0 | 2,093 | 0 |
| South Staffordshire PCT | 0 | 106 | 0 | 0 |
| The Dudley Group Of Hospitals NHS Foundation Trust | 0 | 0 | 106 | 0 |
| University Hospital Birmingham NHS Foundation Trust | 270 | 130 | 767 | 2,473 |
| Walsall Teaching PCT | 0 | 156 | 1,830 | 0 |
| Warwickshire PCT | 0 | 0 | 1,230 | 0 |
| Welsh Assembly Government | 0 | 0 | 988 | 0 |
| West Midlands Strategic Health Authority | 0 | 0 | 2,093 | 0 |
| Western Cheshire PCT | 0 | 465 | 498 | 0 |
| Wolverhampton City PCT | 0 | 0 | 421 | 0 |
| Worcestershire PCT | 380 | 0 | 4,937 | 0 |

The Trust has also received revenue payments from a number of charitable funds, certain members of the Trustees for which are also members of the NHS Trust Board. The Trust charged the Trust's charity for finance administration services totalling £14,241 during the year (£13,603 – 31 March 2012).

## 22 Private Finance Initiatives

The Trust did not have any Private Finance Initiative schemes as at 31 March 2013, (2011-12 £nil).

## 23 Financial Instruments

The Royal Orthopaedic Hospital NHS Foundation Trust seeks to minimise its financial risks and through its treasury management policy does not buy or sell financial instruments. The Trust's treasury activity is subject to review by the Trust's internal auditors.

### Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

### Interest Rate Risk

The Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest. The Foundation Trust is not, therefore, exposed to significant interest-rate risk.

### Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

### Liquidity Risk

The Trust's operating costs are incurred under contracts with NHS Primary Care Trusts (replaced by Clinical Commissioning Groups from 1 April 2013), who are financed annually from resources voted from Parliament. Such contract income is received in accordance with the NHS funding mechanism Payments by Results with regular twelfth payments made monthly and a quarterly adjustment made to bring payments in line with actual activity. This can generate a short-term cash flow impact which would be covered by the Trust's own cash reserves. 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 2013. Fair value approximates to the book value because of the short maturity of these instruments.

### 23.1 Financial Assets

| | Carrying value 31 March 2013 | Fair value 31 March 2013 | Carrying value 31 March 2012 | Fair value 31 March 2012 |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Current financial assets** | | | | |
| Trade and other receivables | 1,834 | 1,834 | 3,329 | 3,329 |
| Other current assets | 1,347 | 1,347 | 681 | 681 |
| Cash and cash equivalents | 21,448 | 21,448 | 19,711 | 19,711 |
| | 24,629 | 24,629 | 23,721 | 23,721 |
| Non-current financial assets | | | | |
| Trade and other receivables | 0 | 0 | 27 | 27 |
| **TOTAL FINANCIAL ASSETS** | **24,629** | **24,629** | 23,748 | 23,748 |

### 23.2 Financial Liabilities

| | Carrying value 31 March 2013 | Fair value 31 March 2013 | Carrying value 31 March 2012 | Fair value 31 March 2012 |
|---|---|---|---|---|
| **Current financial liabilities** | **£000** | **£000** | **£000** | **£000** |
| Measured at amortised cost: | | | | |
| Finance leases | 148 | 148 | 164 | 164 |
| Trade and other payables | 7,976 | 7,976 | 7,498 | 7,498 |
| Provisions under contract | 76 | 76 | 177 | 177 |
| | 8,200 | 8,200 | 7,839 | 7,839 |
| **Non-current financial liabilities** | | | | |
| Finance leases | 693 | 693 | 842 | 842 |
| Provisions under contract | 259 | 259 | 240 | 240 |
| **TOTAL FINANCIAL LIABILITIES** | **9,152** | **9,152** | 8,921 | 8,921 |

### 24 Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. In the year 2012/13 the Trust had 34 (31 March 2012: 20) separate losses and special payments, totaling £83,178 (31 March 2012: £19,003). These were in relation to cash losses and ex-gratia payments to patients.

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment for the individual case exceeded £100,000.

These amounts are reported on an accruals basis but excluding provisions for future losses.

### 25 Third Party Assets

The Trust did not hold assets in the bank which relate to monies held by the Foundation Trust on behalf of patients.

## 26 Going Concern

After making enquiries, the directors have a reasonable expectation that The Royal Orthopaedic Hospital NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

## 27 Auditor's Liability

The auditors have a limitation of their liability in accordance with their engagement letter signed on the 1''March 2013 for the amount of £1 million.