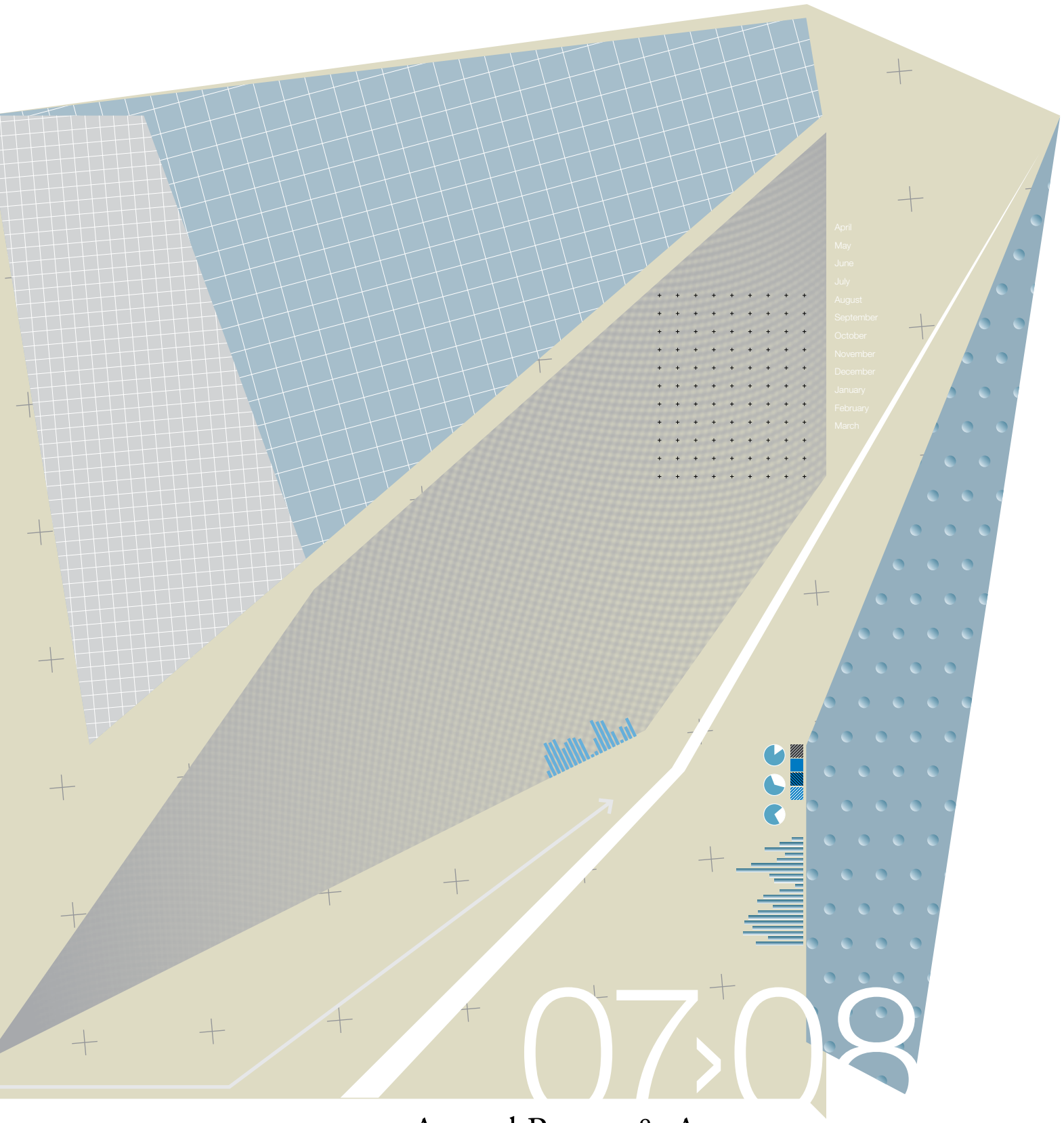


Annual Report & Accounts

This annual report covers the period 1 April 2007 to 31 March 2008

The Royal Orthopaedic Hospital NHS

NHS Foundation Trust

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

The Royal Orthopaedic Hospital NHS Foundation Trust Annual Report and Accounts 2007-2008

Contents

Section 1

Chairman's statement

This report covers the first full financial year for The Royal Orthopaedic Hospital NHS Foundation Trust, founded under the National Health Services Act 2006.

The period covered in this report has presented major opportunities and significant challenges. Building on proven financial and operational strengths, the trust has been able to maintain very high standards of clinical quality and financial performance. Nonetheless, the challenge of delivering the nationally determined 18 weeks milestone was major. The proportion of tertiary referrals coupled with the highly specialised nature of some of our treatments, which themselves required patient pathways beyond 18 weeks, meant that the 15% tolerance built into the 2007/08 milestone was sometimes insufficient to accommodate our clinical needs. Delivering the referral to treatment target of 18 weeks has required real focus in terms of our administrative arrangements, clinical pathways and partnership relationships. As a small, specialist trust delivering an area of clinical practice recognised as one of the most difficult to control within this level of tolerance, we can feel a sense of significant achievement in coming close to the March milestone and are now actively working to achieve the December 2008 target.

Our most significant developments have been in two key areas that will each form the bedrock of our future. Clinical engagement through our new directorate structure and active dialogue with our consultants has already demonstrated added value through work on 18 weeks and we have been able to make the decision to go ahead with the long awaited relocation of our Outpatient Department. The clarity of purpose, local determination and freedoms to act afforded us as a foundation trust are already bearing fruit. Patient care will benefit by the Board being able to initiate long-awaited plans for the development of the new outpatient department. Our patients and staff have been concerned at the 'long walk' suffered by many patients with restricted mobility as they move from the Outpatient Department to the Imaging Department. Despite the welcome ameliorative effects of the buggy system, in efficiency and ergonomic terms, the physical site configuration was at odds with the obvious needs of best practice.

A new building has been commissioned and the first signs of work have begun on site for completion in 2009. This could not have happened had we not become a foundation trust as the project was simply too small or deemed too low a priority for standard funding regimes. Our Members' Council has been actively involved in the project planning and has worked alongside staff and patients, together with members of the Board to ensure a design fit for purpose and built for the future.

The trust benefited from the input of its new Members' Council to its Annual Plan for the year and has engaged them through sub-committees in the strategic revisions and operational challenges throughout the year. Joint meetings between the Board and the Members' Council working to a normal Board agenda have been initiated and this has allowed the Council to hold the Board to account and to have direct and robust dialogue. This has supported their better understanding of the main issues facing the trust, the balancing of diverse considerations that regularly face the Board and has given assurance that the processes explained as underpinning organisational management are regularly reviewed.

The Members' Council has also successfully recruited a non-executive director to the Trust Board and worked effectively with the Board to ensure skills were matched and enhancement to the team secured.

Financial performance this year has once again been robust. The Board has regularly reviewed information to ensure that key indicators were achieved. It has been recognised that the additional surplus generated has been as a result of factors that have challenged our planning assumptions – a change in case mix and an underspend as a result of the delayed move to an off-site decontamination facility.

Our staff deserve a special mention for their commitment and dedication during a year that has seen us move into a new era, and has placed demands on them they have not previously experienced. In every instance they have risen to the challenge and on behalf of the Trust Board I would like to put on record our thanks to them.

Looking to next year, the Board is optimistic that its service quality and clinical excellence will be maintained. The significant pressures on this particular trust's ability to meet the 18 weeks waiting time target will not abate and the Board recognises that, in a black and white situation of predetermined arbiters of success and failure, it will remain a key challenge to meet these national demands. In the next year, this will not only have impact on external ratings but will also potentially mean enforcement of penalties within our commissioner contracts. This 'one size fits all' approach does have a major impact on a trust such as ours, however good our clinical quality – indeed the situation could actually be exacerbated as a result of what we regard as positive patient choice in accessing our services. The Board will therefore continue to lobby for recognition of genuinely special circumstances and to mitigate reputational risk through active work with our patients and constituents

Les Lawrence Chairman

Section 2

Directors' Report

The trust has spent the last year embedding itself as a foundation trust and is starting to reap the benefits associated with this status. The organisation remains committed to the rationale of a single specialist orthopaedic centre and the belief that this is the best way of providing high quality, safe and efficient orthopaedic services. The last twelve months have seen some changes to the Board of Directors with a new non-executive director appointed by the Members' Council.

The trust again saw an excellent track record maintained in relation to its financial performance and delivered a surplus of £6.255 million.

During 2007/08, the trust delivered additional activity as it moved forward to hit the target of no patient waiting longer than 18 weeks from referral to first definitive treatment. Although it was slightly short of the March milestone our performance is well on the way to achieving the government target in December 2008. Linked to this an additional ward was opened during the course of the year and a significant improvement in theatre utilisation was achieved. Theatres are now routinely used during evenings and weekends and additional capacity is also purchased from private sector organisations in order to increase activity.

In addition, during the autumn period the trust saw its new private pharmacy provider take over the service, enabling it to declare compliance with the Medicines Management Standard of Standards for Better Health. The organisation continues to build on this relationship and the support from Nottingham University Hospitals. Also in the autumn the trust saw a significant improvement in its Healthcare Commission ratings, scoring 'excellent' for Use of Resources and 'good for Quality of Services. This was a pleasing move forward from our ratings of 'fair' and 'fair' in these two areas in 2006/07.

The trust is an active member of the Specialist Orthopaedic Alliance – a group of five specialist orthopaedic hospitals that work together to share best practice and secure the future of the essential patient services, clinical training and research they provide.

The trust is also part of the Pan-Birmingham Decontamination Partnership and is scheduled to begin using the new decontamination facilities provided locally through this project in late 2008.

During the course of the year the trust underwent an inspection linked to the Hygiene Code in August 2007. It was disappointing that the final report was not received until February 2008. However during this time the trust had further strengthened its processes, procedures and infrastructure for control of infection with the appointment of in-house control of infection and nursing posts. It continued with excellent performance on hospital acquired infections and had no MRSA bacteraemia cases during the year. 22 cases of Clostridium Difficile were reported during the course of the year and we will be working to improve this during the next 12 months. We are not complacent however and the trust has an active Control of Infection Committee with a clear action plan to drive further improvement in monitoring and surveillance of in this particularly important area.

The year also saw the embedding of the new Clinical Service Unit management structure and progress towards the production of Clinical Service Unit service plan strategies as integral parts of our Annual Plan.

The trust has continued to build on its working relationship with its Members' Council and has seen a number of changes in its membership, particularly from stakeholder organisations. The sub-committee structure however has been highly successful, particularly the sub-groups looking at membership and the environment. The trust has also appointed a Membership Manager during the course of the year who has worked actively to recruit new members and build robust communication structures with the existing membership. A number of events around clinical services and conditions were held and were extremely well attended during the course of the year as well as social events such as the Burns Night Supper celebrating the hospital's first year as a foundation trust.

The trust has working groups and committees that deal with environmental matters covering a range of issues including waste, energy and transport. These groups consider environmental issues facing the trust and advise on appropriate action in order to comply with current legislation and regulations in areas such as building construction and green travel.

Although the trust fell slightly short of the 18 weeks milestone, we achieved 80% for admitted and 81% for non-admitted patients during March 2008. As a single specialty orthopaedic trust it was felt that this was a good grounding to move towards the achievement of the December 2008 targets. It is acknowledged nationally that orthopaedics is a difficult specialty in which to achieve this target and the trust does not provide any other specialties that could off set this as in the case of district general hospitals. This poses for us the same difficulties experienced previously with the 62 day cancer target, which the trust has now had confirmation from the Healthcare Commission will not be assessed due to the difficulties of applying this target to single specialty organisations.

The trust also saw the implementation of a radiology picture archiving and communication system (PACS) as part of its IM&T strategy, which was thoroughly and efficiently implemented and will be a great benefit over future years.

The trust is preparing to move forward into an extremely exciting year as it begins to realise some of the benefits of foundation trust status by the improvement and development of services on site linked to a capital redevelopment strategy. 2008/09 will see the planning and building of a new Outpatient Department co-located with the Imaging Service. The trust is aware from the input of its PPI Forum and Members Council that this will be of extreme benefit to the patients it serves and will work with colleagues in these and other forums to ensure the best possible design of the unit and an improved patient experience.

So far as the directors of the trust are aware, there is no relevant audit information of which the auditors are unaware and the directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

After making enquiries, the directors have a reasonable expectation that the 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.

2.1 Background Information

The Royal Orthopaedic Hospital was established as a NHS trust in 1995 and founded under the National Health Services Act 2006 as The Royal Orthopaedic Hospital NHS Foundation Trust on February 1st 2007. The trust is located within the South Birmingham Primary Care Trust (PCT) health economy area. It is situated around 5 miles from Birmingham city centre and 2 miles from Birmingham University. It is one of a number of acute trusts within the Birmingham area.

The Royal Orthopaedic Hospital NHS Foundation Trust is a single specialty orthopaedic hospital providing routine and elective orthopaedic treatment to a population of around 1 million. Through its spinal service it provides a regional service to the West Midlands and a bone and soft tissue tumour service to the Midlands and North of England as well as Wales. With around 140 beds and 10 operating theatres the trust is one of the largest and busiest orthopaedic centres in Europe.

48% of the clinical work undertaken is for residents outside Birmingham. The trust's main commissioner is South Birmingham PCT, but we provide services to patients from more than fifty commissioners from across England and Wales.

The table below shows where our patients come from:

Admitted Patient Care "spells" for 2007/08

Commissioner	% of total activity
South Birmingham PCT	34.69
Other Birmingham PCTs	17.80
Other West Midlands PCTs	34.80
Non-West Midlands PCTs	12.71

87.29 % of the admitted patient activity came from PCTs within the West Midlands as a whole.

2.1.1 Sub-specialisation – the quality factor

What differentiates us from many local orthopaedic NHS hospitals is the degree of sub-specialisation. Our clinicians tend to focus on very specialist areas, rather than one consultant providing a wide spectrum of services. This results in patients often being referred by other hospital consultants to our specialists. We have over 40 orthopaedic specialists involved in providing our range of services, including orthopaedic surgeons, musculo-skeletal physicians, anaesthetists, radiologists, rheumatologists, radiologists and a general physician. They are supported by a number of multidisciplinary specialist teams and advanced nurse practitioners.

The proportion of activity in 2007-08 analysed by sub-specialty is shown below:

Sub-specialty	Percentage of total activity for admitted patient care	Percentage of total activity for outpatient attendances
Arthroplasty	26.79	18.46
Arthroscopy and reconstruction	16.19	21.19
Foot surgery	6.80	9.97
Hand surgery	8.37	10.85
Musculo-skeletal medicine	9.85	6.14
Bone tumour treatment service	14.70	8.42
Paediatric orthopaedics	5.84	4.71
Pain management	3.27	12.78
Spinal surgery	8.83	7.49

The trust predominantly provides planned orthopaedic surgical care to patients with disorders of the bones and joints. Only a small amount of emergency and urgent activity is undertaken, generally in the field of spinal disorders. No trauma activity is undertaken in the early stages after injury. The main elective surgery activities are joint replacement surgery (arthroplasty), joint arthroscopy and reconstruction (keyhole surgery and ligament repairs), plus hand and foot surgery. We are one of only a small number of specialist centres for the diagnosis and treatment of bone and soft tissue cancers in the UK and as previously mentioned, provide a regional spinal service.

2.2 Operating and Financial Review

2.2.1 Aims

Our vision is: To be one of the leading orthopaedic services in Europe

To achieve this vision, the Trust Board and Members' Council are committed to providing:

- World class clinical services
- An experience that exceeds expectations
- Leading edge research, innovation and education

During the year the trust has focused on the key national target of delivering 18 weeks referral to treatment for its patients. This work has afforded several opportunities to build foundations for a still more effective year in 2008/09, including:

- Reviewing in detail patient pathways
- Securing data integrity across the pathway
- Enhancing clinical leadership and engagement
- Creating a directorate structure with the hospital
- Creating the basis for patient level costing
- Revising the governance structure to better manage risk.

During the course of the year the trust has implemented key IT systems (the ORMIS theatre system, digital picture archiving), which have helped support patient pathways within the trust and those moving from secondary to tertiary care. At the same time, the trust has been able to develop its plans for a major capital scheme to relocate the Outpatient Department.

The strategic benefits of building strong relationships between patients, members, governors and staff have been realised in the commitment to deliver demanding targets, maintain quality and retain robust financial performance.

The trust has made successful proposals to deliver spinal surgery for Worcestershire and made joint consultant appointments with other trusts such as Birmingham Children's Hospital and Dudley Group of Hospitals.

Managing risk

The trust takes a robust approach to managing risk and identifies key risks at every level from strategic (at board level) to operational (at ward level). A comprehensive risk register is maintained and the Board receives exception reports, regularly reviewing its red risks. Local risk registers are reviewed and issues escalated through the governance structure as appropriate. The trust uses risk management as a tool for learning rather than as a vehicle to identify and apportion blame.

2.2.2 Activity and finance review

The actual performance for the period is shown below:

Treatments	April 07 to March 08 plan	April 07 to March 08 actual	Variance (%)
Elective	7,311	7,311	0
Non-elective	530	501	-5.47
Day case	8,198	8,594	4.83
New outpatient attendances	16,900	17,189	1.71
Follow up outpatient attendances	47,180	52,332	10.92

In the first year as a foundation trust, the trust has continued its strong track record and delivered a surplus of £6.255 million.

The trust delivered a capital programme investing in improved facilities and equipment for the treatment of patients totalling £5,382,000 in the year.

The trust set out on an ambitious cost improvement target identifying schemes to the value of £1,374,000. At 31st March there was a slight underachievement of this programme, mainly due to the fact that some schemes needed to be refocused due to the significantly increased activity planned to deliver the 18 Week Referral to Treatment (RTT) milestone. Some procurement savings have yet to be recognised due to a variance from plan in completing competitive tendering exercises.

The risk rating of 4 was awarded by the independent regulator in each of the first three quarterly reviews, which is the most favourable that can be attained in the hospital's first year operating as a foundation trust. The hospital was awarded a fourth quarter risk rating of 5.

A significant surplus has been built up over the year and the Trust Board plan to use the funds to build a new outpatient department. The need for a more patient-friendly, appropriately located Outpatient Department has been identified by patients, public and the Members' Council along with the Board of Directors. The ability to build up and retain surpluses has meant that this scheme can now proceed more quickly than originally planned.

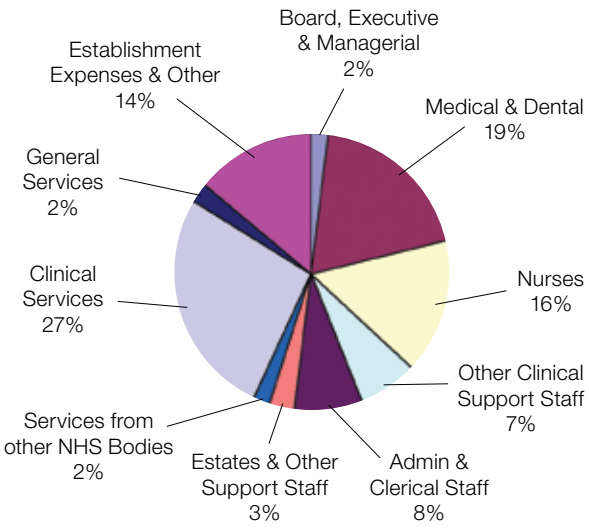
Clinicians and managers worked to manage the resources required to meet the demanding waiting time initiatives as well as delivering cost improvements. The Cost Improvement Programme has been delivered by making substantial savings on procurement, a revised management structure and nursing skill mix review, as well as savings on implant purchases and rationalisation and a more cost-effective way of treating certain types of patients in alternative hospital locations.

The Capital Programme for the year invested in additional and replacement medical and IM & T equipment, the implementation of picture archiving (PACS) and the purchase of surgical instrumentation required to support the move to an off-site instrument decontamination service, equipment for the prevention of infections and further smaller schemes to improve access for disabled patients and general maintenance of the site.

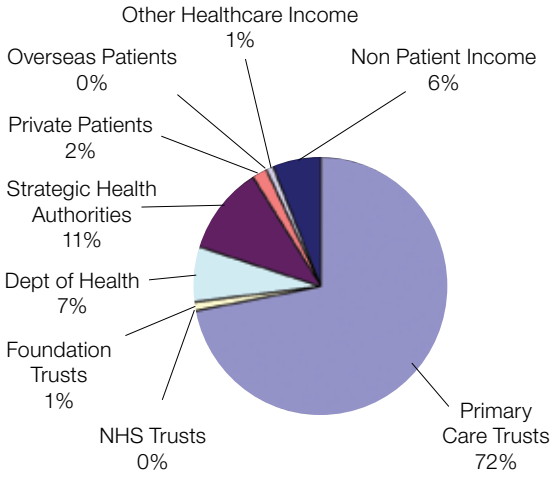
70% of the resources expended were clinically focused with clinical staffing accounting for 42% of the trust's expenditure and clinical supplies 28%. Non-clinical support spending represented 30%, being split between staffing at 14% and non-staffing at 16%. Further information on staff numbers can be found in section 6.2 of the accounts.

The split of how the resources were expended is illustrated in the chart below:

		%
A.	**Board, Executive & Managerial**	2
B.	**Medical**	19
C.	**Nurses**	16
D.	**Other Clinical Support Staff**	7
E.	**Admin & Clerical Staff**	8
F.	**Estates & Other Support Staff**	3
G.	**Services from other NHS Bodies**	2
H.	**Clinical Services**	27
I.	**General Services**	2
J.	**Establishment Expenses & Other**	14



From the chart below it can be seen that 94% of income is generated directly from healthcare activities, of which 2% relates to private patient income. The amount that a foundation trust can generate from private patient activity is controlled by a set limit (or cap) and the trust did not exceed this.



Income from activity is further analysed below:

	2007/08 £'000
Elective income	37,986
Non-elective income	2,835
Outpatient income	7,414
Other types of activity income	10,260
Total Income at Full Tariff	**58,495**
PBR Clawback	(427)
Income from Activities (before private patient income)	**58,068**
Private patient income	1,289
Income from activities	**59,357**

The trust operates in accordance with the Better Payments Practice Code and Government Accounting Rules, which require public bodies to pay trade creditors within 30 days of receipt of goods or a valid invoice. The trust achieved the target of paying 97% of the bills within the 30 day target. The trust did not incur any expenditure in relation to interest payments to suppliers for the late payment of bills during the period.

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.

Looking forward to 2008/09

The trust will continue to utilise its flexibilities to develop both patient services and buildings so as to improve the patient safety and experience of individuals being treated at the hospital.

In order to ensure that waiting time targets can be sustained significant investment is being made in permanent medical, nursing and other clinical support staff as well as associated non-clinical support services with the intention of streamlining processes and delivering greater efficiencies for the benefit of patients.

The trust plans to make a surplus in year of £1.9 million to generate funds to support a programme to improve the site over the next five years without resorting to a high level of long-term borrowing. In addition, exploratory discussions are taking place with other organisations to provide increased capacity in order to meet future demands of patient care.

The trust has a programme that will deliver £2.1 million cost improvements during the year from continuing the schemes for redesign of patient services and more efficient procurement. A reserve has been set aside to provide funds where it is necessary to invest before savings can be generated. Included in the £2.1 million target are those schemes that have not delivered the savings planned in 2007/08. The Trust Board will continue to monitor on a monthly basis the

delivery of the Cost Improvement Programme and targets leading to greater efficiency.

The major capital scheme to be commenced on site during 2008/09 is the new Outpatient Department. This will provide modern facilities for up to 60,000 patients per annum and will be located close to the trust's imaging facilities. Other schemes planned include replacement and additional medical and IM & T equipment, improved medical records and theatre support accommodation together with maintenance schemes such as a boiler replacement.
The Capital Programme for 2008/09 will be approximately £8.3 million. All schemes will be delivered within the cash resources available to the trust and will not require use of the prudential borrowing limit.

The trust derives 70% of its income through the NHS funding system - the Payment by Results tariff - which allocates a fixed price for each procedure undertaken at the trust. The Payments by Results tariff is an average price and it is recognised that this does not always adequately reimburse the specialist organisations even after a specialist top-up is added. As a specialist orthopaedic hospital the trust is expected to benefit from the more refined National Tariff that has been developed after consultation with the National Health Service for 2008/09. Further refinements of the tariff will need to take place over the coming years in order that it fully represents the costs of specialist procedures and the more complex case mix that hospitals such as The Royal Orthopaedic treat.

The Trust Board has approved the implementation of a Patient Level Costing system on an accelerated pathway with the intention that data will be available from September 2008. The introduction of Patient Level Costing is seen as a key driver for clinical involvement and change to provide a more modern and cost-effective health care service.

The key financial risks facing the trust during 2008/09 are to manage the costs of delivering the 18 weeks waiting time targets within the income received together with significantly progressing the new outpatient development within an acceptable financial envelope.

The introduction of the mandatory healthcare contract with commissioners and its associated penalties for non-delivery of information will be monitored carefully during the year to ensure that it does not have any detrimental impact on the year-end position, 2009/10 and beyond.

The trust is looking to review its long-term business and financial strategy and maximise the benefits by working in partnership with primary care services as well as other secondary care organisations with the intention of reducing waiting times and delivering surpluses in future years.

The trust does not expect to exceed its prudential borrowing limit or breach the Monitor risk metrics during the period.

External Auditor

The trust's external auditor is:

Mr Mark Stocks
Audit Commission
2nd Floor
No 1 Friars Gate
1011 Stratford Road
Solihull B90 4EB.

The external auditor's remuneration for the year was £44,910 plus VAT. During the period the external auditors also carried out non-audit work which was approved both by the Audit Committee and Members' Council and involved a review of the trust's outpatient appointment process and a web-based survey on information governance.

2.2.3 Quality and clinical governance

Annual Health Check

The trust improved on its assessment in the previous year's Standards for Better Health 'Annual Health Check'. In 2005/06 the Trust scored 'fair' for use of resources and 'fair' for quality of services. This year the scores improved to 'excellent' for use of resources and' good' for quality of services. The current declaration for 2007/08 can be found on our website www.roh.nhs.uk

Infection prevention and control

The profile of infection prevention and control has risen significantly during the year. The nursing element of the infection prevention and control service has been brought in-house and additional funding allocated to support this team on a permanent basis. This has resulted in the provision of more training for staff, more audit activity, the updating of policies and a trustwide launch day attended by over 300 staff, patients and visitors in December 2007.

There were no MRSA bacteraemias during the year and 22 cases of clostridium difficile. During the latter six months of the year the average number of C. Diff cases per month acquired within the trust dropped to 1 per month.

A programme of deep cleaning as directed by the Department of Health was completed across the organisation over the Christmas and Easter periods and included all inpatient areas and most outpatient areas. This involved the de-cluttering, repairing, cleaning and hydrogen peroxide fogging of these areas.

The Healthcare Commission undertook an unannounced Hygiene Code inspection visit in August 2007. They identified that infection prevention and control was taken seriously within the organisation. Their recommendations were incorporated into the infection prevention and control plan for the year.

Risk management

The trust successfully achieved level 1 in the new NHSLA risk management standards assessment in February 2008. An IT based solution to support risk management and some of the overall governance processes was purchased during the year. The benefits of this will be fully appreciated during the coming year.

Patient feedback

During the year, patient feedback has been sought in a number of different departments in a number of different ways. A process for real time patient feedback has been developed and piloted during the year and will run throughout the forthcoming year.

As a result of feedback received, work has been done to develop more written information for patients, make changes to menus, provide new discharge lounge facilities and introduce the role of the Discharge Liaison Nurse.

The trust's Patient Council has played an important role in advising on the style, content and quality of patient information and their hard work and commitment is much appreciated.

Clinical leadership

During the year the trust ran a clinical leadership programme for senior nurses and allied health professionals facilitated by the Royal College of Nursing. This gave 20 participants the opportunity to be involved in action learning sets, undertake 360° feedback and conduct a series of observations and patient stories. As a result of this work priorities were set and working groups established to improve the patient experience. This included the development of knee workshops, patient journals and improving privacy and dignity.

A series of away days was also run for other groups of nurse and allied health professionals consisting of a series of presentations from executive directors on key issues facing the trust and customer care workshops.

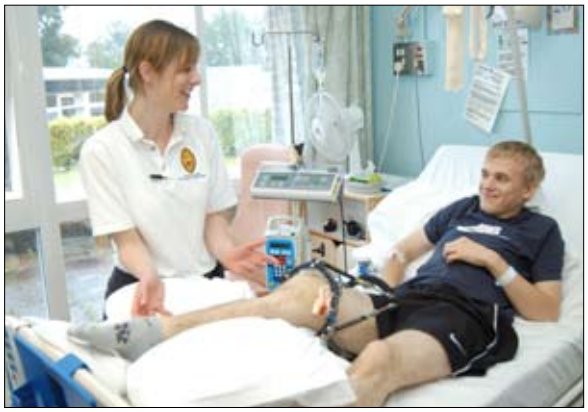
The trust recognises the importance of quality standards for patient care and taxpayer accountability. It actively engages with a range of partners within the health community to continuously improve standards.

Improving our environment for patients, visitors and staff

Being a NHS foundation trust will enable us to continue the pace of improvement and change to our environment.

A longer term solution to the pressure of parking on site is being actioned with the support of Birmingham City Council. Our Patient and Public Involvement Forum has played an important part in progressing this, and we are grateful to them for their support.

We are also committed to improving environmental and energy management, and continue to promote recycling across all areas of the trust.



Patient advocacy and complaints

The Patient Advice and Liaison Service (PALS) works together with patients and staff to help improve services for our patients and their carers. PALS also leads on the development and provision of patient information across the trust, and has undertaken a considerable amount of work in this area over the year.

The trust takes complaints seriously and acts to ensure problems are resolved quickly, to improve experiences for future patients. The total a number of complaints received during the year was 172, a reduction on the previous year's figure of 218. All complaints received were acknowledged within two days.

The trust aims to respond to all complaints within 25 working days, but unfortunately only achieved a 25 day response rate of 75.25%, compared to 79% for the previous year. Complainants who did not receive a full response within 25 working days were contacted to explain the reason for the delay. This will be an area for focused improvement over the coming year.

During the year four complaints were referred to the Healthcare Commission and all were closed swiftly. No cases were sent to the ombudsman.

Stakeholder relations

The trust has built on its relationships with key stakeholders and is excited to be developing its new governance structure with its Members' Council.

During the year, closer working relationships have been developed with South Birmingham PCT as the trust's co-ordinating PCT, with regular review meetings and a clinical engagement forum in place.

We continue to work closely with our Patient and Public Involvement Forum (PPIF), and are grateful for their support and enthusiasm. As already mentioned, they have played a significant part in producing improvements to car parking and patient access. The PPIF holds public meetings, to which everyone is welcome. They also meet bi-monthly with the Trust Board, where issues are raised and debated and action plans agreed. The PPIF has a particular interest in the prevention of hospital-acquired infection and has fully supported the routine screening of patients on admission.

The trust's League of Friends has played a vital role during the year in not only supporting the work of the trust through the work of its volunteers, but also in their support for our future as a foundation trust.

Consultation and communication with staff

The trust maintains an excellent and active relationship with the Trust Consultative Committee (TCC). The TCC represents staff side interests, and systems are in place to share financial information and matters relating to employees through this committee. The TCC meets regularly and is chaired by the Chief Executive. In addition, there is a local negotiating committee for debating and consulting on issues in relation to medical staff.

A new programme of core briefing was introduced during the year for all staff, and this has helped ensure that information disseminates in a timely and accurate manner within the trust. Through

core briefing, staff at every level of the trust are informed about matters relating to the trust, performance issues and other business issues. The briefing process has also facilitated an additional route for feedback from staff.

The trust magazine, 'Cutting Edge' was relaunched during the year, providing information for staff and patients alike. This has been welcomed and feedback has been positive. The employment of a Web Content and Development Manager has enabled us to improve the quality of information available through the trust Intranet, as well as developing a new external website for the trust.

Equality and diversity

The trust is committed to equality and fairness. We recognise the value and dignity of all individuals and will treat them with fairness and respect regardless of age, disability, ethnic or national origin, gender, marital status, race, religion or sexual orientation. All staff are made aware of their responsibilities in respect of equality and diversity through the trust induction programme and the staff handbook. The Trust Board receives regular reports on equality and diversity monitoring.

Policies and procedures are in place to ensure full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities. These policies also ensure that opportunities for continuing employment and training are available for staff who are disabled, or who become disabled during the course of their employment.

The trust's Single Equality Scheme, which refers to our policies on disabled employees and equal opportunities, can be found on our website: www.roh.nhs.uk

Health and safety

Throughout the year all managers have received training in completing health and safety and risk assessments for their areas and have been supported by the trust's Health & Safety Advisor in completing these risk assessments.

Theatres have identified their own health & safety representative and manual handling trainer to address issues specific to that area.

Manual handling training has been further developed, resulting in a split into two groups, clinical & non-clinical. This has given the Health & Safety Advisor the opportunity to include hoist and emergency evacuation chair training on the clinical mandatory training day.

The trust became a smoke free site on 1st April 2007. In partnership with South Birmingham PCT smoking cessation clinics have been organised for staff. These have been very successful with around sixty staff pledging to give up and attend the programme.

Health & safety training continues to be included on the mandatory training days for all staff and includes:

- Legislation
- Policy
- First aid
- Display screen equipment
- COSHH
- Security
- Risk assessments
- Incident reporting

External consultations

The trust has not consulted on any major changes since its consultation on foundation trust status. It actively takes part in consultations with regard to the overall local health economy and has responded recently to those for Sandwell and West Birmingham NHS Trust and the acquisition of Good Hope hospital by Heart of England NHS Foundation Trust.

2.3 Our governance structures

The trust has a range of structures to ensure accountability and good governance. These include:

- The Members' Council as a key advisory body with responsibility for appointing auditors and the non-executive directors of the board as well as steering strategic direction
- The board of directors as the key accountable body responsible for all trust activities and performance
- Board sub-committees responsible for detailed scrutiny and operational co-ordination
- The wider membership, which, while not having a constitutional role in governance of activity, give the trust a unique connection to the community and act as ambassadors on its behalf.

2.3.1 Members' Council

The 25 representatives on our Members' Council, elected by our members, are fundamental to our success as a NHS foundation trust. Their role is important as they play a key part in appointing the most senior officers of the trust, help shape its future strategy and oversee its performance. As a result, they have a major influence on the quality of health services that the public can expect to receive from us, contributing to how we deliver services and our continued role as a centre of orthopaedic excellence.

The Members' Council meets quarterly in public. Ultimately the role of its members is to help ensure that the trust serves the needs of its communities and patients as effectively as possible.

There are three categories of representatives on the Members' Council and the Chairman of the Board of Directors, Les Lawrence, is also Chair of the Members' Council. This ensures a continuity of communication between the two forums.

Non-executive directors regularly attend meetings of the Members' Council and are allocated to each of the Members' Council sub-committees to ensure active dialogue on key strategic issues and ensure that good governance and accountability processes are in place. All meetings are minuted and reported to each meeting of the Members' Council.

A register of interests of members of the Members' Council is maintained and reviewed annually. It is available for review by contacting the Company Secretary on 0121 685 4000 or via the trust website www.roh.nhs.uk

In October 2006 we held contested elections for our Members' Council overseen by the Electoral Reform Society. We had 67 nominations, and filled all 25 places on our Members' Council. These members serve for varying terms from the date of authorization as indicated in the table below.

Public: South Birmingham	Council meetings attended (out of 5)	Committee Membership
1. SIMS, John Roger (For 3 years) (Resigned 25 November 2007)	2	
ROSKELL, Gary appointed March 08 until end January 2010	1	Membership
2. COOKE, Carole Ann (For 3 years)	3	Remuneration
3. HART, Neil (For 3 years)	4	Remuneration (Chair)
4. PORTER, Ken (For 2 years)	4	Membership (Chair)
5. RICHMOND, Isobel Ingrid (For 2 years)	4	Environment
Public: Rest of England and Wales	**Council meetings attended (out of 5)**	**Committee Membership**
SMITH, Anne Hartland (For 3 years)	5	
Public: Rest of West Midlands	**Council meetings attended (out of 5)**	**Committee Membership**
1. BARWICK, Joan Margaret (For 3 years)	5	Membership
2. NOON, Stella (For 3 years)	5	Governance (Chair)
3. GILL, Judy (For 2 years)	4	
4. SCOTT, Yvonne (For 2 years)	4	Governance
Public: Heart of Birmingham	**Council meetings attended (out of 5)**	**Committee Membership**
OSBORNE, Rex (For 3 years)	1	Governance
Public: Northern & Eastern Birmingham	**Council meetings attended (out of 5)**	**Committee Membership**
1. CASWELL, Rita Ann (For 3 years)	5	Remuneration Environment (Chair)
2. MERRY, Christina Mary (For 3 years)	2	Membership

Staff: Clinical	Council meetings attended (out of 5)	Committee Membership
1. CHURCHMAN, John (For 2 years)	5	Membership (Vice chair)
2. BRADISH, Christopher (For 2 years)	4	
Staff: Non-Clinical	**Council meetings attended (out of 5)**	**Committee Membership**
GILMARTIN, Tracy Anne (For 2 years)	5	Remuneration Governance

All election boundaries 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 Members' Council elected by the public, patient and staff members, a number of key organisations that work closely with the trust appoint representatives for the Members' Council. The following organisations make such nominations and the following individuals held posts during the period of this report:

Nominating organisation	Nominee		Council meetings attended (out of 5)	Committee Membership
South Birmingham PCT	Sandra Cooper		4	Governance
Heart of Birmingham PCT	Zulfqar Hussein		2	Remuneration Governance
Birmingham City Council	Cllr Keith Barton (from March 08)		1	Governance
University of Birmingham	Peter Marquis to December 07,	Jean Broadfield from March 08	1 (JB)	Membership
Birmingham City University	Rosemary Klem to September 07	Marion Thompson from March 08	3 (RK) 1 (MT)	Remuneration
Bournville Village Trust	Bronwen Lilley to January 08		3	
Patient Support Groups	Sue Arnott		4	Governance
Member of Parliament	Richard Burden MP		2	Membership
Birmingham Council of Faiths	Parwez Hussain		1	Remuneration Membership

There are four sub-groups within the Members' Council, reflecting key strategic areas within the trust. They are:

Environment

Governance

Membership development

Remuneration

Work during the year through these sub-groups reflected key strategic areas within the trust and included:

- Environment

This group has reviewed in detail issues such as car parking and the physical patient journey within the trust and has been instrumental in supporting the Board in developing its plans for major capital investment in the relocation of the Outpatient Department.

- Governance

This committee has reviewed PEAT inspections, the patient survey, and the Annual Health Check commentary from the Council. It has been actively involved in events to support the trust's campaign to maintain the highest possible standards of infection prevention and control.

- Membership Development

The work of this committee has been to prepare a membership strategy, programme of member events and review of representative membership. This has fed into the strategies for membership development supported by the Board.

- Remuneration

The committee has set remuneration for non-executive directors and the trust Chairman, overseen the appointment of a new non-executive director and embarked on the process of recruiting a new Chairman. The committee managed the appointment of the non-executive directly via public advertisement and has reviewed the performance of the Chairman and non-executives, supported by the Senior Independent Director.

2.3.2 Our wider membership

The three categories of membership are public, staff and partner organisations. Public and staff members are elected; partners make nominations to Council. Public membership is open to those over the age of 16 from across England and Wales because the trust is a national provider of services. Anyone wishing to learn more about being a member should contact our Membership Manager on 0121 685 4000 extension 55909 or visit our website: www.roh.nhs.uk

The trust's membership development is led by the Members' Council through a sub-group chaired by one of the public members of council. The Members' Council is aware of the requirement to ensure that the membership is representative in terms of gender, age and ethnicity. The key risk regarding membership is to ensure that there is appropriate representation from the diverse population the trust serves.

Membership has grown in the past year, supported by a dedicated member of staff and the acquisition of an improved database. The demographic balance of members remains broadly in line with that of the community served by the trust. During 2008/09 the trust will use its enhanced data to support active targeting of membership from areas where the trust is experiencing lower than hoped for referrals. This will be by active outreach work undertaken by the Members' Council in their constituencies.

The trust took decisive action through its membership sub-group and Membership Manager to investigate the high losses suggested by its database management company (33.5%). Thorough investigation revealed that flawed interpretation of the management data externally was an issue and the trust has appointed a new external database company to remedy this. Actual losses over the last twelve months have primarily been as a result of deaths, with a small proportion of members moving without leaving forwarding addresses (3.5%).

A conscious decision was made during the year not to focus attention on particular groups but to initially increase our overall membership to the desired level and following this focus on under-

represented groups and constituencies. The trust is satisfied with the growth and diversity of the membership during this period.

The constituency profiles have changed marginally with the increase in membership. Percentages more closely reflect usage of our services by each of the constituencies. Ethnicity profiles for each constituency closely mirror the profiles given by the Office for National Statistics.

In our first full year as a foundation trust, membership efforts have primarily focused on two areas:

a) Investigation of high membership losses, external database provision and risk management procedures to protect the integrity of the membership data.

b) Utilising membership feedback to provide effective engagement and involvement opportunities

In the next twelve months, the trust will be concentrating its efforts on continuing to provide effective engagement opportunities for members, moving towards a co-production model of engagement in conjunction with the membership sub-group. As part of the Membership Strategy, which is regularly reviewed by the Members' Council and Trust Board, we will be concentrating on creating a more age diverse membership profile.

The trust also plans to:

- Identify further ways in which members can become engaged and remain engaged
- Consider the diversity of members in comparison to the local population and patient population, identifying any key omissions
- Identify new methods of recruitment and models of joint working with community partners
- Develop relationships with external organisations in order to increase membership.

The plans for 2008/09 are to increase the public membership, paying particular attention to diversity and the barriers to effective engagement for under represented groups.

Membership size and movements:

Public constituency	2007-08	2008-09 (estimated)
At year start (April 1)	2236	3757
New members	1654	1593
Members leaving	133	150
At year end (March 31)	3757	5200
Staff constituency	**2007-08**	**2008-09 (estimated)**
At year start (April 1)	792	1026
New members	275	50
Members leaving	41	40
At year end (March 31)	1026	1036

Analysis of current membership:

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	4	5,690, 271
17-21	110	
22+	3624	
Not stated	19	
Ethnicity		
White	2894	1,138,054
Mixed	52	16,501
Asian or Asian British	215	83,078
Black or Black British	160	44,384
Other	436	4,408,252

Public constituency	Number of members	% of membership
Socio-economic Category		
Wealthy Achievers	774	21
Urban prosperity	254	7
Comfortably Off	1244	33
Moderate Means	494	13
Hard Pressed	915	24
Not Available	76	2
Gender		
Male	1572	42
Female	2178	58
Unspecified	7	

Constituency	Males	Females	Unspecified
South Birmingham	634	993	3
North & East Birmingham	177	225	0
Heart of Birmingham	112	114	1
Rest of West Midlands	527	693	3
Rest of England/ Wales	110	130	
Public Staff	12	23	

Membership age profile:

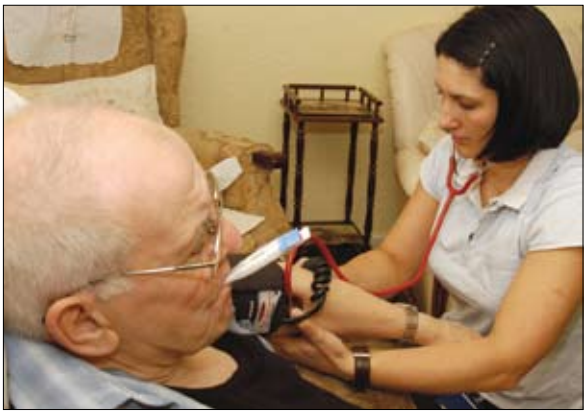
Age	Public members
16 year olds	4
17-21	110
22-29	189
30-39	358
40-49	426
50-59	656
60-74	1285
Over 75	710
Unspecified	19

Membership ethnic profile

Ethnicity	Total
White British	1989
White Irish	108
White any other white background	797
Mixed white and black Caribbean	29
Mixed white and black African	6
Mixed white and Asian	2
Mixed any other mixed background	15
Asian or Asian British Indian	83
Asian or Asian British Pakistani	49
Asian or Asian British Bangladeshi	12
Asian or Asian British – any other Asian background	71
Black or Black British Caribbean	83
Black or Black British African	30
Black or Black British any other black background	47
Other ethnic groups Chinese	15
Other ethnic groups - any other	10
Not stated	411

Membership socio-economic category

Socio-economic category	Total
Wealthy achievers	774
Urban prosperity	254
Comfortably off	1244
Moderate means	494
Hard pressed	915
Not available	76



2.3.3 The Trust Board

Mr Les Lawrence chairs the Board. Mr Lawrence's appointment was ratified by the Members' Council upon authorisation as a NHS foundation trust with effect from1st February 2007 and his term of office ends on October 31st 2008.

The Deputy Chair and Senior Independent Director is Professor Andrew Stevens (appointment ratified by the Members' Council upon authorisation as a Foundation Trust) with effect from 1st February 2007 and his term of office ends on February 28th 2009.

Notice of termination of non-executive directors is served at the request of the Members' Council either six months before the expiry of their current appointment period or by giving notice of dissatisfaction with their performance following an agreed review procedure.

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

Mr Les Lawrence	Chair
Professor A Stevens	Senior Independent Director and Deputy Chair
Mr Roger Otto	Non-executive director
Mr Chris Monk	Non-executive director
Dr Elizabeth Hensel	Non-executive director
Mr Robert Millinship	Non-executive director – appointed October 2007
Ms Penny Venables	Chief Executive Officer
Mr Graham Bragg	Director of Finance and Infomation
Mr Andrew Crawshaw	Director of Operations
Mrs Lindsey Webb	Director of Nursing and Governance
Mr Andrew Thomas	Medical Director

Professor Stevens joined the trust in December 2000, and his current term of office is due to expire on 28.02.09

Mr Roger Otto, Dr Elizabeth Hensel and Mr Chris Monk commenced on 1st January 2007 for a 4 year term of office

Mr Robert Millinship commenced on 5.10.07 for a 4 year term of office

Committees of the Trust Board are as follows:

Audit Committee:

Mr R Otto (Chair)
Mr C Monk
Dr E Hensel
Mr R Millinship
(Mr G Bragg in attendance as Director of Finance and Information)

Integrated Governance Committee membership:

Mr Les Lawrence (Chair)
Dr E Hensel
Professor A Stevens
Ms P Venables
Mr A Crawshaw
Mrs L Webb
Mr A Thomas

Nomination and Remuneration Committee

Mr Les Lawrence (Chair)
Professor A Stevens
Mr R Otto

Charitable Funds

The Trust Board is a corporate trustee for the charitable funds of the hospital.

Chairman and non-executive directors

The Chairman and non-executive directors are independent directors, having neither been appointed by an external body nor representing any other material interest. The following table shows the attendance of the Chairman and non-executive directors at board and committee meetings during the period:

	Board and board assignments 12 meetings	Audit Committee 8 meetings	Integrated Governance Committee 9 meetings	Nomination & Remuneration Committee 3 meetings	Charitable Funds 4 meetings
Les Lawrence **Chairman** Mr Lawrence also holds office as Cabinet Member Children and Young People, Birmingham City Council.	11		Chairman 8	Chairman 2	Chairman 3
Andrew Stevens **Deputy Chairman and Senior Independent Director** Mr Stevens is a professor at Birmingham University and also works with NICE	11 Undertaking chair appraisal and feedback to Members' Council		6 Focus on clinical guidance and outcomes	2 Acts as interface with Members' Council	4
Chris Monk Mr Monk is a Partner in King Sturge, a firm of property agents and also serves on Advantage West Midlands and several other bodies	11 Leading on capital development and estates	6 Particular focus on best practice HR & organisational development			3
Roger Otto Mr Otto is a qualified accountant and was a partner with Baker Tilly. He has also served as a non-executive director on a PCT	10 Reporting on work of audit and annual report to Members' Council	7 Chairman from April 2007		2	2
Elizabeth Hensel Dr Hensel is a clinical psychologist and was previously a non-executive director of an NHS ambulance trust	10 Leading on information systems and patient flows	6 Acts as link person with integrated governance	5 Acts as link person with audit particular focus on governance structures		4
Robert Millinship (from October 2007) Mr Millinship held senior posts in the automotive and technology sector prior to his retirement. He has a particular interest in strategy, business development and retention	6 Leading on 18 weeks project delivery	4 Key focus on performance criteria			1
Brief synopsis of major areas of work undertaken during the year	Monthly corporate performance review; key national target review; strategic planning; capital project development	Review of overall Board assurance.	Ongoing review of Assurance Framework; clinical governance; policy review	Approval of pay awards; Agreement of external advertising and specification for non-executive director (with Members' Council, Nominations & Remuneration Committee); HR Review	Review of investment strategy; prioritisation of fund allocation

Evaluation of the performance of the Board

The Board undertakes an annual self-appraisal using peer group questionnaires. These are reviewed by the Chair and underpin individual board member appraisal interviews from which objectives are set. The Chairman discusses these with the Nomination and Remuneration Committee of the Members' Council. The appraisal of the Chairman is undertaken by the Senior Independent Director and discussed with the Members' Council Nomination and Remuneration Committee who add the perspective of the Members' Council and agree objectives. In future years the Nomination and Remuneration Committee will work with the Senior Independent Director jointly on this appraisal.

Board committees review their work annually and agree work programmes that are then evaluated. The audit committee seeks confirmation from The Integrated Governance Committee that it has covered its workplan. A major evaluation of the effectiveness of the committee structure introduced on authorisation began at the end of this financial year to compare against best practice and fitness for purpose. This was supported by some work undertaken by internal audit on the Assurance Framework as one of the key underpinning tools used by Integrated Governance and Audit Committees.

Members of the Trust Board and Members' Council can be contacted through the Company Secretary 0121 685 4000 or via the trust's website: www.roh.nhs.uk

Balance, completeness and appropriateness of the Board

The Board has a balance of skills drawn from the public and private sectors within and beyond health. The Board benefits from having a qualified accountant and two senior private sector professionals who have held significant full profit & loss responsibility. The public sector interface with the local authority perspective brought in particular by the Chairman allows the organisation to ensure it is connected with the broader strategies and ambitions for the city. The health expertise of the two non-executive directors with academic and psychology backgrounds ensures robust focus on clinical activity and performance management. The Board had an unplanned vacancy for a non-executive director during the year and the Members' Council made an appointment with effect from October 2007.

Under the seasoned chairmanship of Mr Lawrence, who continues to fulfil additional external commitments, the Board has operated during this period with 11 members.

The Chief Executive of the trust throughout the period of this report was Mrs Penny Venables. The Director of Finance and Information was Mr Graham Bragg. The Director of Operations was Mr Andrew Crawshaw. The Director of Nursing and Governance was Mrs Lindsey Webb. The Medical Director was Mr Andrew Thomas. There were no executive director vacancies during the period of this report.

In January 2007, the month before authorisation as a NHS foundation trust, the Board benefited from the appointment of three new non-executive directors with a broad range of business and professional skills. This strengthened the existing skills portfolio of public sector, marketing and consultancy, and medical academic experience, with property, accountancy, clinical psychology and broad external and NHS engagement competence.

The Board has well-qualified and experienced NHS professionals within its executive team (the Chief Executive and two Executive Directors were appointed during the previous 12 months as a result of recruitment through open competition). The Board therefore has, in addition to the Chief Executive, a Medical Director, Director of Nursing and Governance, Director of Finance and Information and Director of Operations. Taking these two complementary skill sets together, the board amply demonstrates breadth, depth and diversity in its experience base.

The Members' Council Remuneration Committee received detailed feedback from the Chairman on the peer appraisal process undertaken by the Board and endorsed the non-executive directors'

objectives. The Senior Independent Director provided feedback on the Chairman's appraisal and the Members' Council agreed a revised process for the subsequent year that allowed their fuller participation in review and objective setting through a joint process between the committee and the Senior Independent Director.

2.3.4 The work of the Audit Committee

The Audit Committee is recognised as the senior committee of the Trust Board and operates to an annual work plan. External audit, with which non-executive directors can meet separately to discuss issues of concern, supports it at every meeting. Internal audit also report to each meeting. The Chair of the Audit Committee is a qualified accountant with previous experience (as a non-executive) of an NHS governance regime and audit function.

The Committee reviews and monitors the arrangements for promoting a counter fraud environment. There is a counter fraud annual plan that is adopted and monitored by the Audit Committee. The day-to-day responsibility is delegated to the Director of Finance and Information and there is a dedicated section of the trust Intranet relating to counter fraud.

The committee further revised its terms of reference to reflect best practice and fit within a context of integrated governance. The committee uses the Assurance Framework to steer its direction of scrutiny and so to manage risk. The work plan for the Audit Committee is scheduled such that it is required to meet at least six times per year. The Chair of the Audit Committee reports to the next meeting of the Trust Board the issues that it has considered. Any member of the executive may be called to attend the committee to be held accountable for action within the organisation.

We have undertaken the audit in accordance with the Audit Code issued by Monitor. The audit has assessed whether:

- The accounts were prepared in accordance with directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006
- The accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the accounts
- Proper practices have been observed in the compilation of the accounts and
- The NHS foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our report, setting out our findings, is included in the Annual Report and Accounts in section 4.

2.3.5 The work of the Nomination and Remuneration Committee

Membership of the Committee

The Committee consists of two Non-Executive Directors and the Chairman. A minimum of one non-executive director and Chairman must be present at a meeting. At least one of the non-executives must be the member of the Audit Committee. The Committee meets quarterly and, if required, meetings can be arranged to deal with specific issues as and when required.

The members of the Committee are:

Mr Les Lawrence, Chairman

Professor Andrew Stevens, non-executive director

Mr Roger Otto, non-executive director

Senior Managers Remuneration Policy

The Committee advises the Board on appropriate remuneration and terms of service for the Executive Directors and other senior employees on Trusts salaries and performance related pay. This will include:

- All aspects of salary
- Provisions for other benefits, including pensions.

The Committee is responsible for the following:

- Making recommendations to the Board to ensure senior employees are fairly rewarded for their individual contribution, having proper regard to the trust's affordability and any applicable national arrangements
- Receiving annual objectives, monitoring and evaluating the performance of senior employees
- Advising and overseeing contractual arrangements for senior managers including the proper calculation and scrutiny of termination payments taking account of national guidance
- The development of any PRP system and non-pay system
- Monitoring the progress on review of consultant job plans.

Information is provided by the Director of Human Resources as appropriate and will include:

- The position of salaries in the market place
- The balance between basic salaries and performance payments
- How pay should be linked with performance
- The relationship between Board and other staff's salaries
- The balance between cash and non-cash benefits.

Performance Conditions

Annual objectives are set for senior managers with twice yearly appraisals being conducted by the Chief Executive for Directors and by the Chairman in respect of the Chief Executive.

Policy on duration of contracts

No permanent appointments are made on fixed term contracts other than where secondment arrangements exist. None of the senior managers included in the table below were employed on a secondment basis in the year concerned.

Salary and pension entitlements of senior managers

A) Salaries						
Name and Title	2007-08 (12 months to 31st March 2008)			2006-07 (2 months to 31st March 2007)		
	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
Mr L Lawrence Chairman	20-25	0	0	0-5	0	0
Mrs P Venables Chief Executive	105-110	0	0	15-20	0	0
Mr G Bragg Director of Finance and Information	90-95	0	0	10-15	0	0
Mr A Thomas Medical Director	15-20	100-105	0	0-5	15-20	0
Mr A Crawshaw Director of Operations	75-80	0	0	10-15	0	0
Mrs L Webb Director of Nursing & Governance	65-70	0	0	5-10	0	0
Professor A Stevens non-executive director	5-10	0	0	0-5	0	0
Dr E Hensel non-executive director	5-10	0	0	0-5	0	0
Mr R Otto non-executive director	5-10	0	0	0-5	0	0
Mr R Millinship non-executive director (From 1st October 2007)	0-5	0	0	0-5	0	0
Mr C Monk non-executive director	10-15	0	0	0-5	0	0

No compensation for loss of office has been paid or is payable in respect of this financial period to any voting director nor senior manager listed above.

B) Pension Benefits						
Name and title	Real increase/ (decrease) in pension and related lump sum at age 60	Total accrued pension and related lump sum at age 60 at 31 March 2008	Cash Equivalent Transfer Value at 31 March 2008	Cash Equivalent Transfer Value at 31 March 2007	Real Increase/ (decrease) in Cash Equivalent Transfer Value	Employers Contribu-tion to Stakehold-er Pension
	(Bands of £2500) £000	(Bands of £5000) £000	£000	£000	£000	To nearest £100
Mrs P Venables Chief Executive	2.5-5	130-135	474	436	19	0
Mr G Bragg Director Of Finance and Information	0-2.5	135-140	606	574	13	0
Mr A Thomas Medical Director	0-2.5	175-180	738	694	19	0
Mr A Crawshaw Director of Operations	2.5-5	80-85	258	235	12	0
Mrs L Webb Director Of Nursing and Governance	17.5-20	55-60	178	121	38	0

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 2006-07 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.

Penny Venables
Chief Executive

Date: 16th June 2008

2.3.6 Register of Interests

The trust maintains a Register of Interests for all Board members. No material interests have been declared during the period of this report.

Related party transactions

Under the terms of the trust's constitution, the Board of Directors is required to declare any individual interest that may conflict with their appointment as a director of the foundation trust. During the year none of the Board members, key management staff or parties related to them has undertaken any material transaction with The Royal Orthopaedic Hospital NHS Foundation Trust.

Section 3

Statement of Accounting Officer's responsibilities as the Accounting Officer of The Royal Orthopaedic Hospital NHS Foundation Trust

The National Health Services 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 accounting officers' memorandum issued by the Independent Regulator of NHS Foundation Trusts (Monitor).

Under the National Health Services 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 Financial Reporting Manual have been followed
- 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 that disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable her to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Penny Venables
Chief Executive

Date: 16th June 2008

Section 4

Annual Accounts

for the Year Ended 31st March 2008

Statement on Internal Control

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Royal Orthopaedic Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2008 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is the Board member with overall responsibility for Risk Management within the trust.

The Integrated Governance Committee is a sub-committee of the Trust Board and is chaired by the Chairman of the trust; the Chief Executive is a member of this committee. The committee meets regularly every two months and reviews the risk assurance framework and the risk register.

The awareness and management of risk is an integral part of staff induction and on the annual mandatory day staff learn how to report or deal with these issues. Root cause analysis training has been provided for senior staff within the organisation alongside training on 'Being Open'. Root cause analysis aids managers understanding of the cause of incidents to compare with good practice and therefore improve. Additional training is provided to managers attending the trust management programme.

Training has also been provided on the use of local risk registers and these are now embedded within the organisation, along with health and safety risk assessments. The local risk registers feed into the corporate risk register where necessary.

The electronic incident reporting processes have been further developed across the organisation using the Ulysses system. All staff and managers have been provided with training regarding the system. Systems to analyse serious events have also been initiated. Ulysses is also being used to record complaints, PALS and litigation cases.

The risk and control framework

The purpose of the risk management strategy, which was updated in December 2007 is to:

- Improve the quality of patient care
- Protect patients, staff, visitors and all stakeholders from harm
- Be in the best position to deliver corporate objectives both strategic and operational
- Minimise the trust's financial liability

The trust recognises the importance of collecting meaningful and relevant data in a statistical format so that analysis and trends can be monitored and appropriate action taken. Quarterly reports to the Integrated Governance

Committee highlight trends and pertinent risk issues. Summary reports are provided to the Board monthly as part of the corporate performance report.

Information on clinical incidents is shared with key staff and the electronic incident reporting system allows appropriate managers both to be notified of incidents and to review incidents in a timely fashion. Information on non-clinical incidents is collated on a quarterly basis and discussed at the Health and Safety Committee. Serious untoward incidents are monitored by the Safety & Patient Experience Committee and reported to the Trust Board. Actions and learning are detailed within the Clinical Governance quarterly report to the Integrated Governance Committee. This report is made available to all wards and departments via the trust's intranet.

The internal and external auditors have included audit work around the current risk management systems including the Trust Board Assurance Framework and risk management.

The 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 Assurance Framework has been received by the Integrated Governance and Audit Committees during the year.

The board has reviewed the systems and procedures for securing personal data, including patient data in transit, and confirms that it is satisfied that these have been and remain compliant with relevant information governance guidance and the Data Protection Act 1998. During 2007/08 the trust did not have any Serious Untoward Incidents involving data loss or confidentiality breach and the trust's Senior Information Risk Owner at Board level is the Director of Finance.

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 include NHS West Midlands, South Birmingham and Birmingham East and North Primary Care Trusts, subcontractors, voluntary groups, the Members' Council, patient groups (including the statutory Patient and Public Involvement Forums and the trust's Patient Council), patients, the local community and the Local Authority Overview and Scrutiny Committee.

General public awareness of the strategy is achieved through its presentation to the Members' Council, explicit references within the trust's annual report and by ensuring the general availability of the strategy on the trust's website

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

The key processes that are embraced within the trust in order to ensure that resources are used economically, efficiently and effectively centre around a robust budgetary setting and control system which includes activity related budgets and periodic reviews during the year which are considered by the Executive Management Team and the Trust Board. The introduction of a new management structure has facilitated quarterly reviews with each Clinical Service and Support Unit. The budgetary control system is complemented by a clear scheme of delegation

and financial approval limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis.

The trust 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. This area will be further developed in 2008/09.

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. The trust compares its reference costs with national tariffs to highlight the potential areas of inefficiency and compares its use of resources with other specialist orthopaedic centres.

The management team and the Trust Board have commissioned independent reviews of specific services during the year to ensure that they are fit for purpose and deliver economy, efficiency and effectiveness. Part of the internal audit programme during the year has been both to review core systems but also specific areas where there may be an opportunity to improve the use of resources.

The Board receive regular updates from its Audit Committee on the reviews carried out by both Internal Audit and value for money studies carried out by the External Audit services. 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 Healthcare Commission assessments in the autumn of 2007 awarded the trust a scoring of "good" for quality of services and "excellent" for value for money.

The risk rating of 4 was awarded by the independent regulator in each of the first three quarterly reviews, which is the most favourable that can be attained in the hospital's first year operating as a foundation trust. The hospital was awarded a fourth quarter risk rating of 5.

The Finance and Performance Task and Finish Group, Audit or Integrated Governance Committees consider the recommendation of all audits carried out and ensure corrective action is undertaken where necessary.

As a member of the Specialist Orthopaedic Alliance both formal and informal reviews of services and their cost effectiveness are carried out.

The Trust Board holds regular meetings with the Public and Patient Involvement Forum and discusses areas for improvement in the provision of services that the trust provides. The trust also works closely with the Patient Forum and other specialist patient care groups to ensure it takes account of any concerns or recommendations for service improvement.

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 and the executive managers within The Royal Orthopaedic Hospital NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and 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 reviews progress against a number of action plans including the Assurance Framework to ensure that identified actions are implemented in the timely manner.
- The Audit Committee receives regular reports on reviews undertaken by the Internal and External Auditors and monitors the system of financial control.

- The Integrated Governance Committee monitor progress and suggest action to be taken as appropriate in relation to regular reports regarding complaints, incidents, legal claims and other risks identified.
- The Executive Management Team ensures actions on lapses in the core standards are implemented.
- The Audit Committee reviews its objectives annually and revises 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.
- Directors and senior managers of the trust have specific responsibilities in respect of the domains of the Standards for Better Health and more generally in maintaining internal control systems.

No significant internal control issues were identified for the trust during the year. However, the trust has declared that it did not meet the Medicines Management Core Standard 4d for quarter 1. A detailed action plan was produced and monitored closely by the Executive Management Team and Trust Board. The standard has now been compliant from 1st July 2007.

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
- The Standards for Better Health final declaration
- The local Counter Fraud Reports
- The NHSLA Level 1 Assessment
- The National Patient Satisfaction Survey
- Dr Foster
- The National Staff Opinion Survey
- The CPA accreditation for the Histopathology Lab
- Data Quality Audits
- The Independent Regulator's assessment of the trust as part of the Compliance Framework
- The review of the outpatient appointments arrangements
- The Members' Council meetings
- Connecting for Health - Payment by Results Assurance Framework Clinical Coding Report
- The Hygiene Inspection carried out by the Healthcare Commission in August 2007
- The review meetings held with the trust's host commissioner

Penny Venables
Chief Executive

Date: 5th June 2008

Independent Auditor's report to the Members' Council of The Royal Orthopaedic Hospital NHS Foundation Trust

I have audited the financial statements of The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2008 under the National Health Service Act 2006. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Members' Council of The Royal Orthopaedic Hospital NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Members' Council those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be

audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the Directors Report, and the un-audited part of the Remuneration Report, included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual 2007/08. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I are aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the Directors Report, and the un-audited part of the Remuneration Report, included in the Annual Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial

statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.
- In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of The Royal Orthopaedic Hospital NHS Foundation Trust as at 31 March 2008 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the Directors' Report included in the annual report, is consistent with the financial statements.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Mark Stocks
(Officer of the Audit Commission)

2nd Floor, No.1 Friarsgate
1011 Stratford Road
Solihull
B90 4EB

16 June 2008

Foreword to the Accounts

These accounts for the year ended 31 March 2008 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.

Penny Venables
Chief Executive

5th June 2008

Income and Expenditure Account
For the year ended 31st March 2008

	NOTE	£'000	2 Months to 31 March 2007 £'000
Income from activities	3	59,350	8,835
Other operating income	4	3,575	531
Operating expenses	5-6	(55,921)	(8,561)
OPERATING SURPLUS (DEFICIT)		7,004	805
Cost of fundamental reorganisation/restructuring		0	0
Profit (loss) on disposal of fixed assets	7	0	4
SURPLUS (DEFICIT) BEFORE INTEREST		7,004	809
Finance Income		663	64
Finance costs - interest expense		0	0
Other net gains/(losses) on financial instruments		0	0
Other finance costs - unwinding of discount		(8)	(2)
Other finance costs - change in discount rate on provisions		0	0
SURPLUS (DEFICIT) FOR THE FINANCIAL YEAR		7,659	871
Public Dividend Capital dividends payable		(1,404)	(291)
RETAINED SURPLUS (DEFICIT) FOR THE YEAR		6,255	580

The notes on pages 13 to 42 form part of these accounts.

All income and expenditure is derived from continuing operations.

Balance Sheet
As at 31st March 2008

	NOTE	£'000	31 March 2007 £'000
FIXED ASSETS			
Intangible assets		0	0
Tangible assets	9	41,108	36,948
Investments	12	0	0
		41,108	**36,948**
CURRENT ASSETS			
Stocks and work in progress	10	1,870	1,216
Debtors	11	5,755	3,980
Investments	12	0	0
Cash at bank and in hand	19.3	9,486	8,624
		17,111	**13,820**
CREDITORS: Amounts falling due within one year	13	**(4,600)**	**(5,573)**
NET CURRENT ASSETS / (LIABILITIES)		**12,511**	**8,247**
TOTAL ASSETS LESS CURRENT LIABILITIES		**53,619**	**45,195**
CREDITORS: Amounts falling due after more than one year	13	**0**	**0**
PROVISIONS FOR LIABILITIES AND CHARGES	14	**(271)**	**(259)**
TOTAL ASSETS EMPLOYED		**53,348**	**44,936**
FINANCED BY:			
Public dividend capital	16	38,905	38,905
Revaluation reserve	17	6,165	4,349
Donated asset reserve	17	1,976	2,058
Available for sale investments reserve	17	0	0
Other reserves	17	0	0
Income and expenditure reserve	17	6,302	(376)
TOTAL TAXPAYERS EQUITY		**53,348**	**44,936**

The financial statements were approved by the Audit Committee on behalf of the Board of Directors on 05 June 2008 and are signed on its behalf by:

Penny Venables
Chief Executive

Statement of Total Recognised Gains and Losses
For the year ended 31st March 2008

	£'000	2 Months to 31 March 2007 £'000
Surplus (deficit) for the financial year before dividend payments	7,659	871
Fixed asset impairment losses	0	0
Unrealised surplus/(deficit) on fixed asset revaluations/ indexation	2,239	0
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	0	0
Reductions in the donated asset reserve due to depreciation, impairment, and/or disposal of donated assets	(82)	(13)
Additions/(reductions) in "other reserves"	0	0
Total recognised gains and losses for the financial year	**9,816**	**858**
Prior period adjustment	0	0
Total gains and losses recognised in the financial year	**9,816**	**858**

Cash Flow Statement
For the year ended 31st March 2008

	NOTE	£000	2 Months to 31 March 2007 £000
OPERATING ACTIVITIES			
Net cash inflow/(outflow) from operating activities	19.1	6,991	2,290
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		657	52
Interest paid		0	0
Interest element of finance leases		0	0
Net cash inflow/(outflow) from returns on investments and servicing of finance		**657**	**52**
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		(5,382)	(339)
Receipts from sale of tangible fixed assets		0	4
(Payments) to acquire intangible assets		0	0
Receipts from sale of intangible assets		0	0
(Payments to acquire)/receipts from sale of fixed asset investments		0	0
Net cash inflow/(outflow) from capital expenditure		**(5,382)**	**(335)**
DIVIDENDS PAID		**(1,404)**	**(874)**
Net cash inflow/(outflow) before management of liquid resources and financing		**862**	**1,133**
MANAGEMENT OF LIQUID RESOURCES			
(Purchase) of current asset investments		0	0
Sale of current asset investments		0	0
Net cash inflow/(outflow) from management of liquid resources		**0**	**0**
Net cash inflow/(outflow) before financing		**862**	**1,133**
FINANCING			
New public dividend capital received		0	3,260
Public dividend capital repaid		0	(1,150)
Loans received from Foundation Trust Financing Facility		0	0
Other loans received		0	0
Loans repaid to Foundation Trust Financing Facility		0	0
Other loans repaid		0	0
Other capital receipts		0	0
Capital element of finance lease rental payments		0	0
Net cash inflow/(outflow) from financing		**0**	**2,110**
Increase/(decrease) in cash		**862**	**3,243**

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 Financial Reporting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2007/08 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual 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.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

1.3 Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:

a. The sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;

b. If a termination, the former activities have ceased permanently;

c. The sale or termination has a material effect on the nature and focus of the reporting of NHS foundation trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS foundation trust's continuing operations; and

d. The assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as continuing.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

1.4 Income recognition

Income is accounted for by applying the accruals convention. The main source of income for the trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Partially completed spells are valued at the intermediate stage of production. Where income is received for a specific activity that is to be delivered in the following financial year, that income is deferred.

The NHS foundation trust changed the form of its contracts with NHS commissioners to follow the Department of Health's Payment by Results methodology in 2004/05. To manage the financial impact of this change on the NHS foundation trust and its commissioners, where the previously charged local prices exceeded the national tariff Trusts were reimbursed 75% of the difference in 2005/06 reducing by 25% in each of the following three years. Where the national tariff exceeded previously charged local prices the Trust paid the Department of Health as follows:

- In 2005/06 75% of the difference.

- In 2006/07 the Royal Orthopaedic Hospital NHS Foundation Trust gained on tariff and had to reimburse £0.8m (50% of the gain) for the full year.

- In 2007/08, the last transitional year, the trust gained on tariff and reimbursed £0.4m (25% of the gain) of which 16.67% was attributable to the two months ended 31st March 2007.

- In 2008/09 the amount reimbursed will be nil

1.5 Expenditure

Expenditure is accounted for by applying the accruals convention.

1.6 Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

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

- 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.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

All land and buildings are revalued using professional valuations in accordance with FRS 15 every five years. A three yearly interim valuation is also carried out.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent asset valuations were undertaken on 31 March 2008 by the District Valuer. The revaluation undertaken at that date has been accounted for in these accounts on 31 March 2008 as follows:

- Land £6,500,000
- Buildings and Dwellings £29,531,000

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

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use.

Residual interests in off-balance sheet Private Finance Initiative properties are included in assets under construction within tangible fixed assets at the amount of unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in the fair value of the residual as estimated at the start of the contract and at the balance sheet date.

Operational equipment is valued at net current

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

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land, and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS foundation trust's professional valuers. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life.

Fixed asset impairments resulting from losses of economic benefits are charged to the income and expenditure account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

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

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

1.7 Intangible fixed assets

The trust does not recognise computer software licences as intangible assets. The trust does not hold any Intangible Fixed Assets.

1.8 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

1.9 Investments

Investments in subsidiary undertakings, associates and joint ventures are treated as fixed asset investments and valued at market value. Fixed asset investments are reviewed annually for impairments.

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cash flow statement. These assets, and other current assets, are valued at cost less any amounts written off to represent any impairments in value, and are reviewed annually for impairments.

1.10 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 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 Income and Expenditure account to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset.

1.11 Private Finance Initiative (PFI) transactions

The trust did not enter in to any PFI transactions in the year covered by these accounts.

1.12 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. The trust holds consignment stocks owned by third parties which are not recognised in the Trust's accounts as the trust has no beneficial interest in them.

1.13 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the NHS foundation trust's cash book. These balances exclude monies held in the NHS foundation trust's bank account belonging to patients (see "third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.14 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 income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued 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 Income and Expenditure account 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.

1.15 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure 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 HM Treasury's discount rate of 2.2% in real terms.

1.16 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 22 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 22 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.

1.17 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 14.

1.18 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.

1.19 Pension costs

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.pensions.nhsbsa.nhs.uk. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General 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.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was

that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008 is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme provisions as at 31 March 2008

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. 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. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

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, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die 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 income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk.

1.20 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.

1.21 Corporation Tax

All surpluses are generated by activity authorised as an activity relating to the provision of core healthcare or fall below the determined Private Patient Cap and therefore the trust has determined that there is not a Corporation Tax liability.

1.22 Foreign exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the income and expenditure account.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.24 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 a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease.

The asset and liabilty are recognised at the inception of the lease and are de-recognised when the liability is discharged, cancelled or expires.

The interest element of the finance lease payment is charged to the income and expenditure account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the income and expenditure account on a straight-line basis over the term of the lease.

1.25 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance.

A charge, reflecting the forecast cost of capital utilised by the NHS foundation trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held or on investment. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

1.26 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 did not hold any financial assets or liabilities in respect of assets acquired or disposed of through finance leases at 31 March 2008.

The trust has not entered into any regular way purchases or sales in the year to 31 March 2008.

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'.

Loans and receivables

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

The trust's loans and receivables comprise: cash at bank and in hand, NHS debtors and other debtors.

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 income and expenditure account.

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 balance sheet date, which are classified as long-term liabilities.

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 balance sheet 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 cashflows 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 income and expenditure account and the carrying amount of the asset is reduced through the use of a bad debt provision.

2. Segmental Reporting

The trust does not have more than one business segment.

3. Income from Activities

3.1 Operating Income

		2 Months to 31 March 2007
	£'000	£'000
Elective income	37,986	5,739
Non-elective income	2,835	416
Outpatient income	7,414	1,102
Other NHS clinical income	9,901	1,557
Total Income at Full Tariff	**58,136**	**8,814**
PBR Clawback	(427)	(139)
Income from Activities (before private patient income)	**57,709**	**8,675**
Private patient income	1,585	160
Other non-protected clinical income	56	0
Income from activities	**59,350**	**8,835**

As an NHS foundation trust, the majority of income in respect of patient care is received under Payment by Results (PBR), which is intended to reimburse trusts based on the actual activity delivered using the National Tariff of procedure prices. Income is shown above gross with a 25% clawback of the excess of national tariff over previously charged local prices (50% in 2006/07) to reduce our income to the amount received in the year.

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 Private Patient Income

		2 Months to 31 March 2007	Base Year
	£'000	£'000	£'000
Private patient income	1,585	160	1,446
Total patient related Income	59,350	8,835	33,956
Proportion as a percentage	2.67%	1.81%	4.3%

Section 44 of the 2006 Act requires that the proportion of the private patient income to the total patient related income of NHS foundation trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03. The note above shows that it was compliant for the year ended 31 March 2008.

4. Other Operating Income

		2 Months to 31 March 2007
	£'000	£'000
Research and development	191	36
Education and training	1998	378
Charitable and other contributions to expenditure	0	0
Transfers from donated asset reserve	82	13
Non-patient care services to other bodies	0	0
Other income	1304	104
Total	**3,575**	**531**

Other income is derived from Local Information Strategy funding of £483,000, deep cleaning funding of £185,000, catering income of £162,000 and numerous other small amounts.

5. Operating Expenditure

5.1 Operating expenses comprise of:

	£'000	2 Months to 31 March 2007 £'000
Services from NHS foundation trusts	0	0
Services from NHS trusts	0	0
Services from other NHS bodies	0	0
Purchase of healthcare from non-NHS bodies	898	88
Executive directors costs	469	86
Non-executive directors' costs	76	8
Staff costs	30,380	4,787
Drug costs	1,346	219
Supplies and services - clinical (excluding drug costs)	13,841	2,295
Supplies and services - general	1,024	162
Establishment	788	115
Research and development	0	0
Transport	152	28
Premises	2,233	311
Increase/(decrease) in bad debt provision	(341)	(198)
Other impairment of financial assets	0	0
Depreciation and amortisation	2,869	440
Fixed asset impairment	592	0
Audit fees for statutory audit and regulatory work	85	24
Audit fees for further assurance and other services	46	5
Clinical negligence	368	48
Exceptional items	0	0
Other	1,095	143
	55,921	**8,561**

5.2.1 Operating expenses include:

	£'000	2 Months to 31 March 2007 £'000
Hire of plant and machinery	124	20
Other operating lease rentals	24	4
Total	**148**	**24**

5.2.2 Annual commitments under non-cancellable leases are:

	Land and Buildings		Other Leases	
	2007/08 £'000	2006/07 £'000	2007/08 £'000	2006/07 £'000
Operating Leases which expire:				
Within 1 year	17	24	127	94
Between 1 and 5 years	0	17	368	442
After 5 years	0	0	0	28
Total	**17**	**41**	**495**	**564**

6 Staff Costs and Numbers

6.1 Staff Costs

	Total	Permanently Employed	Other	2 Months to 31 March 2007 Total
				£'000
Salaries and wages	**26,042**	25,169	873	4,118
Social Security Costs	**2,211**	2,211	0	340
Employer contributions to NHSPA	**2,596**	2,596	0	415
Other pension costs	**0**	0	0	0
Total	**30,849**	**29,976**	**873**	**4,873**

The total Employer Pension contribution payable for the year is £2,596,336 (2 months to 31 March 2007 £415,000)

6.2 Average number of persons employed

	2007/08			2006/07
	Total	Permanently Employed	Other	Total
	Number	Number	Number	Number
Medical and dental	**101**	99	2	98
Ambulance staff	**0**	0	0	0
Administration and estates	**214**	212	2	215
Healthcare assistants and other support staff	**77**	77	0	69
Nursing, midwifery and health visiting staff	**320**	320	0	311
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**109**	104	5	103
Social care staff	**0**	0	0	0
Other	**6**	5	1	9
Total	**827**	**817**	**10**	**805**

6.3 Retirements due to ill-health

During the year reported of 2007/08 there were no early retirements from the trust agreed on the grounds of ill-health.

7. Profit/(Loss) on Disposal of Fixed Assets

Profit/(Loss) on the disposal of fixed assets is made up as follows:

	£000	2 Months to 31 March 2007 £000
Profit on disposal of plant and equipment	0	4
Total	**0**	**4**

8. 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 2007/08 the trust had 20 separate losses and special payments, totaling £62,773 (2 months to 31 March 2007 £166). These were in relation to cash losses and ex-gratia payments to patients.

There were no clinical negligence, fraud, personal injury, compensation under legal obligations or fruitless payment cases where the net payment for the individual case exceeded £100,000.

Payments are on a cash basis.

9. Fixed Assets

9.1 Tangible Fixed Assets

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account*	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2007	6,055	28,556	976	337	8,185	33	972	322	45,436
Additions purchased	0	873	133	673	1,739	18	1,946	0	5,382
Additions donated	0	0	0	0	0	0	0	0	0
Impairments	0	(244)	(278)	(70)	0	0	0	0	(592)
Reclassifications	0	265	72	(337)	0	0	0	0	0
Other in year revaluation	447	1,792	0	0	0	0	0	0	2,239
Disposals	0	0	0	0	(1,677)	0	(16)	0	(1,693)
Cost or Valuation at 31 March 2008	**6,502**	**31,242**	**903**	**603**	**8,247**	**51**	**2,902**	**322**	**50,772**
Depreciation at 1 April 2007	0	1,423	44	0	5,984	22	697	318	8,488
Charged during the period	0	1,524	46	0	980	5	310	4	2,869
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	(1)	1	0	0	0	0	0	0
Other in year revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(1,677)	0	(16)	0	(1,693)
Depreciation at 31 March 2008	**0**	**2,946**	**91**	**0**	**5,287**	**27**	**991**	**322**	**9,664**
Net book value									
Purchased at 1 April 2007	6,055	25,313	932	337	2,170	11	275	4	35,097
Donated at 1 April 2007	0	1,820	0	0	31	0	0	0	1,851
Total at 1 April 2007	**6,055**	**27,133**	**932**	**337**	**2,201**	**11**	**275**	**4**	**36,948**
Purchased at 31 March 2008	6,502	26,242	812	603	2,929	24	1,911	0	39,023
Donated at 31 March 2008	0	2,054	0	0	31	0	0	0	2,085
Total at 31 March 2008	**6,502**	**28,296**	**812**	**603**	**2,960**	**24**	**1,911**	**0**	**41,108**

9.2 Analysis of Tangible Fixed Assets

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account*	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
Protected assets at 31 March 2008	6,502	28,296	812	-	-	-	-	-	35,610
Unprotected assets at 31 March 2008	-	-	-	603	2,960	24	1,911	-	5,498
Total at 31 March 2008	**6,502**	**28,296**	**812**	**603**	**2,960**	**24**	**1,911**	**-**	**41,108**
Protected assets at 1 April 2007	6,055	27,133	932	-	-	-	-		34,120
Unprotected assets at 1 April 2007	-	-	-	337	2,201	11	275	4	2,828
Total at 1 April 2007	**6,055**	**27,133**	**932**	**337**	**2,201**	**11**	**275**	**4**	**36,948**

9.3 The net book value of land, buildings and dwellings at 31 March 2008 comprises of:

	31 March 2008	31 March 2007
	£'000	£'000
Freehold	35,470	33,980
Long leasehold	140	140
Short leasehold	0	0
Total	**35,610**	**34,120**

9.4 Intangible Fixed Assets

The trust did not hold any intangible fixed assets as at 31st March 2008.

10. Stocks and Work in Progress

	31 March 2008	31 March 2007
	£'000	£'000
Raw materials and consumables	1,870	1,216
Work-in-progress	0	0
Finished goods	0	0
Total	**1,870**	**1,216**

11. Debtors

	31 March 2008	31 March 2007
	£'000	£'000
Amounts falling due within one year:		
NHS debtors	4,771	3,316
Provision for irrecoverable debts	(24)	(364)
Other prepayments and accrued income	538	250
Other debtors	422	693
Sub Total	**5,707**	**3,895**
Amounts falling due after more than one year:		
NHS debtors	48	85
Provision for irrecoverable debts	0	0
Other prepayments and accrued income	0	0
Other debtors	0	0
Sub Total	**48**	**85**
Total	**5,755**	**3,980**

No provision has been made as at 31 March 2008 for impairment of NHS debtors (£334,000 – 31 March 2007). The provision for irrecoverable debts relates to non-NHS debts.

There is no recent history of default within NHS non-impaired debts. The ageing analysis of these non-impaired debts is as follows:

	31 March 2008	31 March 2007
	£'000	£'000
Up to three months	1093	1107
In three to six months	499	624
Over six months	0	0
	1,592	**1,731**

12 Investments

12.1 Current Asset Investments

The trust did not hold current asset investments in the year to 31st March 2008.

12.2 Fixed Asset Investments

The trust did not hold fixed asset investments in the year to 31st March 2008.

13. Creditors

	31 March 2008	31 March 2007
	£'000	£'000
Amounts falling due within one year:		
Bank overdrafts	0	0
Current instalments due on loans	0	0
Interest payable	0	0
Payments received on account	0	0
NHS creditors	612	1,788
Tax and social security costs	19	668
Obligations under finance leases and hire purchase contracts	0	0
Capital creditors	753	474
Other creditors	2,869	1,862
Accruals and deferred income	347	781
Sub Total	**4,600**	**5,573**
Amounts falling due after more than one year:		
Long - term loans	0	0
Obligations under finance leases and hire purchase contracts	0	0
NHS creditors	0	0
Other	0	0
Sub Total	**0**	**0**
Total	**4,600**	**5,573**

Other Creditors include £324,149 outstanding pension contributions at 31st March 2008 (31 March 2007 - £302,932). There are no payments due in future years under arrangements to buy out the liability for early retirements over five years.

Capital creditors of £473,647 were included in other creditors in 2006/07. The 2006/07 comparatives have been restated to make them consistent with the 2007/08 disclosure.

14. Provisions for Liabilities and Charges

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Restructur-ings	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April 2007	0	0	12	0	247	259
Change in discount rate	0	0	0	0	0	0
Arising during the year	0	0	17	0	0	17
Utilised during the year	0	0	(3)	0	(10)	(13)
Reversed unused	0	0	0	0	0	0
Unwinding of discount	0	0	0	0	8	8
At 31 March 2008	**0**	**0**	**26**	**0**	**245**	**271**
Expected timing of cashflows:						
Within one year	0	0	26	0	18	44
Between one and five years	0	0	0	0	39	39
After five years	0	0	0	0	188	188
Total	**0**	**0**	**26**	**0**	**245**	**271**

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. From 1 April 2005 this rate is 2.2%. 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 2008 has £652,514 (£579,152 – 31 March 2007) in respect of clinical negligence liabilities of the trust included in its accounts.

15. Movement in Taxpayers' Equity

		2 Months to 31 March 2007
	£000	£000
Taxpayers' equity at 1 April 2007	44,936	42,259
Surplus for the period	7,659	871
Public dividend capital dividends	(1,404)	(291)
Fixed asset impairment	(109)	0
Gains from revaluation of purchased fixed assets and current asset investment	2,348	0
Net gains / (losses) on available sale investments	0	0
New public dividend capital received in year	0	3,260
Public dividend capital repaid in year	0	(1,150)
Public dividend capital repayable	0	0
Public dividend capital written off	0	0
Other movements in public dividend capital in year	0	0
Additions/(reductions) in donated asset reserve	(82)	(13)
Additions/(reductions) in other reserve	0	0
Taxpayers' equity at 31 March 2008	**53,348**	**44,936**

16. Movement in Public Dividend Capital

		2 Months to 31 March 2007
	£000	£000
Public dividend capital at 1 April	38,905	36,795
New public dividend capital received	0	3,260
Public dividend capital repaid in period	0	(1,150)
Public dividend capital repayable (creditor)	0	0
Public dividend capital written off	0	0
Other movements in public dividend capital in year	0	0
Public dividend capital at 31 March	**38,905**	**38,905**

17. Movements on Reserves

	Revaluation Reserve	Donated Asset Reserve	Available for sale investments reserve	Other Reserves	Income and Expenditure Reserve	Total
	£000	£000	0	£000	£000	£000
At 1 April 2007 as previously stated	4,349	2,058	0	0	(376)	6,031
Prior Period Adjustments	0	0	0	0	0	0
At 1 April 2007 as restated	4,349	2,058	0	0	(376)	6,031
Transfer from the income and expenditure account	0	0	0	0	6,255	6,255
Fixed asset impairments	0	0	0	0	0	0
Surplus/(deficit) on other revaluations of fixed assets	2,239	0	0	0	0	2,239
Revaluations of available for sale investments - gross	0	0	0	0	0	0
Revaluations of available for sale investments - tax	0	0	0	0	0	0
Transfer of realised profits (losses) to the Income and Expenditure reserve	0	0	0	0	0	0
Net gains/(losses) on available for sale investments through the income and expenditure account	0	0	0	0	0	0
Receipt of donated/ government granted assets	0	0	0	0	0	0
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated/government granted assets	0	(82)	0	0	0	(82)
Other transfers between reserves	(423)	0	0	0	423	0
Other movements on reserves	0	0	0	0	0	0
At 31 March 2008	**6,165**	**1,976**	**0**	**0**	**6,302**	**14,443**

18. 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 five 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 £16,100,000 in 2007/8 (£11,600,000 in 2006/7). The trust borrowed/repaid a net £0 in 2007/08 (£0 in 2006/7) and at 31 March 2008 had £0 of outstanding borrowing (£0 at 31 March 2007) The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £12.1m, and

(ii) Approved working capital facility of: not to exceed £4.0m

Financial Ratio	Actual 2007/08	Plan 2007/08
Maximum Debt / Capital Ratio	0%	0%
Maximum Dividend Cover	3x	3x
Maximum Interest Cover	0%	0%
Maximum Debt Service Cover	0%	0%
Maximum Debt Service to Revenue	0%	0%

The trust has an approved working capital facility of £4.0m (£4.0m in 2006/7). The trust had drawn down £0 of its working capital facility at 31 March 2008 (£0 at 31 March 2007).

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.

19. Notes to the Cash Flow Statement

19.1 Reconciliation of operating surplus to net cash flow from operating activities:

	2007/08	2006/07
	£000	£000
Total operating surplus (deficit)	7,004	805
Depreciation and amortisation charge	2,869	440
Fixed asset impairments	592	0
Fixed asset reversal of impairments	0	0
Transfer from donated asset reserve	(82)	(13)
Other Movements	(2)	450
(Increase)/decrease in stocks	(654)	8
(Increase)/decrease in debtors	(1,775)	42
Increase/(decrease) in creditors	(973)	670
Increase/(decrease) in provisions	12	(112)
Net cash inflow/(outflow) from operating activities before restructuring costs	**6,991**	**2,290**
Payments in respect of fundamental reorganisation/restructuring	0	0
Net cash inflow from operating activities	**6,991**	**2,290**

19.2 Reconciliation of net cash flow to movement in cash and liquid resources:

	2007/08	2006/07
	£000	£000
Increase/(decrease) in cash in the period	862	3,243
Cash inflow from new debt	0	0
Cash outflow from debt repaid and finance lease capital payments	0	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	0	0
Change in net debt resulting from cashflows	862	3,243
Non - cash changes in debt	0	0
Net debt at 1 April 2007	8,624	5,381
Net debt at 31 March 2008	**9,486**	**8,624**

19.3 Analysis of changes in cash and liquid resources

	As at 31 March 2008	Changes in period	As at 31 March 2007
	£'000	£'000	£'000
Cash at bank and in hand	9,486	862	8,624
Current asset investments	0	0	0
Total	**9,486**	**862**	**8,624**

Cash at bank and in hand as at 31/3/2008 includes £5,349,934 in respect of balances held in the Office of Paymaster General.

20. Capital Commitments

Commitments under capital expenditure in the Balance Sheet were £214,394 (£211,660 - 31 March 2007).

21. Post Balance Sheet Events

There are no disclosable Post Balance Sheet Events.

22. Contingencies

	2007/08 £000	2006/07 £000
Gross contingent liabilities	17	12
Amounts recoverable	0	0
Net value of contingent liabilities	**17**	**12**

The contingent liabilities relate to two employee liability claims.

The trust does not have any contingent assets at 31st March 2008.

23. 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 1st 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 Trust.

The Department of Health is regarded as a related party. During the year The Royal Orthopaedic Hospital NHS 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. These entities are listed below:

- Department of Health
- West Midlands Strategic Health Authority
- London Strategic Health Authority
- Birmingham East & North PCT
- Dudley PCT
- Heart of Birmingham PCT
- South Birmingham PCT
- Sandwell PCT
- Warwickshire PCT
- Worcestershire PCT
- Birmingham Childrens Hospital NHS Foundation Trust
- Heart of England NHS Foundation Trust
- University Hospital Birmingham NHS Foundation Trust

In addition, the trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

- HM Customs & Excise
- Inland Revenue
- NHS Pensions
- NHS Litigation Authority
- Birmingham City Council
- NHS Purchasing and Supply Agency

The trust has also received revenue payments from a number of charitable funds, certain 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 £12,415 during the year.

24 Private Finance Initiatives

The trust did not have any Private Finance Initiative schemes as at 31 March 2008.

25 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.

Liquidity Risk

The trust's operating costs are incurred under service level agreements with NHS Primary Care Trusts 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 £4,000,000 working capital facility. 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.

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.

Foreign Currency Risk

The trust has negligible foreign currency income or expenditure.

25.1 Financial Assets

	Floating rate
	£000
Denominated in £ Sterling	9,486
In other currencies, restated in £ sterling	0
Gross financial assets at 31 March 2008	**9,486**
Denominated in £ Sterling	8,624
In other currencies, restated in £ sterling	0
Gross financial assets at 31 March 2007	**8,624**

25.2 Financial Liabilities

	Floating rate
	£000
Denominated in £ Sterling	0
In other currencies, restated in £ sterling	0
Gross financial liabilities at 31 March 2008	**0**
Denominated in £ Sterling	0
In other currencies, restated in £ sterling	0
Gross financial liabilities at 31 March 2007	**0**

25.3 Financial Assets and Liabilities

Set out below is an analysis, by category, of the trust's financial assets and liabilities as at March 31st 2008. Fair value approximates to the book value because of the short maturity of these instruments.

25.3a Financial Assets

	Total	Loans and receivables	Assets at fair value through the I&E *	Held to maturity	Available-for-sale
	£000	£000	£000	£000	£000
Assets as per balance sheet					
Fixed asset investments	0	0	0	0	0
NHS Debtors (net of provision for irrecoverable debts)	4,747	4,747	0	0	0
Accrued income	0	0	0	0	0
Other debtors	422	422	0	0	0
Current asset investments	0	0	0	0	0
Cash at bank and in hand	9,486	9,486	0	0	0
Total at 31 March 2008	**14,655**	**14,655**	**0**	**0**	**0**
Fixed asset investments	0	0	0	0	0
NHS Debtors (net of provision for irrecoverable debts)	2,952	2,952	0	0	0
Accrued income	0	0	0	0	0
Other debtors	693	693	0	0	0
Current asset investments	0	0	0	0	0
Cash at bank and in hand	8,624	8,624	0	0	0
Total at 31 March 2007	**12,269**	**12,269**	**0**	**0**	**0**

25.3b Financial Liabilities

	Total	Loans and receivables	Liabilities at fair value through the I&E *
	£000	£000	£000
Liabilities as per balance sheet			
Bank overdrafts	0	0	0
Loans	0	0	0
Interest Payable	0	0	0
NHS Creditors	(612)	(612)	0
Other creditors	(2,869)	(2,869)	0
Accruals	(163)	(163)	0
Finance lease obligations	0	0	0
Total at 31 March 2008	**(3,644)**	**(3,644)**	**0**
Bank overdrafts	0	0	0
Loans	0	0	0
Interest Payable	0	0	0
NHS Creditors	(1,788)	(1,788)	0
Other creditors	(1,862)	(1,862)	0
Accruals	(781)	(781)	0
Finance lease obligations	0	0	0
Total at 31 March 2007	**(4,431)**	**(4,431)**	**0**

26. 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.