Annual Report & Accounts 2008›2009

This annual report covers the period 1 April 2008 to 31 March 2009

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 2008-2009

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Section 1

Chairman's Statement

I am delighted to be making my first report as Chairman of The Royal Orthopaedic Hospital NHS Foundation Trust. Since I took up the appointment in November I have quickly come to appreciate the excellent work that is undertaken at the Trust and the reputation that it has developed both locally and internationally as a foremost centre for routine and leading edge orthopaedic treatment.

For patients this means that they are receiving the very best care possible and this view is reflected in the independent assessments that the Trust receives each year from Monitor and the Healthcare Commission, the two organisations that are responsible for regulating our services. On important measures such as standard of care and safety and cleanliness the Trust scored very highly and this reflects the focus and attention that everyone at the Trust pays to these matters on a daily basis.

We are still finding the maintenance of the 18 Week Referral to Treatment Target for non-admitted patients a challenge as there are a number of issues, particular to specialist orthopaedic Trusts, that make the consistent achievement of this target so difficult. The number of patients treated at the Trust has increased over the year and we are constantly looking at ways in which we can improve our own efficiency without compromising patient care.

On a financial note the Trust has been very successful over the past year and as you will see later in this report has recorded a surplus. During the year we were awarded the very highest rating by Monitor for our financial management; an improvement on our performance last year.

As a Foundation Trust good financial management is an important part of our own wellbeing and it enables us to develop the services and care that we already provide. One of the major capital initiatives that we have already initiated is the development of a new Outpatient Department. Plans are well progressed and building work will start in late spring 2009. In preparation for this work we have relocated a number of departments on site and when the development is complete the configuration of the outpatient and associated departments will be far more suitable for those patients with restricted mobility.

Our Members' Council has been very much involved in Trust matters during the year, working on various committees looking at membership, governance and capital development in addition to regular Council and joint Board meetings. The Members' Council also led the recruitment process for a new chairman, which took place over the summer and culminated in my appointment in November.

Since joining the Trust I have worked closely with the Members' Council to understand how the two Boards can work closer together and the wealth of skills and experience of members used to the full. It is a continuous learning process for us all and one that will undoubtedly benefit patients both in the short and long term.

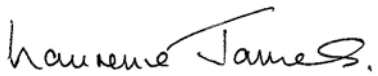
The context in which the Trust operates is an ever-changing one. The Darzi Review, World Class Commissioning by PCTs and a new Operating Framework have all been considered by the Board and taken into account within our plans for the future. We are an ambitious Trust and we have plans to build upon our position as an internationally renowned centre for the treatment of bone and joint disorders and the care

of children with orthopaedic problems. It is a challenging goal but one we believe is within our grasp although we recognise that the external factors that impinge upon the Trust will present us with some significant challenges.

As I have experienced, there is something 'special' about The Royal Orthopaedic Hospital and it is this essence that makes the difference. Our staff are excellent and consistently demonstrate the highest levels of commitment and dedication. We have an extensive group of loyal and hard working volunteers that support us in our efforts to improve the experience of patients when they visit and we have a Board and Members' Council that challenge and support the Trust in the achievement of its goals. It is an excellent team that works together in the pursuance of a common goal - to provide the very best standard of care in a safe, clean and friendly environment.

At the very end of this financial year, the Trust received the resignation of one of its Executive Directors, Andrew Crawshaw, the Director of Operations. He had wrestled with the challenge of 18 weeks and finally saw the Trust achieve the target as a final reward for his efforts. We wish him well in his future career.

Finally I would like to thank my predecessor, Les Lawrence, for the contribution that he made to the Trust during his seven year tenure. Les has been a passionate supporter of the Royal Orthopaedic Hospital over these years and he was instrumental in the Trust attaining Foundation Trust status in 2007. I look forward to building upon his legacy and playing my part in the achievement of the long-term vision for the Trust.



Laurence James
Chairman

Section 2

Chief Executive's Preface

2008/2009 has been one of the most challenging in the Trust's history. Our clinical teams have, over the years, built on the reputation of the Trust for excellent orthopaedic services by focusing on listening to patients, providing first rate in-house triage and then delivering second-to-none surgical and therapeutic interventions. The esteem in which our patients hold us is witnessed through our membership, letters of thanks and the number of recommendations they make regarding our services.

This year, however, we have faced the major challenge of delivering a referral to treatment target of 18 weeks for our admitted and non-admitted patients. We knew at the outset that the Department of Health had recognised the significant difficulties faced by certain specialties in meeting this target and that orthopaedics was one of these. We also knew that, as a single specialty Trust, there was no way to balance our performance against that of another service that could easily meet the target. We also entered the year having not met the milestones set for March 2008.

Over the year we have made huge strides in tackling this. Our information systems, developed in-house to compensate for the lack of a national system, now allow us to track patient pathways in detail. Our clinicians have adopted new ways of working that ensure they use data to assess their own performance against the target and our processes for scans and therapy interventions have been dovetailed into care pathways so that delays are minimised. Our theatre efficiency has continued to rise and we have boosted theatre capacity by using off-site facilities.

Nonetheless, there have been some aspects over which we have had little or no control. The volume of referrals for spinal treatment has grown beyond our capacity to meet demand within 18 weeks and we know this is a systemic problem across the country with a national shortage of spinal surgeons. As a tertiary centre receiving referrals from other Trusts, we know that we remain at risk from any delays in their processes (these can result in late referrals to us, close to the 18 week deadline). This can mean that we, as the receiving Trust, are unable to meet the target, given the time needed for diagnosis and treatment after the patient is referred to the Royal Orthopaedic Hospital.

Our performance in all areas other than that of 18 weeks referral to treatment was extremely strong throughout the year, and by year-end this target had also been achieved. Nonetheless, the Trust recognises the need to maintain these national targets in 2009/10 and that this remains a challenge. As we move into 2009/10, we shall consider still more revisions to the way we do things and will actively engage our medical teams in developing solutions appropriate to their sub-specialty and continue to work with colleagues locally and nationally to assist in solving some of the national capacity issues.

I am pleased that the Trust has been able to maintain its focus on the delivery of quality outcomes and keep infection rates at a minimum. The Board and staff are each committed to enhancing the patient experience at our Trust by building on our clinical excellence and offering quality support in all areas.

I have confidence that our team of people at the Royal Orthopaedic Hospital will rise to the challenge yet again and build on the reputation of the Trust as we move through our major anniversary of 100 years on site at The Woodlands.

Penny Venables
Chief Executive

Section 3

Directors' Report

Principal Activities and Business Review

The Royal Orthopaedic Hospital was established as an NHS Trust in 1995 and founded under the National Health Services Act 2006 as The Royal Orthopaedic Hospital NHS Foundation Trust on the 1 February 2007. The Trust is located within 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, the North of England and Wales.

The principal activities of the Trust in 2008/09 were the provision of orthopaedic services to patients primarily from the West Midlands but also from across the UK.

Operational Risk

It is clear that a significant risk remains around the delivery of the 18 week target as the Trust is a single specialty orthopaedic hospital and has faced immense challenges to reach its current position. At the end of March 2009 the Trust achieved the 18 week targets. The Trust had to meet a significant challenge to build capacity to meet the peaks of demand in order to meet this target. This necessitated the appointment of new staff and greater use of theatre facilities in the private sector. Demand seems to have settled at above the previous level, due in part to the stimulating effect on patient expectations as a result of much reduced waiting times.

The management of medicines was greatly improved through the introduction of an external pharmacy management system and this will be further reviewed in early 2009.

Looking ahead, the Trust aims to consolidate and extend the progress made in this area and also continue its work in building an organisation and culture that is able and capable not only of responding to change but of being pro-active within the health economy.

One major change that will be realised in 2009 will be the move to an offsite decontamination facility. The Trust is the last organisation in Birmingham to move to this facility and extensive preparation has taken place with the Commercial Directorate of the Department of Health as well as the external decontamination provider to minimise risks linked to this facility.

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.

Financial Risk

The Trust is preparing itself to meet the challenges around the implementation of HRG v4 and the new tariff with a negative impact of significance

due to the changes in Market Forces Factor application. We continue to lobby nationally with other hospitals within the Specialist Orthopaedic Alliance to ensure the specialist nature of orthopaedic work undertaken is recognised. We are also continuing dialogue with the Payment by Results Team at the Department of Health to ensure that concerns are heard, particularly in relation to spinal surgery.

As we move forward into 2009/10, our plans will need to reflect our response to the next phases of NHS reform, in particular the impact of the NHS Next Stage (Darzi) Review which is likely to have significant impact on the development of our business, as will increased regulation, higher standards in the delivery of services and the drive to provide more care in the community.

All these will test the organisation's resilience and capacity to adapt and respond and the Trust is already taking measures to increase and develop its clinical leadership to meet these new challenges.

Directors holding office during 2008/09

The following persons served as directors during the year:

Mr Les Lawrence	Chair until 31st October 2008
Mr Laurence James	Chair from 1st November 2008
Professor Andrew Stevens	Vice Chair and Senior Independent Director
Mr Roger Otto	Chair of Audit Committee
Dr Elizabeth Hensel	Vice Chair of Audit and Integrated Governance Committees
Mr Chris Monk	Non-Executive Director
Mr Bob Millinship	Non-Executive Director
Mrs Penny Venables	Chief Executive
Mr Graham Bragg	Deputy CEO/Executive Director of Finance
Mr Andrew Thomas	Medical Director
Mr Andrew Crawshaw	Director of Operations
Mrs Lindsey Webb	Director of Nursing and Governance

The biographies of our Non-Executive Directors are detailed later in the report and these, plus their register of interest declarations, serve to demonstrate their continued independence.

Review of the Year

This review highlights the work of the Trust over the last year and describes its quality, operational and financial performance in key areas. The organisation has performed very well across a range of indicators, coping with a changing case mix, significant demands on some specialist services whilst maintaining negligible levels of healthcare acquired infection and implementing enhanced IT systems to underpin data integrity. The clear focus of the organisation remains its patients. Staff have worked diligently to ensure that patient needs come first and improvements in administration, management training and internal communication systems have ensured that good ideas are spread throughout the organisation. The team has had to work harder and smarter to meet national targets, with everyone in the organisation focused on the key issues of delivery.

Responding to People

Over the last year the Trust has focused its work to ensure that the needs of patients, stakeholders and commissioners are met. The work of the organisation in tackling key issues of infection control, responding to patient feedback and identifying how best to engage with the public has resulted in innovative approaches that have, in some cases, gained external recognition.

A Members, Patient and Public Involvement Strategy was developed and approved with wide consultation. This strategy provides a framework for putting the patient at the heart of

the Trust's activity and connects all aspects of public involvement across the organisation as a whole. The Trust has utilised a research-based 'engagement tool' for building in patient views to the design of its new Outpatient Department so that it reflects patient aspirations as well as organisational demands.

The Patient Council has continued its role in the development of information and environmental inspection and has also informed a number of service re-design projects.

Organisational Changes

In response to the need for greater focus on the Trust's strategic direction, the Trust Board supported a change in the role of the Deputy Chief Executive to embrace strategic development. As a direct result, whilst this main Board member retains full accountability for financial matters in the Trust, the Deputy Director of Finance moved into the role of Finance Director. This change is made on a 12 month basis with an interim and end of term review, retaining an option to return to the original roles as necessary.

The Director of Operations left the Trust in March 2009 and will be replaced as soon as possible with the role being covered on an interim basis pending an appointment. One of the Clinical Service Unit managers (CSMs) left the Trust in February and we are grateful to the significant cover provided by the remaining two CSMs during the transitional period. The Trust paved the way for a strengthened clinical management structure by creating new corporate clinical director roles for consultants, further embedding a culture of medical engagement and leadership.

Activity has been at planned levels and contractual thresholds have been met. Quality issues have been addressed through the revised governance and operational structures within the organisation.

Looking Forward to 2009/10

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 continued 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 major capital scheme to be commenced on site during the year 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.

The key financial risks facing the Trust during the coming year 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 acceptable financial parameters.

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.

Directors' Obligations

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

The directors confirm that the above requirements have been complied within the financial statements. In addition, the directors are responsible for maintaining adequate accounting records and sufficient internal controls to safeguard the assets of the Trust and to prevent and detect fraud or any other irregularities, as described further in the Statement of Accounting Officer's Responsibilities.

Audit arrangements

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 Auditors' remuneration for 2008/09 was £55,000.

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

Valuation of Fixed Assets

In 2008/09 the Trust has revalued its fixed assets base using the market equivalent asset method to bring it in to line with International Financial Reporting Standards and to better reflect the true value of the asset base in a falling market. The Trust has recognised an exceptional loss on the revaluation of £1.4m in the Income and Expenditure Account with a total write down of assets of £2.8m.

Political and Charitable Donations

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

Post Balance Sheet Events

The 2008/09 annual accounts include a post-balance sheet event referring to the contract due to be signed early in 2009 for a new outpatients development with an approximate value of £7million. The project has a proposed build time of 12 months.

Equality and Diversity

The Trust has established a group called the Equality Committee that is chaired by the Deputy Director of HR and is taking forward important developments in this area. This includes overseeing the training plan on Equality Impact Assessments and overseeing the policies and procedures and updating of the Single Equality Scheme within the Trust.

The Trust is committed to an active approach to equal opportunities from recruitment and selection through training and development, appraisal and promotion to retirements. It is our policy to promote an environment free from discrimination, harassment and victimisation, where everyone will receive equal treatment regardless of gender, colour, ethnic or national origin, disability, age, marital status, sexual orientation or religion. All decisions relating to employment practices will be objective, free from bias and based solely upon work criteria and individual merit. The Trust has a Single Equality

Scheme linked to an action plan that is monitored via its Workforce and Organisational Development Committee. This can be found on our website www.roh.nhs.uk. Work in this area continues to develop and will be built upon in 2009/10.

The Trust has a dedicated room for all staff, visitors and patients for spiritual use; the Prayer, Mediation and Contemplation Room. The room has resources and facilities for multi-faith use. The room is open at all times with the resources being held in individual cupboards, allowing change of use by the user. The room is also used for regular services, which are open to all.

The Trust has links with multi-faith representatives to ensure the room and facilities are reviewed regularly and are suitable for all. Additionally, a number of hospital chaplains, representing a variety of religious bodies, regularly visit patients on the wards.

Consultation with Staff

The Information and Consultation of Employees Regulation 2004 came into force on 6 April 2005. The regulations give the Foundation Trust's workforce the right to be informed and consulted about certain employment issues in their workplace. The Trust complies in full with the regulations. The Trust maintains an excellent and active relationship with the Trust Consultative Committee (TCC). The TCC voices and discusses 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.

The programme of core briefing continued during the year. 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.

Comprehensive consultation has taken place with appropriate members of the workforce when service changes have taken place. Trades Union colleagues have been fully engaged in these processes.

Health and Safety at Work

The Trust takes its responsibilities for the health and safety of its staff and patients very seriously. Throughout the year work has taken place to raise awareness of security issues and improve lockdown procedures. More robust procedures for staff in dealing with violent and aggressive individuals and lone working have been developed and links with the local police station have been established, with a variety of drop in sessions and police initiatives taking place on site.

Procedures have been put in place to ensure that contractors are fully aware of their responsibilities regarding health and safety alongside more robust mechanisms for making staff aware of Health and Safety policies.

Risk assessment training has now taken place for 22 members of staff (either Heads of Department or those nominated as having health and safety risk assessment responsibilities). As part of the Trust's approach to corporate management responsibility being devolved to areas of work, further training sessions are being provided for managers/nominated persons and this will continue throughout the next year until all areas have a responsible, competent person to carry out risk assessments.

All trained staff are provided with a risk assessment folder which contains the Royal Orthopaedic Hospital Risk Assessment Policy and the HSE 5-step approach to risk assessment used by the Royal Orthopaedic Hospital.

Key staff and members of the Board have received training on the Corporate Manslaughter Act and the Trust has benchmarked itself against recommended best practice to ensure it fulfils its obligations.

Occupational Health

The Trust has a Service Level Agreement in place with University of Birmingham Hospitals NHS Foundation Trust for the provision of Occupational Health Services. This service is open to all staff and has strong working links with the Human Resources Department in relation to staff sickness and support.

External Consultations

The Trust has responded to a range of consultations from aspirant Foundation Trusts in the West Midlands and to various documents affecting Trust contracts and authorisations. The Trust was pleased to be at the forefront in securing responses to a consultation on the NHS Constitution where over 600 members submitted their views. This demonstrates the level of interest and engagement of our members in broader NHS issues.

Specialist Orthopaedic Alliance

The Trust's Chief Executive was elected as Chair of the Specialist Orthopaedic Alliance in recognition of her leadership and consensual style This group ensures that the broad interests of those providing orthopaedic services are recognised and that any necessary lobbying for change takes place effectively and in a cohesive manner, while allowing member organisations to continue to operate in their own individual ways, in response to local circumstance. This group continues to argue for specialist commissioning of orthopaedic services.

Quality and Clinical Governance

The Trusts' assessment for the 2007/08 Annual Health Check scored 'good' for Quality of Services and 'excellent' for Use of Resources. The current declaration is on our website at www.roh.nhs.uk. The results of the 2008/9 declaration will be available in October 2009.

The Trust saw its second Annual Hygiene Code Inspection in December 2008 and noted significant progress year on year in relation to this area. The Trust fully met three of the four duties on which it was inspected. The duty that the Trust was found to be in breach of was as a result of not meeting one of the eight sub-duties within it regarding environmental policies. Work is already underway to address this and will be completed in 2009.

Later in this report is a full Quality Report that outlines actions to date and plans for the coming year.

Patient Feedback

A 'real time' patient survey has been conducted for much of the year and is an example of the added value offered by the integration of volunteers into the heart of the organisation's capability. The survey provides valuable feedback at a local level so that individual wards can respond very quickly to adverse feedback and can benchmark themselves within the organisation. In general, this has reinforced the findings of the national survey and resulted in key pieces of work to improve patient information and food.

Recognising Excellence

The Trust was pleased to welcome in May 2008 the Executive Chairman of Monitor, Bill Moyes. His visit allowed us to showcase some of our work on infection control and innovations in patient outcome recording. He met privately with representatives of our Members' Council and took questions from Board and Council members in open session.

Infection Prevention and Control

The Trust has worked hard to develop a model of practice for infection prevention and control that is universally adopted within the organisation. Interactive events have been used to teach all staff and volunteers about infection prevention and control and the use of fun activities and illuminating presentations have helped to get the message embedded within the Trust. During the year our Head of Infection Control and her team gained an IPCT Award through the British Journal

of Nursing.

Staff Development, Awards and Long Service

The annual awards celebration for staff allowed a real celebration of service and achievement from long-service awards to gaining first and advanced level clinical and customer care qualifications. The Trust's learning and development processes encourage staff to undertake top-up training in a wide range of clinical and non-clinical areas that offer support for them as professionals and employees.

NHS 60

The Trust participated in or organised events to mark 60 years of the NHS in July 2008. Two tickets were allocated to the Trust for the national service of celebration at Westminster Abbey on the 2nd July. In recognition of their commitment to the hospital over many years, these were allocated to Joan Barwick, Vice-Chairman of the League of Friends' Volunteers and John Comiskey, the Trust's longest serving employee.

The Trust was also asked to nominate a member of staff to be put forward for selection for invitation to a special Royal Garden Party at Buckingham Palace in July. Dia Martin from Theatres was successfully nominated and went along to what she described as a 'wonderful day'.

Rosemarie Seaton-Smith was also one of the lucky nominees for an invitation to a special NHS 60 event at 10 Downing Street, hosted by the Prime Minister Gordon Brown and his wife Sarah. Rosemarie trained at the hospital and retired in 2008, having latterly been sister on the Day Case Unit.

On the 4th July a special event was held for staff to celebrate NHS 60. The Catering Department provided a special afternoon tea and cakes with a 1940s theme. Special mugs marking 60 years of the NHS at the Royal Orthopaedic Hospital were produced for each member of staff, and t-shirts and other goodies were also available.

Emergency Planning

The Trust is classified as a Category 1 Responder under the Civil Contingencies Act 2004. It has in place both major incident and business continuity plans and has undertaken table top exercises to test the resilience of its plans during 2008/09.

The Trust has focused on developing, testing and implementing a Pandemic Flu Plan. This has been done in collaboration with other key stakeholders and memorandums of understanding have been established with neighbouring organisations.

Environment

The Trust recognises its responsibilities with respect to the environment and we focus on reducing our environmental impact by using less, recycling more and disposing of waste sensitively and we remain committed to reducing our carbon footprint. The Trust is installing new, efficiently fuelled boilers in the Nurses' Home and administration building and is pursuing sustainability by joining the NHS Forest Scheme. The new Outpatients Department will be more energy efficient and meet BREEAM standards on insulation and energy usage. The Trust is working on recycling initiatives for aluminium cans and waste paper and is piloting a composter scheme.

Better Payment Practice

The Trust paid 85% of invoices within 30 days against the target of 95%. The average time taken to pay invoices was 22.4 days. The Trust did not incur any late payment penalties during 2008/09 under the Late Payment of Commercial Debts (Interest) Act 1998.

Compliance with the Cost Allocation and Charging Requirements

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

Freedom of Information (FOI) Act

The Trust met the deadline of 1st January 2009 for implementation of the new FOI Publication Scheme and has continued to comply with the requirements of the Act to meet deadlines for information wherever possible. The Trust has seen a rise in the rate of requests for information during the year but believes that the availability of more information via its website will make responding to queries more efficient in future. The nature of enquiries has also followed a pattern of more requests being generated to NHS organisations en masse as part of media or interest group research.

Data Protection Act

The Trust has complied with the requirements of the Data Protection Act and has had no reportable incidents with regard to the loss of patient data.

Serious Untoward Incidents relating to data loss and breaches of confidentiality

There have been no SUIs with regard to data loss or breaches of confidentiality.

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.

Remuneration and Pensions Disclosures

Details of senior employees' remuneration can be found in the remuneration Report on pages 43 to 44 and accounting policies for pensions 1.19 can be found on pages 65.

Management Costs

Management costs, calculated in accordance with the Department of Health's definitions, were 5.8%.

Sickness absence data

The Trust reported the following days as lost to sickness absence in each of the four quarters of 2008/09:

April – June	2,238.16
July – September	2,661.93
October – December	3,760.04
January – March	3,112.08

Going Concern

After making enquires, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they have adopted the going concern basis in preparing the financial statements.

Section 4

Quality Report

Statement from Chief Executive

The top priority of both the Board and staff within the Royal Orthopaedic Hospital is to continually improve the quality of the care we offer to our patients. During the course of the year we have signed up to the National Patient Safety Campaign and taken greater strides to improve and maintain the outstanding care we constantly strive to deliver. I would like to take this opportunity to thank all of our staff for their contribution to this over the last 12 months. We continue to make significant strides in relation to our work on healthcare-acquired infections and are actively embedding new quality and safety initiatives throughout the hospital.

The Trust is wholly committed to quality patient care and the Board has taken steps to ensure that this is reflected in its governance mechanisms and its operational activity. From next year, quality accounts will be prepared as a requirement of equal importance to that of the Annual Report and the statements below prepare for that by giving a comprehensive overview of the quality agenda and delivery within the Trust.

Penny Venables
Chief Executive

Quality Improvement Priorities

During 2008/9 we focused on a number of quality initiatives. These included:

1. To reduce the rates of clostridium difficile infection
2. To increase incident reporting
3. To improve privacy and dignity
4. To reduce complaints
5. To increase patient satisfaction with food

2008/9 Target - to reduce the rates of clostridium difficile infection by 10%

Although the rates of clostridium difficile continued to be below the national average we believed that we could reduce these further.

In 2007/8 there were 22 cases; in 2008/09 there were 6 cases. This demonstrates a reduction of 73%.

However, we believe that we can continue to build on this excellent performance and will be implementing a number of new initiatives in 2009/10:

- Increased auditing of compliance with antibiotic guidelines
- Presentation of all clostridium difficile cases at the surgical audit meetings
- Increased surveillance to identify other areas for improvement e.g. wound infections

(2009/10 target – to improve surveillance of urinary tract and wound infections).

2008/9 Target - to increase incident reporting rates by 5%

In line with national priorities we identified that we could improve the quality of our services by encouraging the reporting of incidents. We did not believe that the incident reporting rates accurately reflected the true extent of safety incident occurrence within the organisation

Current Status

In 2007/8 the Trust reported 1,651incidents. This increased to1,887 in 2008/9, representing an increase of 14%.

Identified areas for improvement

- To improve feedback from incidents to all staff
- To identify learning from incidents more robustly

Current Initiatives in 2008/9

To support this we have identified areas for improvement.

- Local monthly incident reports provided to ward/department managers
- Governance newsletter
- Review of incidents as part of performance management meetings

Initiatives to be implemented in 2009/10:

- Implementation of patient safety leadership walkabouts
- Sharing more widely information on and learning from patient safety incidents

(2009/10 Target – to reduce the % of staff reporting that they do not receive feedback from errors from 25% to 20% as indicated in the Annual Staff Survey)

2008/9 - to improve privacy and dignity using essence of care benchmarking and patient feedback

In line with national priorities to improve privacy and dignity for patients we identified that improvements could be made. We have used the essence of care privacy and dignity benchmark to identify areas for action as well as feedback from the National Patient Survey.

The Trust aims to improve the scoring using the 'Essence of Care' benchmark tool to ensure a minimum score of B in at least 50% of the indicators within the benchmark.

To reduce the numbers of patients saying they share sleeping accommodation with the opposite sex to 5%.

Current Status

The privacy and dignity benchmark contains 7 indicators, with the possibility of a score from A to E for each (A is excellent, E is poor). In March 2009 these were scored as 5 at level B and 2 at level C.

In the 2007 Patient Survey, 10.2% of patients said they shared sleeping accommodation with the opposite sex. In 2008 this had reduced to 8.7% (national average 20.8%). Although unfortunately we did not meet our challenging internal target of 5% the trust does score better than the national average on this question

Identified areas for improvement:

- The admissions ward and daycase unit are not single sex areas

Current Initiatives in 2008/9:

- Provision of privacy and dignity awareness training
- Improved information for patients that are using the admissions ward and daycase unit
- Implementation of notices in all bed spaces reminding all staff to respect the privacy and dignity of patients

Initiatives to be implemented in 2009/10:

- Refurbishment of admissions ward to improve segregation
- Trialling of single sex daycase lists

(2009/10 target – to reduce the numbers of patients saying they shared sleeping accommodation (from 8.9% to 7%) and toilet facilities with the opposite sex in the national patient survey (from 9.6% to 8%))

2008/9 Target - to reduce complaints by 5%

The Trust takes complaints seriously and acts to ensure problems are resolved quickly, to improve experiences for future patients. The Trust is an early adopter site for new arrangements for the handling of complaints.

Current Status

The Trust received 168 complaints in 2008/9 compared to 169 the previous year. At the end of February 2009 the total received was 141 and the Trust was on target to meets its aim of reducing complaints by 5%. Unfortunately during March there was a large number of complaints across a range of areas and issues, which has resulted in the 55 reduction not being achieved.

Our response rates have improved from 58% to 83% being responded to within 25days. Three cases were referred to the Healthcare Commission; one was not upheld, one resulted in an ex-gratia payment and appropriate outstanding recommendations were actioned.

Areas for Improvement

- Feedback to staff and learning from complaints

Current Initiatives 2008/9:

- Local monthly complaint reports provided to ward/department managers
- Governance newsletters
- Reviews of complaints as part of performance management meetings
- Becoming an early adopter for 'Making Experiences Count'

Initiatives to be Implemented in 2009/10:

- Sharing more widely information on and learning from complaints
- Inclusion of 'patient stories' in Board level quality reports

(2009/10 target – to reduce complaints by 5%)

2008/9 Target - to improve patient satisfaction with food as identified in both the national and local patient surveys

The feedback the Trust received from patients indicated that they were dissatisfied with the food that they received whilst in the hospital.

National survey	2007	2008
% of patients who rated hospital food as poor	12.4%	16.6%
% of patients who were not offered a choice of food	7.3%	4.8%

Local survey	April–Dec 08	Jan–March 09
% of patients who rated hospital food as poor	13.9%	8%

The national results suggest that whilst the choice of food has improved the rating in terms of overall quality has worsened. This may be due to the fact that the patient menu did not change until December 2008 and was therefore not reflected in the national survey results. Encouragingly the local patient surveys (completed monthly) demonstrate improvement in patient satisfaction for Jan - March 2009 and this will continue to be closely monitored

Current Achievements:

- Revision and improvements to menu
- Training programmes for catering and nursing staff
- Implementation of Essence of Care food and nutrition benchmark

Initiatives to be Implemented in 2009/10:

- Monthly monitoring of patient feedback
- Improved quality control systems in catering

(2009/10 target – reduce the % of patients who rated hospital food as poor in the national survey from 16.6% to 12%)

Response to Regulators

The Royal Orthopaedic Hospital NHS Foundation Trust's recent declaration to the Care Quality Commission for the 2008/9 Annual Healthcheck indicated compliance with all of the core standards. These results will be published in October 2009.

The results of the 2007/8 Annual Healthcheck published in October 2008 awarded the Trust a rating of 'good' for Quality of Services.

Response to LINKs and to feedback from Members

During the year particular areas of feedback from members and other patient groups have focused on the provision of wheelchairs, food and orthotics.

This has resulted in the purchase of 20 new wheelchairs, the implementation of a maintenance programme for all wheelchairs and a new 'shopping trolley' style system of managing them on a day to day basis.

The Orthotics Service has been successfully re-tendered within the year and early indications show increased satisfaction from both patients and staff alike.

Performance of the Trust against Key Quality Measures

Safety Measures	2007/8	2008/9
1. Cases of MRSA bacteraemias	0	2
2. Cases of Clostridium Difficile	22	6
3. Incident reporting rates/100 admissions* NA	5.39	(expected 4.63)

*taken from NPSA data for April-September 2008)

Although the Trust was within the target trajectory for MRSA it was disappointing to have two more cases than the previous year when there were none. One case related to a transfer from another hospital. As a result of these cases improvements have been made to the care of plaster casts and wounds.

Higher than average reporting rates for incidents indicate a stronger reporting and learning culture and is recognised by the National Patient Safety Agency as a positive variation.

Clinical Outcomes
(all procedures – taken from Dr Foster)

	2007/8	2008/9 (part year)
Patients readmitted within 28 days	172 (expected 197)	45 (expected 50)
In-hospital deaths	16 (expected 17.4)	6 (expected 10.4)
Above expected length of stay	623 (expected 465)	326 (expected 244)

The 'expected' figures are those provided by Dr Foster on what they would 'expect' to see based on their national data for all Trusts. We will develop this further to benchmark against specialist orthopaedic Trusts.

Further work is being undertaken to identify the reason behind the above expected length of stay. Early work suggests that length of stay for routine joint replacements is better than the national average but that the patients admitted for revision procedures with a longer length of stay affect the overall average.

Patient Experience Measures (taken from the National Patient Survey)

	2007	2008
% of patients who would recommend hospital to relative/ friend	83%	85% (67%)
% of patients who were involved in decisions about their care	56%	65% (54%)
% of patients who had enough privacy when discussing condition/treatment	73%	78% (69%)

The figures in brackets denote the national average score for 2008 surveys undertaken by the Picker Institute.

National Targets and Regulatory Requirements

	2007/8	2008/9	08/9 target
Fully met all HCC core standards	23/24	24/24	24/24
Cases of c diff	22	6	21
MRSA	0	2	2
31 day cancer target	100%	100%	98%
31 day extended cancer targets	NA	100%	100%
62 day cancer target	NA	98%	95%
62 days extended cancer targets	NA	100%	100%
18 week referral to treatment admitted	NA	94.82%	90%
18 week referral to treatment non admitted	NA	95.30%	95%
Cancer 2 week waits	100%	100%	100%

The Trust has maintained a governance rating with Monitor of 'green' throughout the year.

The 2008/9 Annual Hygiene Code Inspection was undertaken by the Healthcare Commission Inspection Team in December. The Trust was found to have met the standards required for three of the four duties assessed. In the fourth duty we were found to have breached one of the eight sub-duties regarding environmental policies. Work is already underway to address this and will be fully completed by the summer.

Section 5

Operating and Financial Review

With the appointment of the new Chairman on the 1st November 2008, the Trust has moved forward in the development of its strategic direction. Building on the recommendations from Lord Darzi, it has looked at its clinical leadership and restructured to create a number of Corporate Clinical Director posts leading on clinical outcomes, medical staff education and training, revalidation and research and development. Linked with the development and expansion of the existing clinical director posts, this will build on the Trust's clinical leadership and reflects our approach following the Next Stage Review, as we move into 2009/10.

In addition, the Trust has commenced work on developing robust clinical outcome measures. As a single specialty orthopaedic hospital we are passionate about clinical and patient outcomes; hence the establishment of a clinical director role to lead on this highly important piece of work. From this we will capitalise on the establishment of our Quality Accounts each year and help us to continually monitor and assess the work we undertake to maintain the Trust as an outstanding centre of orthopaedic care.

The Trust understands it needs to embed the work it has undertaken to date to meet the 18 Week Referral to Treatment Target. It still has work to do in relation to the non-admitted target but has recruited a significant number of surgeons over the last 12 to 18 months to move in this direction. In 2008/09 we appointed three new spinal surgeons, one new paediatric orthopaedic surgeon, two arthroscopy surgeons and one arthroplasty and orthopaedic oncology surgeon.

As we work on our future direction, we are looking to engage in a 3 to 5 year relationship with a local private hospital to ensure we have additional physical capacity to deliver national targets. From April 2009, we will have use of a dedicated operating theatre and ward at the BMI Edgbaston Hospital, which will provide an outpost facility for The Royal Orthopaedic Hospital NHS Foundation Trust. It is envisaged we will carry out mainly arthroplasty and arthroscopy cases through this facility and it will allow us the required expansion while we develop the facilities at The Royal Orthopaedic Hospital site.

In 2008/09, we had a full year of working with our private pharmacy provider and saw an improvement in the service provided and the standards for medicines management across the Trust. As we move into 2009/10, however, we are entering a process of recruiting a new provider as our existing provider has indicated they do not wish to continue their contract; this is partly linked to the issues of managing the contract from a geographical distance.

Connecting for Health

The Trust has continued to use Connecting for Health as its key IT platform and undertook a review of its IT infrastructure during the year. This allowed the Trust to consider the benefits of Connecting for Health in the light of the processes undertaken in-year to develop in-house databases and systems to progress 18 weeks tracking and also prepare for the anticipated requirements of cancer target monitoring.

Research and Development

During 2008/9 the Trust has secured new management services for its research work, created a Corporate Clinical Director role for research and begun to work in partnership with others towards the creation of an 'Academic Health Science Centre'. Outcome measures remain high priority for the Trust with an identified objective of longitudinal studies. It is hoped that the Trust will be able to identify work that reviews deep wound infection rates over the next couple of years. The Trust is actively engaged in the work of the National Joint Registry, which, while not of direct support to research, gives benchmark performance data for hip and knee replacements across the UK.

Education and Training

The Trust continues to train undergraduate and post-graduate doctors and to make use of its in-house teaching facility. Clinical training is a high priority and the use of fellows in surgery supports on-the-job training across a broad spectrum of orthopaedics, often supported by clinical research. All staff and volunteers receive mandatory training annually and the Trust offers a good range of professional and basic skill learning opportunities. All mangers now undertake a programme of development covering both strategic and operational issues.

Risk and Governance Structures

The Members' Council is responsible for representing the interests of the Trust's members and partners, for advising on strategy, for appointing the auditors and for appointing the Chairman and Non-Executive Directors of the Trust. The Council has four Committees – Remuneration, Membership, Governance and Environment.

The Board of Directors is a unitary body accountable for decisions on the running of the organisation, its direction and fiduciary control.

The Board has four Committees – Audit as the key scrutinising committee; Integrated Governance as its progress review committee, Remuneration Committee to address terms of employment for Executive Directors and staff pay awards and Charitable Funds of which the Trust Board is a corporate trustee.

During the course of 2008/09, the Trust undertook an internal review of its governance structures looking at all of the minutes, attendance and outputs from its supporting committees. As a result of this piece of work a new Risk Strategy has been developed and a revised format for the Integrated Governance Committee. This Committee is now chaired by a Non-Executive Director and is changing its focus to look at clinical outcomes and patient safety throughout the organisation. As a result of interim evaluation of this, and in response to an external review of governance related to Trust declarations to Monitor, all Board committees will be reviewed early in 2009/10 in order to embed best practice across all committees.

Financial Review 2008/09

Summary of Financial Performance

2008/09 represented the second full year as a Foundation Trust and the Trust has continued to build on its previous year's strong financial performance by generating greater than the target surplus, investing in new services and quality, commissioning new build assets and managing to a low risk. The Trust continues to be a top performer by achieving a financial risk rating of 5.

The 2008/09 Financial Strategy was agreed by the Board of Directors and Members' Council through the annual planning process and the following key objectives were set:

Objective	Outcome
Deliver a minimum surplus of £3.9m	Achieved £3.98m
Achieve a Monitor Risk rating of 5	Achieved a 5 at each quarter
Deliver £2.1m in cost reduction	Achieved £2.1m
Deliver a capital programme of £2.6m	Delivered £1.8m

Performance against Monitor's Compliance Regime – financial metrics

	Actual	Plan	Risk Rating
EBITDA margin	11.8%	11.7%	5
EBITDA Achieved (%)	103.1%		5
Return on Assets	10.7%	10.6%	5
I&E Margin	6.1%	6.1%	5
Liquidity Risk (days)	125	122	5
Overall Risk Rating			5

The Trust achieved its target position of a risk rating of 5, which represents the lowest risk rating available. The Trust managed its financial position to deliver closely to its plan.

Activity

The actual performance for the period is shown below:

	2008/09			2007/08	
	Actual	Plan		Actual	
	Treated	Treatment	Variance	Treated	Variance
Admitted Patient Care					
Elective	6,853	7,323	-470	7,130	-277
Non-Elective	498	535	-37	465	33
Day Cases	9,208	8,458	750	8,564	644
Total Admitted					
Patient Care	16,559	16,316	243	16,159	400
Outpatients					
First Appointment	18,209	17,462	747	17,241	968
Follow Up Appointment	54,896	51,906	2,990	52,310	2,586
Total Outpatients	73,105	69,368	3,737	69,551	3,554

Income and Surplus Growth

The Trust has continued to grow its income base and from that has produced a material surplus, which will act as a firm base for revenue and capital investment in quality, growth and facilities in the future.

	2007/08 £'m	2008/09 £'m
Income	62.93	65.48
Expenses	52.48	58.10
EBITDA	10.45	7.38
Interest / Depreciation / Dividend	4.20	3.60
Net Operating Surplus	6.25	3.98

In-year patient care tariffs increased by 2.1% net of a 3% efficiency reduction. Overall income growth of 5% was derived by an increased income from activity as other income fell by 14%. The income from the activity increase was driven by an increase in the average tariff received due to a more specialist case mix and an increase in the specialist top-ups charged by the Trust.

Sources of Operating Income 2008/09 (£'m)

Private Patient Cap

In accordance with section 15 of the Health and Social Care (Community Health and Standards Act 2003) the Trust must not exceed the proportion of income generated from treating private patients compared to total patient income as generated in 2002/3. This measure is used to show that the Trust has not moved away from its fundamental aim to treat NHS patients despite its greater commercial freedoms.

The Trust's cap is set at 4.3% and during 2008/09 the Trust percentage of private patient was 2% (2.7% 07/08).

Sources of Other Income 2008/09 (£'m)

Improving efficiency and ensuring continued value for money

The Trust is continually striving for efficiency and to provide improved use of taxpayer resources by reviewing systems, evaluating the skill mix of staff, benchmarking against best practice and ensuring best value through robust procurement. In-year the Trust saved £2.1m which represents 3.5% of our cost base through a programme of one-off and recurring schemes. The Trust Board and the Trust's Executive Management Team monitor this work.

Trust Expenditure

The Trust has a rigorous control mechanism to ensure that it achieves its target surplus, delivers the patient targets within a safe environment and within the allocated budget. The Trust Board and the Executive Management Team monitor this.

Analysis of Trust Expenditure 2008/09 (£m)

Capital Investment

As a Foundation Trust the Trust has increased freedom to select the most appropriate capital schemes to ensure the most modern equipment and technology are available in a clinically appropriate environment to support patient care. The Trust funds these developments by generating cash surpluses. Since being licensed the Trust has set aside monies to fund a new Outpatient building. Other key areas of spend in year were:

- Medical equipment purchases (£0.6m)
- Information equipment (£0.2m)
- Outpatient scheme (£0.4m)
- Rationalising the Trust estate (£0.4m)
- Relocating the Therapies Department (£0.1m)
- Other (£0.1m)

Charitable Funds

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

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

At the 31st March 2009 the Charitable Funds have a Balance of £568,275. During 2008/09 the trust raised £17,700 whilst spending £119,167. The main schemes supported were:

1. Supporting the oncology service £6,500

2. Purchase of medical equipment £47,000

3. Touch screens and IT equipment for physiotherapy £3,000

4. Supporting the volunteer network £35,000.

To donate to the ROH Charitable Funds or get involved in raising funds please contact the Finance Department on 0121 685 4000.

Section 6

About the Members' Council

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

There are three categories of representatives (public and patient; staff and partner nominated members) on the Members' Council. The Chairman of the Board of Directors, Mr Laurence James, is also Chair of the Members' Council. This ensures a continuity of communication between the two forums. The Chairman meets with Council members between meetings and sends a regular update after each Board meeting, together with the Trust's monthly Corporate Performance Report.

Non-Executive Directors regularly attend meetings of the Members' Council and explain their areas of activity within the Trust and Executive Directors attend most meetings. In this way the Council can ask directly for supplementary information.

The Members' Council meets quarterly in public and attends two Board meetings each year and is fully engaged in discussions, although any decisions taken remain the sole responsibility of the Board.

Doing its job – as a whole Council

In 2008/09 the Members' Council discharged its responsibilities by agreeing to an extension of appointment for the incumbent External Auditors (taking into consideration the impending change of internal auditors and the quality of service provided).

The Members' Council exercised its duty to consider the appointment of the Trust Chairman when the term of office of Mr Les Lawrence expired. The Members' Council used its Remuneration and Nominations Committee to procure professional support for this recruitment and worked in tandem with the Trust Board on the person specification, interview process and appointment timetable. As a result, the appointment of Mr Laurence James was approved in June 2008 with a start date of the 1st November allowing for an active handover during October. The Members' Council was pleased to put on record its thanks to Mr Lawrence for his leadership through the Foundation Trust application and in its infancy as an authorised Trust.

The Members' Council also approved the appointment of Professor Andrew Stevens as Vice-Chairman for an additional period of up to 2 years from February 2009.

The Members' Council was able to approve a commentary on the Trust's Healthcare Commission Declaration, which was evaluated as well above average in quality for Foundation Trusts and also fully discussed the Trust's Annual Plan.

The Members' Council was involved in consideration of the Trust's future clinical strategy and held an AGM with ancillary events attended by over 200 people.

One of the joint meetings with the Board covered the Trust's declaration to Monitor and Members' Council was able to work with the board in its exercise of judgment, supported by underpinning assurance prior to approving its declaration.

Evaluation of the performance of the Members' Council will be undertaken formally by the incoming Chairman during 2009 and an interim review has been conducted with individual members during 2008/09, resulting in revised meeting schedules and work plans for the forthcoming year.

In Sub-Groups

There are four sub-groups within the Members' Council, reflecting key strategic areas within the Trust. Each group reports its work at each of the public Members' Council meetings,

Environment

This group reviewed in detail the Trust's plans for development of the new Outpatient Department and also looked at aspects of Good Corporate Citizenship such as waste recycling and energy conservation. New wheelchairs were secured and located at strategically appropriate points of patient access across the Trust.

Governance

The subgroup is primarily concerned with patient focused aspects of governance. It developed the Member's Council commentary for the Annual Healthcheck and received the report and subsequent action plan following publication of the national patient survey results. It also reviewed the findings of an internal governance review undertaken by the Trust to ensure that its internal processes of governance were effective.

Membership

The Membership Sub-Group agreed to increase public membership by 1000 within this year, with a specific focus on the under 30 age group. It also looked at new ways of engaging with members and was responsible for the organisation of the AGM. The sub-group also worked with the membership manager to look at the role of public engagement for the Foundation Trust, encompassing existing groups such as volunteers and the League of Friends. The group welcomed the amalgamation of the volunteer and membership teams to allow greater streamlining with League of Friends' activity, events and fundraising.

Remuneration and Nominations

The Remuneration Committee tackled the recruitment of the Trust Chairman to 2011. The Committee worked on detailed proposals for remuneration, job description and recruitment processes and secured the support of full council for its work. The process began in early 2008 and was completed in June 2008. The Trust was fortunate to secure a range of high quality candidates and to undertake a robust two-stage and multi-faceted recruitment process befitting the importance of the role. The Committee liaised regularly with the Senior Independent Director of the Trust Board and with the Board itself.

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. South

Elections

Elections to our Members' Council for vacancies arising in 2008/09 have been overseen by the Electoral Reform Society.

Election turnout for the Heart of Birmingham constituency vacancy that arose as a result of a resignation was:

Heart of England by-election (August 2008)	
Number of members in constituency	226
Number of seats contested	1
Number of contestants	2
% Election turnout	28.3

Results of elections and turnout figures for those seats falling vacant in February 2009 will be available in the first month of the new financial year, 09/10. The elections were re-run following an administrative error.

Elected Members

South Birmingham

1. ROSKELL, Gary appointed March 08 until end January 2010

Attended 2 Council meetings and serves on the Membership Committee

2. COOKE, Carole Ann (For 3 years until end January 2010) Attended 3 Council meetings and serves on the Remuneration Committee

3. HART, Neil (For 3 years until end January 2010) Attended 3 Council meetings and serves on the Remuneration Committee (Chair)

4. PORTER, Ken (For 2 years until end January 2009) Attended 3 Council meetings and serves on the Membership Committee (Chair)

5. RICHMOND, Isobel Ingrid (For 2 years until end January 2009) Attended 3 Council meetings and serves on the Environment Committee

Heart of Birmingham

1. OSBORNE Rex (until July 08) Attended 0 Council meetings and served on no committees

2. GATES, Shirley (from September 2008) Attended 1 Council meeting and serves on no committees

Rest of the West Midlands

1. BARWICK, Joan Margaret (For 3 years) until end January 2010) Attended 3 Council meetings and serves on the Environment Committee

2. NOON, Stella (For 3 years until end January 2010) Attended 3 Council meetings and serves on the Governance Committee (Chair)

3. GILL, Judy (For 2 years until end January 2009) Attended 3 Council meetings and serves on the Environment Committee

4. SCOTT, Yvonne (For 2 years until end January 2009) Attended 3 Council meetings and serves on the Environment Committee

5. CASWELL, Rita Ann (For 3 years until end January 2010) Attended 2 Council meetings and serves on the Remuneration Committee and Environment Committee (Chair)

6. MERRY, Christina Mary (For 3 years until end January 2010) Attended 2 Council meetings and serves on the Membership Committee

Rest of England

SMITH, Anne Hartland (For 3 years until end January 2010) Attended 3 Council meetings and serves on no committee

Clinical Staff Representatives

1. CHURCHMAN, John (For 2 years until end January 2009) Attended 3 Council meetings and serves on the Membership Committee (Vice chair)

2. BRADISH, Christopher (For 2 years until end January 2009, resigned from the Trust effective end 2008) Attended 1 Council meeting Non-Clinical Council

Non-Clinical Staff Representatives

GILMARTIN, Tracy Anne (For 2 years until end January 2009) Attended 2 Council meetings and serves on the Remuneration and Governance Committees 5)

Partner Nominees

The following organisations make nominations to the Members' Council and the following individuals held posts during the period of this report:

Nominating

South Birmingham PCT	Sandra Cooper Attended 1 Council meeting and serves on the Governance committee
Heart of Birmingham PCT	Zulfqar Hussein until October 2008 Attended 3 Council meetings and serves on the Environment Committee; Jacqui Francis from December 2008 Attended 1 Council meeting
Birmingham City Council	Cllr. Keith Barton Attended 3 Council meetings and serves on the Governance Committee
University of Birmingham	Jean Broadfield Attended 2Council meetings and serves on the Membership Committee
Birmingham City University	Marion Thompson Attended 2 Council meetings and serves on the Remuneration Committee
Bournville Village Trust	Roger Wilson Attended 2Council meetings and serves on the Environment Committee
Patient Support Groups	Sue Arnott Attended 1 Council meeting and serves on the Governance Committee
Member of Parliament	Richard Burden MP Attended 3 Council meetings and serves on the Membership Committee
Birmingham Council of Faiths	Parwez Hussain Attended 1 Council meeting and serves on the Remuneration and Membership Committees

No Governor declared a material conflict of interest during the year and all interests were registered and available for inspection.

Members' Council involvement in Strategy

The Council has received several presentations on the potential direction for the organisation and approves the Annual Plan prior to submission each year at one of its public meetings. Council members attend two Board meetings each year and these focus on performance and future direction – with a major discussion in March 2009 of the future direction of the Trust within its Annual Plan. In this way the Council can be actively engaged in the work of the Trust, directly assess the work of the Board and observe the work of the Chairman in a context other than as Chairman of the Members' Council.

Members' Council Register of Interests

This is available for inspection on application to the Trust's Company Secretary, The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

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

Section 7

Our Members

Membership Commentary

The past twelve months have seen major changes in the delivery of public engagement within the Trust. Membership and Volunteering have joined together to create a new Department of Public Engagement. The new department has additional responsibilities for the development of community links and exploring and developing social enterprise opportunities within the Trust.

The Membership Sub-Group and the Membership Manager agreed for the primary focus to be the recruitment of 1000 new members this year, with a particular emphasis on younger people. It was felt that by growing our membership at a reasonable rate, we would be able to invest more time in meaningful engagement.

There have been some particular good indications of success in this period:

a) The NHS Constitution Consultation feedback from our members gave over a 30% response. The significance of the Royal Orthopaedic Hospital response was acknowledged by the West Midlands NHS Community and showed the connection that our members have with us and the NHS as a whole.

b) There has been a 37% increase in the number of members under the age of 30 and a 32% increase in the number under the age of 21. The overall increase in membership is 21%.

c) The Trust has been accepted as a member of the local Constituency Strategic Partnership. This has enabled more community contacts to be identified and developed in order to facilitate more opportunities to participate in local activities and events.

d) The development of a Young Persons' Volunteering Strategy, in partnership with Changemakers. Young people aged 16 and 17 are frequently excluded from volunteering in NHS organisations. The Trust has developed partnerships with six local sixth forms and colleges to facilitate better understanding of young peoples needs with regard to understanding and working with the NHS.

In the next twelve months, the Trust will be concentrating its efforts on continuing to develop opportunities for members to become engaged with us.

This will include:

- The development of an interactive web facility to encourage fast dissemination of information and collection of feedback
- The creation of social enterprise opportunities in conjunction with the local Town Centre Partnership and others
- The development of a Public Engagement 'roadshow' to facilitate local events including consultation and membership events.
- Further developing relationships with external organisations in order to increase membership involvement and opportunities.

The plans for 2009/10 are to increase the public membership, paying particular attention to all areas of diversity and the barriers to effective engagement for under represented groups.

Membership Report

Membership Size and Movements

Public constituency	2008-09	2009-10 (estimated)
At year start (April 1)	3757	4768
New members	1091	1100
Members leaving	80	100
At year end (March 31)	4768	5768
Staff constituency	**2008-09**	**2009-10 (estimated)**
At year start (April 1)	798	821
New members	113	90
Members leaving	90	100
At year end (March 31)	821	811

Analysis of current membership

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	7	5,690, 271
17-21	160	
22+	4268	
Not stated	333	
Ethnicity		
White	3392	1,138,054
Mixed	80	16,501
Asian or Asian British	277	83,078
Black or Black British	205	44,384
Other	814	4,408,252

Public constituency	Number of members	% of membership
Socio-economic Category		
ABC1	2518	52.80
C2	897	18.81
D	1021	21.42
E	332	6.97
Gender		
Male	1944	41
Female	2786	58
Unspecified	38	1

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

There are five public constituencies within Public membership:

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

There are two constituencies within Staff membership

- Clinical
- Non-clinical

All members over the age of 18 are eligible to stand as candidates to represent their constituencies on the Members' Council and also to vote for their candidates

Section 8

The Board of Directors and Corporate Governance

The Board of Directors was chaired by Mr Les Lawrence until the expiry of his term of office on the 31st October 2008 and by Mr Laurence James from the 1st November following his appointment by the Trust's Members' Council for a three year term to the end of October 2011.

The Chief Executive is Mrs Penny Venables.

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

Access to the register of directors' interests is available on application by writing to:

Company Secretary
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham, B31 2AP

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

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

The Board has appointed a Senior Independent Director (SID), Professor Andrew Stevens. The SID has held one meeting with Non-Executive Directors without the Chairman during the period covered by this report. Non-Executive Directors have met with the Chairman on two occasions during this period.

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

In addition, the Board designates two Board meetings per annum as joint meetings with the full Members' Council.

The Board meets every month and ad hoc as necessary. A formal schedule of matters specifically reserved for decision by the Board of Directors was adopted by the Board in May 2008. This schedule is available on the Trust's website. The Board delegates other matters to the Executive Directors and other senior

management. The directors are given accurate timely and clear information so that they can maintain full and effective control over strategic, financial, operational, compliance and governance issues. The directors have a range of skills and experience and each brings independent judgment and considerable knowledge to the Board's discussions and determinations. This range of skills and experience ensures balance, completeness and appropriateness to the requirements of the Trust. The attendance of directors at Board and Committee meetings is set out later in this report.

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

Directors during 2008/09

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

Mr Les Lawrence	Chair until 31st October 2008
Mr Laurence James	Chair from 1st November 2008 (term of office expires 31/10/11)
Professor Andrew Stevens	Senior Independent Director and Deputy Chair (term of office expires 31/01/10, renewable thereafter for 1 year on agreement of Members' Council)
Mr Roger Otto	Non-Executive Director (term of office expires 31/12/10)
Mr Chris Monk	Non-Executive Director (term of office expires 31/12/10)
Dr Elizabeth Hensel	Non-Executive Director (term of office expires 31/12/10)
Mr Robert Millinship	Non-Executive Director (term of office expires 4/10/11)
Ms Penny Venables	Chief Executive Officer
Mr Graham Bragg	Deputy Chief Executive and Director of Finance (to Jan 09, then also Director of Strategy and Business Development)
Mr Andrew Crawshaw	Director of Operations (to 20th March 2009)
Mrs Lindsey Webb	Director of Nursing and Governance
Mr Andrew Thomas	Medical Director

Committees of the Trust Board:

Nominations and Remuneration Committee

Membership:
Mr L Lawrence (Chair) - until November 2008
Mr L James (Chair) - from November 2008
Professor A Stevens
Mr R Otto

Purpose

The Remuneration and Nominations Committee of the Board undertakes to:

- Review the structure, size and composition of the Board and make recommendations with regard to any changes.
- Give full consideration to succession planning.
- Evaluate the balance of skills, knowledge and experience in relation to the appointment of both executive and non-executive directors.
- Identify and nominate suitable candidates to fill executive director vacancies.

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

In the case of Executive Director vacancies, the Remuneration and Nominations Committee draws up the job description and person specification, and undertakes the recruitment process and then makes a recommendation to the Trust Board which may accept or reject the recommendation. It is for the Non-Executive Directors to appoint and remove the Chief Executive and such an appointment requires the approval of the Members' Council.

Audit Committee

Membership:
Mr R Otto (Chair)
Mr C Monk
Dr E Hensel
Mr R Millinship

(Mr G Bragg in attendance as Director of Finance to January 2009, then Mr S. Bloomer as Finance Director while Mr Bragg assumes amended role within the Trust.

Purpose

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

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

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

to the Members' Council. This work plan is made available to the Members' Council and the Chair of Audit is available to update Council on any matters of interest. Any work undertaken by committee

Integrated Governance Committee

Membership
Mr Les Lawrence - Chair until September 2008
Professor A Stevens Chair from September 2008
Dr E Hensel
Ms P Venables
Mr G Bragg
Mr A Crawshaw (resigned March 2009)
Mrs L Webb
Mr A Thomas

Purpose

The work of the Committee is primarily to:

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

IGC minutes are made available at every Trust Board meeting.

The Committee has an annual work plan that ensures it receives effective reporting from appropriate executive sub-groups. This work plan is available to the Members' Council and the Chairman attends meetings to update as required.

Charitable Funds

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

Non-Executive Directors' Attendance at Meetings:

Name	Board and board assignments	Audit Committee	Integrated Governance Committee	Remuneration & Nomination Committee	Charitable Funds
	13 meetings	8 meetings	3 meetings	1 meeting	3 meetings
Les Lawrence Chairman (until 31st October 2008) Mr Lawrence also holds office as Cabinet Member Children and Young People, Birmingham City Council.	8		Chairman until Sept 08 2	Chairman until October 08 0	Chairman until October 08 3
Laurence James Chairman (from 1st November 2009) Mr James is also Chairman of Stroud and Swindon Building society and owner of a Lighting Company.	5	1 (as observer)	4 (as observer)	1	1
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		9 Chairman from Sept 08 Focus on clinical guidance and outcomes	1 Acts as interface with Members' Council	3
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	10 Leading on capital development and estates	6 Particular focus on best practice HR & OD			2
Roger Otto Mr Otto is a qualified accountant and was a partner with Baker Tilley. He has also served as a non-executive director on a PCT	10 Reporting on work of audit and annual report to Members' Council	8 Chairman		1	3

Elizabeth Hensel Dr Hensel is a clinical psychologist and has been a non-executive director of an NHS ambulance trust	9 Leading on information systems and patient flows	8 Acts as link person with integrated governance	7 Acts as link person with audit; particular focus on governance structures		2
Robert Millinship Mr Millinship has a background in manufacturing and production businesses and acts as an interim director or consultant	11 Leading on 18 weeks project delivery	8 Key focus on perform-ance criteria			2
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 assurance with internal and external auditors; major project reviews.**	**Ongoing review of Assurance Framework;** **Clinical Governance;** **Policy review**	**Approval of pay awards;** **Agreement of external advertising and specification for NED (with MC N&R Committee);** **HR Review**	**Review of investment strategy;** **Prioritisa-tion of fund allocation**

Executive Directors attended all meetings of the Board and Committee, save for one Board meeting each (due to holidays). Attendance at committee was also at its maximum, save for those meetings which conflicted with unplanned and unavoidable clinical or business commitments.

Evaluation of Board Performance

As Trust chairmanship changed at the time when Board evaluation would normally have taken place, it was agreed that the incoming chairman should undertake an initial evaluation towards the end of the financial year. This would be agreed and shared with the Members' Council Remuneration and Nominations Committee. The Senior Independent Director has responsibility for undertaking the appraisal of the Chairman in conjunction with the Members' Council.

Section 9

Remuneration Report

Salary and Pension Entitlements of Senior Managers

A) Salaries

Name and Title	2008-09 (12 months to 31st March 2009)			2007-08 (12 months to 31st March 2008)		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
Mr. L Lawrence Chairman (to 31st October 2008)	10-15	0	0	20-25	0	0
Mr. L James Chairman (from 1st November 2008)	10-15	0	0	0	0	0
Mrs. P Venables Chief Executive	110-115	0	0	105-110	0	0
Mr. G Bragg Director of Strategic and Business Development	90-95	0	0	90-95	0	0
Mr. A Thomas Medical Director	15-20	100-105	0	15-20	100-105	0
Mr. A Crawshaw Director of Operations (to 20th March 2009)	75-80	0	0	75-80	0	0
Mrs. L Webb Director of Nursing & Governance	75-80	0	0	65-70	0	0
Professor A Stevens Non-executive Director	5-10	0	0	5-10	0	0
Dr. E. Hensel Non-executive Director	5-10	0	0	5-10	0	0
Mr. R. Otto Non-executive Director	5-10	0	0	5-10	0	0
Mr. R. Millinship Non-executive Director	5-10	0	0	0-5	0	0
Mr. C. Monk Non-executive Director	5-10	0	0	10-15	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.

Salary and Pension Entitlements of Senior Managers

B) Pension Benefits

Name and title	Real increase/ (decrease) in pension and related lump sum at age 60	Total accrued pension and related lump sum at age 60 at 31 March 2009	Cash Equivalent Transfer Value at 31 March 2009	Cash Equivalent Transfer Value at 31 March 2008	Real Increase/ (decrease) in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Mrs. P Venables Chief Executive	7.5 - 10	145 - 150	657	474	120	0
Mr. G Bragg Director Of Finance	7.5 - 10	150 - 155	867	606	173	0
Mr. A Thomas Medical Director	0 - 2.5	160 - 165	894	663	150	0
Mr. A Crawshaw Director of Operations	2.5 - 5	85 - 90	350	258	60	0
Mrs. L Webb Director Of Nursing and Governance	7.5 - 10	65 - 70	255	178	51	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 2007-08 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

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

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

Signed:

Penny Venables
Chief Executive

Date: 2nd June 2009

Section 10

Annual Accounts

for the Year Ended 31st March 2009

Statement of the Chief Executive's responsibilities as the accounting officer of Royal Orthopaedic Hospital NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Royal Orthopaedic Hospital NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 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, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/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.

Signed

Penny Venables
Chief Executive

Date: 2nd June 2009

Statement on Internal Control

Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

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 organisation's policies, aims and objectives,
- 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 2009 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 a Non Executive Director of the Trust; the Chief Executive is a member of this committee. The Committee meets regularly every month and reviews the Board Assurance Framework and the Corporate Risk Register.

Sub-Committees reporting to the Integrated Governance Committee also meet regularly and review the risks attributed to their respective committee scrutinising and ensuring that appropriate ratings have been attributed and appropriate mitigation undertaken.

The awareness and management of risk is an integral part of staff induction and on the annual mandatory training day staff learn how to report or deal with these issues. Root cause analysis training has been provided for senior staff within the organisation which 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 Trust has implemented an electronic system which holds the Healthcare Core Standards and Board Assurance Framework. This allows managers to update risks, their rating and mitigating actions as and when there are changes in status and reports are drawn from this system to all relevant sub-committees. This will be developed in 2009/10 to include the NHSLA risk management standards and the Corporate Risk Register.

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 Trusts 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 and the Trust Board 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 Trust has introduced monthly ward reports which detail complaints and incidents relating to the ward allowing the staff to challenge and learn from the issues raised.

The Internal Auditors have included audit work around the current risk management systems including the Trust Board Assurance Framework and risk management. They are able to give significant assurance on control systems but noted a weaker process in supporting standards for better health elements which has been addressed by implementing a new performance management system and by enhancing the supporting processes.

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 draws together the key corporate risks from the Corporate Risk Register and is considered by the Integrated Governance and Audit Committees during the year to ensure a bottom up and top down approach to capturing key corporate risk. The framework includes risks on waiting time targets including resource issues, reputation, finance and information security. Each reported risk has a lead officer, lead executive, action plan and comments on performance to date which assure the Board on progress and management of corporate risk within the organisation.

The Trust commissioned an external review of its governance arrangements. This also reviewed the movement of in year Monitor declarations for the 18 week target and the information and processes that supported this. The review concluded that the Trust has overall good governance procedures, that declarations were made correctly and offered advice on improving the roles of the Audit Committee and Integrated

Governance Committee. All recommendations were accepted and are being implemented by the Board of Directors.

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 2008/9 the Trust did not have any Serious Untoward Incidents involving data loss or confidentiality breach. The Trust's Senior Information Risk Owner at Board level is the Director of Strategic and Business Development.

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, NHS South Birmingham and other associated Primary Care Trusts, subcontractors, voluntary groups, the Members Council, patient groups (including the statutory Patient and Public Involvement Forums (until dissolved earlier in the year), LINKS (replacing the PPI Forum) and the Trusts Patient Council), patients, the local community and the Local Authority Overview and Scrutiny Committee.

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

The Trust is fully compliant with the core Standards for Better Health.

The Trust has an unconditional registration with the Care Quality Commission based upon its compliance with the revised Health Act 2009.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

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

The Trust robustly reviews performance throughout the organisation to ensure that resources are used economically, efficiently and effectively. There is a robust budget setting and financial management control system which includes activity related budgets, monthly budget manager meetings, clinical service area performance meetings, regular reports to the Finance Sub-Committee and periodic reviews during the year which are considered by the Executive Management Team and the Trust Board. The budgetary control system is complemented by a clear scheme of delegation and financial approval limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis. Action plans to correct unacceptable variances are agreed with the responsible managers and monitored by the Finance Sub-Committee. In 2009/10 this will pass to the quarterly service review process.

The Trust is split into service units and there are formal quarterly reviews with each Clinical Service and Support Unit. These reviews combine outcomes with efficiency, effectiveness, use of resources, quality and governance to ensure a holistic view of performance is taken.

The Trust has developed, within its Corporate Performance Report, a scorecard which monitors both national and local targets together with efficiency indicators which are reported on a monthly basis. This area will be further developed in 2009/10.

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 regularly benchmarks its reference costs with national tariffs to highlight the potential areas of inefficiency and compares its use of resources with other specialist orthopaedic centres. As a member of the Specialist Orthopaedic Alliance both formal and informal reviews of services and their cost effectiveness are carried out. This process will be enhanced in 2009/10 with the introduction of a Patient Level Costing System and reporting to relevant managers and clinicians.

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 Finance Sub-Committee, Audit or Integrated Governance Committees consider the recommendation of all audits carried out and ensure corrective action is undertaken where necessary.

The Healthcare Commission assessments in the autumn of 2008 awarded the Trust a scoring of "good" for Quality of Services and "excellent" for value for money.

The financial risk rating of 5 was awarded by the independent regulator is the most favourable that can be attained as a Foundation Trust.

The Trust Board held regular meetings to discuss areas for improvement in the provision of services that the Trust provides with the Public and Patient Involvement Forum (until dissolved) and has engaged with LINKS. 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 Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by comments made by the External Auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Integrated Governance Committee. 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 red risks on 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 Audit Committee receives update reports on audit recommendation tracking to ensure that the management team are implementing the agreed improvements to internal control processes within the agreed timeframe or that there are reasonable explanations for variances.
- the Audit Committee receives updates on prior year audit recommendations from the Trust's Internal Auditors.
- 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.
- The Integrated Governance Committee has a programme for reviewing clinical audit and outcomes including the use of Dr Foster and the National Joint registry. The committee will focus on outcomes and clinical audit during 2009/10.
- 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.

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 independent review of governance focusing on the control systems that enabled the Trust to make its annual and quarterly declarations which was commissioned following the change in declaration for 18 week target compliance
- the Standards for Better Health final declaration
- the local Counter Fraud Reports
- the National Patient Satisfaction Survey
- Dr Foster outcome data
- the National Staff Opinion Survey
- the CPA accreditation for the Histopathology Lab
- the HTA inspection and licence
- Data Quality Audits
- the Independent Regulator's assessment of the Trust as part of the Compliance Framework
- the Members' Council meetings
- Connecting for Health - Payment by Results Assurance Framework Clinical Coding Report
- The Hygiene Inspection carried out by the Health Care Commission in Autumn 2008
- the review meetings held with the Trust's host commissioner and quarterly meetings with associate Primary Care Trusts
- the review of governance undertaken by Price Waterhouse Coopers in January 2009
- the self assessment process for the Care Quality Commission
- the concordat review;
- the review of the Trust's IT and information arrangements carried out in November 2008; and
- the registration for the Care Quality Commission.

Signed

Penny Venables
Chief Executive

Date: 2 June 2009

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 2009 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 Financial Review 2008/09 within the Operating and Financial Review 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 2008/09. 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 Chairman's Message, the Chief Executive's preface, the Quality Report, the non financial information within

the Operating and Financial Review, About the Members' Council, Membership Commentary, The Board of Directors and Corporate Governance and the un-audited part of the Remuneration 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 2009 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 and Financial Review 2008/09 within the Operation and Financial Review 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
Audit Commission
2nd Floor, No.1 Friars Gate, 1011, Stratford Road
Solihull, B90 4EB

8 June 2009

Foreword to the Accounts

These accounts for the year ended 31 March 2009 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

02 June 2009

Income and Expenditure Account
For the year ended 31st March 2009

	NOTE	31 Mar 2009 £'000	31 Mar 2008 £'000
Income from activities	**3**	**62,385**	**59,350**
Other operating income	**4**	**3,097**	**3,575**
Operating expenses	**5-6**	**(60,784)**	**(55,921)**
OPERATING SURPLUS (DEFICIT)		**4,698**	**7,004**
Cost of fundamental reorganisation/restructuring		0	0
Profit (loss) on disposal of fixed assets	7	(16)	0
SURPLUS (DEFICIT) BEFORE INTEREST		**4,682**	**7,004**
Interest receivable		643	663
Interest payable		0	0
Other finance costs - unwinding of discount		(21)	(8)
SURPLUS (DEFICIT) FOR THE FINANCIAL YEAR		**5,304**	**7,659**
Public Dividend Capital dividends payable		(1,325)	(1,404)
SURPLUS AFTER DIVIDENDS FOR FINANCIAL YEAR		**3,979**	**6,255**
Exceptional item - MEA impairment for fixed asset revaluation		(1,379)	0
RETAINED SURPLUS (DEFICIT) FOR THE YEAR		**2,600**	**6,255**

The notes on pages 60 to 90 form part of these accounts.

All income and expenditure is derived from continuing operations.

Balance Sheet
As at 31st March 2009

	NOTE	31 Mar 2009 £'000	31 Mar 2008 £'000
FIXED ASSETS			
Intangible assets	9.1	82	0
Tangible assets	9.2	36,967	41,108
Investments	12	0	0
TOTAL FIXED ASSETS		**37,049**	**41,108**
CURRENT ASSETS			
Stocks and work in progress	10	2,089	1,870
Debtors	11	5,055	5,755
Investments	12	0	0
Cash at bank and in hand	19.3	16,305	9,486
TOTAL CURRENT ASSETS		**23,449**	**17,111**
CREDITORS: Amounts falling due within one year	**13**	**(5,782)**	**(4,600)**
NET CURRENT ASSETS / (LIABILITIES)		**17,667**	**12,511**
TOTAL ASSETS LESS CURRENT LIABILITIES		**54,716**	**53,619**
CREDITORS: Amounts falling due after more than one year	**13**	**0**	**0**
PROVISIONS FOR LIABILITIES AND CHARGES	**14**	**(275)**	**(271)**
TOTAL ASSETS EMPLOYED		**54,441**	**53,348**
FINANCED BY:			
TAXPAYERS EQUITY			
Public dividend capital	16	38,905	38,905
Revaluation reserve	17	5,169	6,165
Donated asset reserve	17	1,888	1,976
Government grant reserve	17	0	0
Other reserves	17	0	0
Income and expenditure reserve	17	8,479	6,302
TOTAL TAXPAYERS EQUITY		**54,441**	**53,348**

The financial statements were approved by the Audit Committee on behalf of the Board of Directors on 02 June 2009 and are signed on its behalf by:

Penny Venables – Chief Executive

Statement of Total Recognised Gains and Losses
For the year ended 31st March 2009

	31 Mar 2009 £'000	31 Mar 2008 £'000
Surplus (deficit) for the financial year before dividend payments	5,304	7,659
Fixed asset impairment losses	(1,379)	0
Unrealised surplus/(deficit) on fixed asset revaluations/indexation	(1,419)	2,239
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	(88)	(82)
Additions/(reductions) in "other reserves"	0	0
Total recognised gains and losses for the financial year	**2,418**	**9,816**
Prior period adjustment	0	0
Total gains and losses recognised in the financial year	**2,418**	**9,816**

Cash Flow Statement
For the year ended 31st March 2009

	NOTE	31 Mar 2009 £000	31 Mar 2008 £000
OPERATING ACTIVITIES			
Net cash inflow/(outflow) from operating activities	**19.1**	**9,831**	**6,991**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE			
Interest received		684	657
Interest paid		0	0
Interest element of finance leases		0	0
Net cash inflow/(outflow) from returns on investments and servicing of finance		**684**	**657**
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		(2,372)	(5,382)
Receipts from sale of tangible fixed assets		1	0
(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		**(2,371)**	**(5,382)**
DIVIDENDS PAID		**(1,325)**	**(1,404)**
Net cash inflow/(outflow) before management of liquid resources and financing		**6,819**	**862**
MANAGEMENT OF LIQUID RESOURCES			
(Purchase) of investments with DH		0	0
(Purchase) of other current assets investments		0	0
Sales of investment with DH		0	0
Sale of other current asset investments		0	0
Net cash inflow/(outflow) from management of liquid resources		**6,819**	**0**
Net cash inflow/(outflow) before financing		**6,819**	**862**
FINANCING			
Public dividend capital received		0	0
Public dividend capital repaid		0	0
Loans received from DH		0	0
Other loans received		0	0
Loans repaid to DH		0	0
Other loans repaid		0	0
Other capital receipts		0	0
Capital element of finance leases		0	0
Cash transferred (to)/from other NHS bodies		0	0
Net cash inflow/(outflow) from financing		**0**	**0**
Increase/(decrease) in cash		**6,819**	**862**

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 2008/09 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 which 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. The national tariff exceeded previously charged local prices the Trust paid the Department of Health. The impact of this phasing has resulted in the following transactions:

- In 2005/06 the Royal Orthopaedic Hospital NHS Trust paid 75% of the difference.
- In 2006/07 the Royal Orthopaedic Hospital NHS 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 is 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 financial 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 FRS15 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 Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent asset valuations were undertaken on 31 March 2009 by the District Valuer. The revaluation undertaken at that date has been accounted for in these accounts on 31 March 2009 as follows:

- Land £5,201,100
- Buildings and Dwellings £27,596,912

The valuations are carried out on the basis of market equivalent value which is used in arriving at fair value for operational assets, subject to assumptions that the property is sold as part of the continuing enterprise in occupation.

For specialised operational assets, if there is no market-based evidence of fair value due to the specialised nature of the property and the item is rarely sold, except as part of a continuing business, fair value is estimated using a depreciated replacement cost approach subject to the assumption of continuing use.

Non-specialised operational assets are valued on the basis of Existing Use Value being the estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's length transaction.

Non operational assets, including surplus land are valued on the basis of Market Value, making the assumption that the property is no longer required

for existing operations, which have ceased.

Where depreciated replacement cost has been used, it is confirmed that the valuer has had regard to the RICS Valuation Information Paper No.10 The Depreciated Replacement Cost (DRC) Method of Valuation for Financial Reporting, as supplemented by Treasury guidance.

All land and buildings are revalued using professional valuations in accordance with IAS16.

Assets in the course of construction are valued at cost and are valued on completion by professional valuers as part of land and buildings revaluation required by IAS16.

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

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

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:
  - Engineering Plant and Equipment – short life 5 years
  - Engineering Plant and Equipment – medium life 10 years
  - Engineering Plant and Equipment – long life 15 years
  - Medical Equipment – short life 5 years
  - Medical Equipment – medium life 10 years
  - Medical Equipment – short life 15 years
  - Decontamination Equipment – short life 2 years
- Transport Equipment – 7 years
- Information Technology – 3 years
- Furniture and Fittings:
  - Furniture – short life 3 years
  - Furniture – medium life 5 years
  - Furniture – long life 10 years

1.7 Intangible fixed assets

Intangible fixed assets are capitalised when they are capable of being used in a trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are amortised over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods of events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets here expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful economic lives.

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. Work-in-progress comprises goods and services in intermediate stages of production. 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 as 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 2009

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 liability 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 based on the excess of assets over liabilities at the time of establishment of the original NHS Trust.

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 2009. The trust has not entered into any regular way purchases or sales in the year to 31 March 2009.

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

De-recognition

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

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

Classification and Measurement

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

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

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. The Trust does not hold any assets in this category.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments 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.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. The Trust does not hold any assets in this category.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the 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

	31 Mar 2009	31 Mar 2008
	£'000	£'000
Elective income	41,041	37,986
Non-elective income	2,837	2,835
Outpatient income	7,766	7,414
Other NHS clinical income	9,425	9,901
Total Income at Full Tariff	**61,069**	**58,136**
PBR Clawback	0	(427)
Income from Activities (before private patient income)	**61,069**	**57,709**
Private patient income	1,240	1,585
Other non-protected clinical income	76	56
Income from activities	**62,385**	**59,350**

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 0% clawback of the excess of national tariff over previously charged local prices (25% in 2007/08) 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

	31 Mar 2009	31 Mar 2008	Base Year
	£'000	£'000	£'000
Private patient income	1,240	1,585	1,446
Total patient related Income	62,385	59,350	33,956
Proportion as a percentage	1.99%	2.67%	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 2009.

4. Other Operating Income

	31 Mar 2009	31 Mar 2008
	£'000	£'000
Research and development	169	191
Education and training	2261	1,998
Charitable and other contributions to expenditure	0	0
Transfers from donated asset reserve	88	82
Non-patient care services to other bodies	0	0
Other income	579	1,304
Total	**3,097**	**3,575**

Other income is derived from Local Information Strategy funding of £147,074, catering income of £128,712, accommodation income of £72,635, coffee bar income of £45,481 and numerous other small amounts.

5. Operating Expenditure

5.1 Operating expenses comprise of:

	31 Mar 2009	31 Mar 2008
	£'000	£'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	2,856	898
Executive directors costs	469	469
Non-executive directors costs	85	76
Staff costs	32,378	30,380
Drug costs	1,383	1,346
Supplies and services - clinical (excluding drug costs)	13,735	13,841
Supplies and services - general	993	1,024
Establishment	784	788
Research and development	0	0
Transport	183	152
Premises	3,057	2,233
Increase/(decrease) in bad debt provision	3	(341)
Other impairment of financial assets	0	0
Depreciation and amortisation	3,038	2,869
Fixed asset impairment	0	592
Audit fees for statutory audit and regulatory work	55	85
Audit fees for further assurance and other services	8	46
Clinical negligence	350	368
Exceptional items	0	0
Other	1,407	1,095
	60,784	**55,921**

5.2 Operating Leases

5.2.1 Operating expenses include:

	31 Mar 2009	31 Mar 2008
	£'000	£'000
Hire of plant and machinery	121	124
Other operating lease rentals	26	24
Total	**147**	**148**

5.2.2 Annual commitments under non-cancellable leases are:

	Land and Buildings		Other Leases	
	2008/09	2007/08	2008/09	2007/08
	£'000	£'000	£'000	£'000
Operating Leases which expire:				
Within 1 year	26	17	113	127
Between 1 and 5 years	71	0	249	368
After 5 years	0	0	0	0
Total	**97**	**17**	**362**	**495**

6 Staff Costs and Numbers

6.1 Staff Costs

	31 Mar 2009	31 Mar 2008
	Total	Total
	£'000	£'000
Salaries and wages	27,820	26,042
Social Security Costs	2,289	2,211
Employer contributions to NHS BSA	2,738	2,596
Other pension costs	0	0
Total	**32,847**	**30,849**

The total Employer Pension contribution payable for the period is £2,738,165

(31 March 2008: £2,596,336).

6.2 Average number of persons employed

	2008/09 Total Number	2007/08 Total Number
Medical and dental	104	101
Ambulance staff	0	0
Administration and estates	219	214
Healthcare assistants and other support staff	74	77
Nursing, midwifery and health visiting staff	311	320
Nursing, midwifery and health visiting learners	0	0
Scientific, therapeutic and technical staff	111	109
Social care staff	0	0
Other	5	6
Total	**824**	**827**

6.3 Retirements due to ill-health

During the year reported of 2008/09 there were no early retirements from the trust agreed on the grounds of ill-health.

7 Other gains and losses

	31 Mar 2009 £'000	31 Mar 2008 £'000
Profit on disposal of plant and equipment	0	0
(Loss) on disposal of plant and equipment	(16)	0
Gain/(loss) on foreign exchange	0	0
Total	**(16)**	**0**

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 2008/09 the Trust had 26 separate losses and special payments, totaling £27,374 (31 March 2008: £62,773). 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 Intangible Fixed Assets

	Software and licences	Licences and trademarks	Patents	Development Expenditure	Total
	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	0	0	0	0	0
Additions purchased	96	0	0	0	96
Additions donated	0	0	0	0	0
Impairments	0	0	0	0	0
Reclassifications	0	0	0	0	0
Other in year revaluation	0	0	0	0	0
Disposals	0	0	0	0	0
Cost or Valuation at 31 March 2009	**96**	**0**	**0**	**0**	**96**
Amortisation at 1 April 2008	0	0	0	0	0
Charged during the period	14	0	0	0	14
Impairments	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0
Reclassifications	0	0	0	0	0
Other in year revaluation	0	0	0	0	0
Disposals	0	0	0	0	0
Depreciation at 31 March 2009	**14**	**0**	**0**	**0**	**14**
Net book value					
Purchased at 1 April 2008	0	0	0	0	0
Donated at 1 April 2008	0	0	0	0	0
Total at 1 April 2008	**0**	**0**	**0**	**0**	**0**
Purchased at 31 March 2009	82	0	0	0	82
Donated at 31 March 2009	0	0	0	0	0
Total at 31 March 2009	**82**	**0**	**0**	**0**	**82**

9. Fixed Assets

9.2 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 2008	6,502	31,242	903	603	8,247	51	2,902	322	50,772
Additions purchased	0	352	46	600	599	0	102	0	1,699
Additions donated	0	0	0	0	0	0	0	0	0
Impairments	0	(1,205)	(174)	0	0	0	0	0	(1,379)
Reclassifications	0	212	278	(490)	0	0	0	0	0
Other in year revaluation	(1,300)	(4,118)	0	0	0	0	0	0	(5,418)
Disposals	0	0	0	0	(222)	0	(296)	(176)	(694)
Cost or Valuation at 31 March 2009	**5,202**	**26,483**	**1,053**	**713**	**8,624**	**51**	**2,708**	**146**	**44,980**
Depreciation at 1 April 2008	0	2,946	91	0	5,287	27	991	322	9,664
Charged during the period	0	1,053	35	0	1,198	8	730	0	3,024
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Other in year revaluation	0	(3,999)	0	0	0	0	0	0	(3,999)
Disposals	0	0	0	0	(210)	0	(290)	(176)	(676)
Depreciation at 31 March 2009	**0**	**0**	**126**	**0**	**6,275**	**35**	**1,431**	**146**	**8,013**
Net book value									
Purchased at 1 April 2008	6,502	26,242	812	603	2,929	24	1,911	0	39,023
Donated at 1 April 2008	0	2,054	0	0	31	0	0	0	2,085
Total at 1 April 2008	**6,502**	**28,296**	**812**	**603**	**2,960**	**24**	**1,911**	**0**	**41,108**
Purchased at 31 March 2009	5,202	24,218	927	713	2,318	16	1,277	0	34,671
Donated at 31 March 2009	0	2,265	0	0	31	0	0	0	2,296
Total at 31 March 2009	**5,202**	**26,483**	**927**	**713**	**2,349**	**16**	**1,277**	**0**	**36,967**

9.3 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 2009	5,202	26,483	927	-	-	-	-		32,612
Unprotected assets at 31 March 2009	-	-	-	713	2,349	16	1,277	-	4,355
Total at 31 March 2009	5,202	26,483	927	713	2,349	16	1,277	-	36,967
Protected assets at 1 April 2008	6,502	28,296	812	-	-	-	-	-	35,610
Unprotected assets at 1 April 2008	-	-	-	603	2,960	24	1,911	-	5,498
Total at 1 April 2008	6,502	28,296	812	603	2,960	24	1,911	-	41,108

9.4 The net book value of land, buildings and dwellings at 31 March 2009 comprises of:

	31 Mar 2009	31 Mar 2008
	£'000	£'000
Freehold	32,472	35,470
Long leasehold	140	140
Short leasehold	0	0
Total	**32,612**	**35,610**

10. Stocks and Work in Progress

	31 Mar 2009	31 Mar 2008
	£'000	£'000
Raw materials and consumables	2,089	1,870
Work-in-progress	0	0
Finished goods	0	0
Total	**2,089**	**1,870**

11. Debtors

	31 Mar 2009	31 Mar 2008
	£'000	£'000
Amounts falling due within one year:		
NHS debtors	3,914	4,771
Provision for irrecoverable debts	(27)	(24)
Other prepayments	493	538
Accrued income	2	0
Other debtors	638	422
Total: falling due within one year	**5,020**	**5,707**
Amounts falling due after more than one year:		
NHS debtors	35	48
Provision for irrecoverable debts	0	0
Other prepayments	0	0
Accrued income	0	
Other debtors	0	0
Total: falling due after more than one year	**35**	**48**
Total Debtors	**5,055**	**5,755**

	31 Mar 2009	31 Mar 2008
	£'000	£'000
Provision for irrecoverable debts:		
Balance at 1 April 2008	24	365
Provided during the year	3	0
Written off during year	0	0
Unused amounts reversed	0	(341)
Balance at 31 March 2009	**27**	**24**

A provision has been made as at 31 March 2009 for impairment of debtors in the amount of £27,000 (£24,000 – 31 March 2008). The provision 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 Mar 2009	31 Mar 2008
	£'000	£'000
Debtors past due date but not impaired:		
Up to three months	793	1093
In three to six months	398	499
Over six months	0	0
	1,191	**1,592**

12 Investments

12.1 Current Asset Investments

The Trust did not hold current asset investments in the period to 31st March 2009.

12.2 Fixed Asset Investments

The Trust did not hold fixed asset investments in the period to 31st March 2009.

13. Creditors

	31 Mar 2009	31 Mar 2008
	£'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	1,354	612
Tax and social security costs	769	19
Vat	0	0
Obligations under finance leases and hire purchase contracts	0	0
Capital creditors	176	753
Other creditors	2,681	2,869
Accruals	388	163
Deferred income	414	184
Sub Total	**5,782**	**4,600**
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 Creditors	**5,782**	**4,600**

Other Creditors include £348,129 outstanding pension contributions at 31st March 2009 (31 March 2008 - £324,149). There are no payments due in future years under arrangements to buy out the liability for early retirements over five years.

14. Provisions for Liabilities and Charges

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Restructurings	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April 2008	0	0	26	0	245	271
Change in discount rate	0	0	0	0	0	0
Arising during the year	0	0	16	0	0	16
Utilised during the year	0	0	(12)	0	(11)	(23)
Reversed unused	0	0	(10)	0	0	(10)
Unwinding of discount	0	0	0	0	21	21
At 31 March 2009	**0**	**0**	**20**	**0**	**255**	**275**
Expected timing of cashflows:						
Within one year	0	0	20	0	19	39
Between one and five years	0	0	0	0	41	41
After five years	0	0	0	0	195	195
Total	**0**	**0**	**20**	**0**	**255**	**275**

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 2009 has £2,561,076 (£652,514 – 31 March 2008) in respect of clinical negligence liabilities of the trust included in its accounts.

15. Movement in Taxpayers' Equity

	31 Mar 2009	31 Mar 2008
	£000	£000
Taxpayers' equity at 1 April 2008	53,348	44,936
Surplus for the period	3,925	7,659
Public dividend capital dividends	(1,325)	(1,404)
Fixed asset impairment	0	(109)
Gains from revaluation of purchased fixed assets and current asset investment	(1,419)	2,348
Net gains / (losses) on available sale investments	0	0
New public dividend capital received in year	0	0
Public dividend capital repaid in year	0	0
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	(88)	(82)
Additions/(reductions) in other reserve	0	0
Taxpayers' equity at 31 March 2009	**54,441**	**53,348**

16. Movement in Public Dividend Capital

	31 Mar 2009	31 Mar 2008
	£000	£000
Public dividend capital at 1 April 2008	38,905	38,905
New public dividend capital received	0	0
Public dividend capital repaid in period	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 2009	**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 2008 as previously stated	6,165	1,976	0	0	6,302	**14,443**
Prior Period Adjustments	0	0	0	0	0	**0**
At 1 April 2008 as restated	6,165	1,976	0	0	6,302	**14,443**
Transfer from the income and expenditure account	0	0	0	0	2,600	**2,600**
Fixed asset impairments	0	0	0	0	0	**0**
Surplus/(deficit) on other revaluations of fixed assets	(1,419)	0	0	0	0	**(1,419)**
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	(88)	0	0	0	**(88)**
Other transfers between reserves	423	0	0	0	(423)	**0**
Other movements on reserves	0	0	0	0	0	**0**
At 31 March 2009	**5,169**	**1,888**	**0**	**0**	**8,479**	**15,536**

Other transfers between reserves show a movement of £423,000 between income and expenditure reserve and revaluation reserve to correct the brought forward figures.

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 £17,900,000 in 2008/9 (£16,100,000 in 2007/8). The trust borrowed/repaid a net £0 in 2008/09 (£0 in 2007/8) and at 31 March 2009 had £0 of outstanding borrowing (£0 at 31 March 2008) The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £13.9m, and

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

Financial Ratio	Actual Ratios 08/09	Approved PBL ratios 08/09	Actual Ratios 07/08	Approved PBL ratios 07/08
Maximum Debt / Capital Ratio	0%	0%	0%	0%
Maximum Dividend Cover	3x	3x	3x	3x
Maximum Interest Cover	0%	0%	0%	0%
Maximum Debt Service Cover	0%	0%	0%	0%
Maximum Debt Service to Revenue	0%	0%	0%	0%

The trust has an approved working capital facility of £4.0m (£4.0m in 2007/8). The trust had drawn down £0 of its working capital facility at 31 March 2009 (£0 at 31 March 2008).

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:

	2008/09	2007/08
	£000	£000
Total operating surplus (deficit)	3,319	7,004
Depreciation and amortisation charge	3,038	2,869
Fixed asset impairments	1,379	592
Fixed asset reversal of impairments	0	0
Transfer from donated asset reserve	(88)	(82)
Other Movements	(20)	(2)
(Increase)/decrease in stocks	(219)	(654)
(Increase)/decrease in debtors	659	(1,775)
Increase/(decrease) in creditors	1,759	(973)
Increase/(decrease) in provisions	4	12
Net cash inflow/(outflow) from operating activities before restructuring costs	**9,831**	**6,991**
Payments in respect of fundamental reorganisation/restructuring	0	0
Net cash inflow from operating activities	**9,831**	**6,991**

The fixed asset impairment shown in 2008/09 represents the exceptional item shown in the income and expenditure account.

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

	2008/09	2007/08
	£000	£000
Increase/(decrease) in cash in the period	6,819	862
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	**6,819**	**862**
Non - cash changes in debt	0	0
Net debt at 1 April 2008	9,486	8,624
Net debt at 31 March 2009	**16,305**	**9,486**

19.3 Analysis of changes in cash and liquid resources

	31 Mar 2009	Changes in period	31 Mar 2008
	£'000	£'000	£'000
Cash at bank and in hand	16,305	6,819	9,486
Current asset investments	0	0	0
Total	**16,305**	**6,819**	**9,486**

Cash at bank and in hand as at 31st March 2009 includes £16,222,054 in respect of balances held in the Office of Paymaster General.

20 Capital Commitments

Commitments under capital expenditure in the Balance Sheet were £149,738 (£214,394 - 31 March 2008).

21 Post Balance Sheet Events

During June the Trust will enter into a contract to construct a new outpatient department with a value of approximately £7million. The project has a proposed build time of 12 months.

22 Contingencies

	2008/09	2007/08
	£000	£000
Gross contingent liabilities	(17)	(17)
Amounts recoverable	0	0
Net value of contingent liabilities	(17)	(17)

The contingent liabilities relate to two employee liability claims.

The Trust does not have any contingent assets at 31st March 2009.

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
- Sandwell and West Birmingham Hospitals NHS Trust
- Sandwell Mental Health and Social Care Foundation Trust
- Warwickshire PCT
- Walsall Teaching PCT
- Worcestershire PCT
- Birmingham Children's Hospital NHS Foundation Trust

- Heart of England NHS Foundation Trust
- University Hospital Birmingham NHS Foundation Trust
- University Hospitals Coventry and Warwickshire NHS Trust
- Leicestershire County and Rutland PCT
- South Staffordshire PCT
- Solihull Care PCT

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

- HM Revenue & Customs
- NHS Pensions
- NHS Litigation Authority
- National Health Service Logistics Authority
- Birmingham City Council
- NHS Purchasing and Supply Agency
- Health Commission for Wales

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 £12,756 during the year (£12,415 – 31 March 2008).

24 Private Finance Initiatives

The Trust did not have any Private Finance Initiative schemes as at 31 March 2009.

25 Financial Instruments

The Royal Orthopaedic Hospital NHS Foundation Trust seeks to minimize its financial risks and through its treasury management policy does not buy or sell financial instruments.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest. The Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2009 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

Liquidity Risk

The Trust's operating costs are incurred under contracts with NHS Primary Care Trusts 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 Trusts £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.

Set out below is an analysis, by category, of the Trust's financial assets and liabilities as at 31 March 2009. Fair value approximates to the book value because of the short maturity of these instruments.

25.1 Financial Assets

	Assets at fair value through the I&E *	Loans and receivables	Available-for-sale	Total
	£000	£000	£000	£000
Assets as per balance sheet				
Embedded derivatives	0	0	0	0
NHS receivables	0	3,922	0	3,922
Cash at bank and in hand	0	16,305	0	16,305
Other financial assets	0	545	0	545
Total at 31 March 2009	**0**	**20,772**	**0**	**20,772**
Embedded derivatives	0	0	0	0
NHS receivables	0	4,795	0	4,795
Cash at bank and in hand	0	9,486	0	9,486
Other financial assets	0	356	0	356
Total at 31 March 2008	**0**	**14,637**	**0**	**14,637**

25.2 Financial liabilities

	Liabilities at fair value through the I&E *	Other	Total
	£000	£000	£000
Liabilities as per balance sheet			
Embedded derivatives	0	0	0
Borrowings	0	0	0
Finance lease obligations	0	0	0
Other financial liabilities	0	4,874	4,874
Total at 31 March 2009	**0**	**4,874**	**4,874**
Embedded derivatives	0	0	0
Borrowings	0	0	0
Finance lease obligations	0	0	0
Other financial liabilities	0	4,668	4,668
Total at 31 March 2008	**0**	**4,668**	**4,668**

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.