Annual Report 2009/10

Royal Orthopaedic Hospital 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 2009-2010

Contents 2009/10

1. Chairman's Message

Despite all the external pressures placed upon the Healthcare system I am pleased to report that our focus at the Royal Orthopaedic Hospital remains unchanged and delivering excellent standards of care to all our patients remains our single biggest priority.

As a Trust we are very pleased that our own evaluation of care is reflected in the independent assessments that the Trust receives each year from Monitor and the Care Quality 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 attention that everyone pays to these issues on a daily basis.

The Board takes these issues very seriously and Directors are actively involved in a number of forums and activities that expose them to the frontline activities of the Trust. One example is a Quality Day where the Board specifically looked at ways in which the Trust could improve care and safety standards even higher. The highlight of the day was when a number of patients and carers relived their experience of care at the Royal Orthopaedic Hospital from their perspective. It was an enlightening discussion and most thought provoking. As always there were lessons to be learned but it was an excellent way to engage the Directors and receive a balanced opinion of our service and standard of care.

Patient involvement is something that we actively encourage and we have commissioned some research in conjunction with the University of Birmingham that involves patients with the design of the new outpatient department currently under construction at the Woodlands site. The research is proving invaluable and we are gaining an important insight into what patients would like to see and expect from services in the new building.

When it comes to more routine feedback our Patient's Council is one of the forums at which any concerns can be aired. The committee is chaired by a public governor from our Members' Council and feedback is given directly to the Trust for action. It is an invaluable barometer of what is happening in the Trust and an ideal opportunity for patients to raise any concerns they may have.

As part of our ongoing appetite for feedback we also carry out an ongoing patient survey, the results of which are reported back to the Board.

Our Members' Council has been very involved in Trust matters during the year, working on various committees looking at member involvement and patient experience. We had two joint Board meetings in the year at which a variety of issues were discussed and the Members' Council were actively involved in the development of our strategy and Annual Plan.

With the passage of time the working relationship with the Members' Council improves and I am pleased to be able to report that we have a very constructive, open and transparent relationship between the Board and the Council. We have seen a number of council members change over the year as their term of office came to an end but interest in the vacant seats remained strong with most being contested. The skills and experience of council members is considerable and throughout the year they have made a significant contribution to the development and governance of the Trust.

On a broader note I would like to make reference to the work that the Trust's public engagement team have been undertaking to develop the relationship the Trust has with the local community and other key stakeholder groups.

One of the key initiatives relates to young volunteers who are both in and out of education where, since the scheme started, we have placed and supported 28 young people into voluntary positions. We are also working with Birmingham City Council Disability Employment Service, Mind, Community Options and Work Directions to place 20 individuals with significant disabilities to undertake voluntary work at the Trust. These initiatives, together with many others, demonstrate our commitment to working with our stakeholders particularly in our local community.

I would like just to make reference to the challenges that the Trust faces as a result of the continuing problems in the economy. As you will see from later in this report the Trust had another successful financial year and was able to record a surplus. During the year we were awarded the very highest rating by Monitor for our financial management thereby maintaining the standard set the previous year. However, looking ahead the financial challenge is considerable and as a Trust we will have to find innovative ways to improve our efficiency without compromising the quality of care or patient safety.

In response to this challenge the Trust has embarked upon a programme we are calling 'Excellent Health' which has presented us with many opportunities to improve efficiency

and patient safety. Although the initial findings are very positive there is still much to be done and we will continue to roll out the programme across the Trust.

Despite difficult times one thing remains constant – the high level of commitment and dedication of all staff. The demands placed on staff are considerable whatever their role within the Trust and they never fail to rise to the challenge by consistently fulfilling their responsibilities to the very highest standard. We also 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 the Trust.

We have a Board and Members' Council that are fully engaged with the oversight of the Trust who always put the patient at the heart of their thinking. 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

Laurence James

2. Chief Executive's Report

2009/2010 has been a year of challenges and celebrations within the Trust's history as we celebrated our 100th year history on the Woodlands site. Our drive to be one of the leading providers of routine and specialist orthopaedic services nationally saw rewards as the Trust received the highest possible ratings from the Care Quality Commission in Autumn 2009. We were delighted to be rated as 'excellent' on Use of Resources and 'excellent' on Quality of Services and this served to reflect the tremendous hard work and dedication of our staff and volunteers. We continued to have positive feedback on our services both from our Annual Patient Survey, our In-House Patient Surveys and through the letters of thanks we receive.

The year was not without its challenges however, and we continued to face the major challenge of delivering a referral to treatment target of 18 weeks for our admitted and non-admitted patients. Orthopaedics is one of the specialities that has significant difficulties across the country in achieving this waiting time target and we understand that this is nationally recognised. We did however achieve the target and have continued to achieve it during the course of the year due again to the tremendous efforts of our staff. We continued to have significant challenges in the delivery of this target in relation to our Spinal Surgery Services and it will be a key area of work during the next 12 months to look at how we can improve this.

The year also saw an exciting new initiative as the Trust entered into a partnership arrangement with the BMI Edgbaston Hospital, expanding our theatre and ward facilities to deal with the increases in patients we are seeing attending the Trust. Although this initiative took some time to take off at the beginning of the year, our medical and nursing staff have embraced it, resulting in our Forelands Ward Team winning "Team of the Year" within the hospital during 2009/10. We continued to have consistently positive feedback for this ward and will build on the services provided there to ensure greater efficiency over the next 12 months.

April 2009 also saw us finally move to an off-site decontamination facility which was approached with some trepidation from staff within the hospital. Leading up to the move off-site in April, a significant amount of work was undertaken jointly between staff at the hospital and colleagues in BBraun Sterilog Limited which resulted in a seamless transfer of service to the new facility. The basis of this working relationship has been built on since April and allowed BBraun to run a priority service successfully across the Trust.

At the turn of the year the Trust was pleased to hear that the partnership bid for a HIEC (Health Innovation and Education Cluster) had been successful. The contract was awarded to the University of Birmingham as the accountable body and means that health organisations and higher education institutions will be working together to capitalise on and embed innovative practice supported by the very best education and training. ROH has secured a seat on the start-up board and been actively involved in preparing the proposal.

Towards the end of 2009 the Trust faced the challenge of losing its kitchen, servery and dining room to a major fire, however in true Royal Orthopaedic Hospital spirit, new temporary facilities were in place within 24 hours and during that period all patients were fed and cared for with no cancellations to service. A significant amount of work was undertaken to achieve this by both the hospital's Estates and Facilities Departments and it is a credit to the staff in all of those areas that we were able to maintain continuity of patient service.

We also saw some new director level appointments during the course of the year with a new Director of Workforce & Organisational Development joining us in September 2009 and a new substantive Director of Operations in October 2009.

I am pleased that during the last 12 months the Trust has not only maintained its focus on the delivery of quality outcomes and seen reductions in infection rates, it has also embarked on a major efficiency project linked to lean methodology and we are already seeing benefits within the Theatre Department of adopting this approach. We are now preparing to take this forward as we move into 2010/11.

Penny Venables

3. Operating and Financial Review 2009/10

Summary of Financial Performance

2009/10 has been a challenging year for the UK economy and the Trust has not been immune to this. Maintaining strong performance and constraining costs has been challenging. During the year the Trust developed its forward strategy which is designed to ensure a stable and resilient future for the organisation in difficult times. At times of pressure, any small organisation finds itself particularly tested as managers have to accelerate plans for efficiency, actively seek new opportunities and maintain a measured approach to risk.

The year was particularly financially challenging year for the Trust as a new tariff regime reduced income by £2.5m (3.8%) before taking in to account the normal cost pressures of running a hospital. The challenge for the Trust Board and Members' Council was therefore to ensure that the Trust was able to set a surplus target and reduce costs significantly in year whilst continuing to strive to improve quality and invest in the Trust's future.

The 2009/10 financial strategy was agreed by the Board of Directors and Members' Council and the following key objectives were set:

Financial Objective	**Outcome**
Deliver a minimum surplus of £2.5m	Surplus £2.16m The above surplus included a £0.4m write off due to site valuation which is excluded when calculating the surplus for Monitor metrics. When excluded the operating surplus achieved was £2.56m.
Achieve a Monitor Risk rating of 5	Achieved a 5 at each quarter
Deliver £3.6m in cost reduction	Achieved £3.5m
Deliver a capital programme of £7.4m	Delivered £4.9m

Monitor Financial Metric	**Actual**	**Plan**
EBITDA margin	9.1%	10.1%
EBITDA Achieved (%)	91.6%	100%
Return on Assets	7.1%	7.3%
I&E Margin	3.8%	3.8%
Liquidity Risk (days)	114	104

For the second year in a row the Trust achieved its target position of a risk rating of 5, which represents the lowest risk rating available. This means that the Trust was rated double excellent, being excellent both for the quality of its care and the use of resources.

This excellent position is the culmination of a lot of hard work from the clinical staff and managers across the Trust who have successfully balanced the pressures of delivering excellent care within a tight financial envelope.

Activity

The Trust treated 16,000 inpatients and saw in excess of 72,000 outpatients throughout the year including 9,000 patients who received a procedure within the outpatient setting.

	2009/10			2008/09	
	Actual Treated	**Plan Treatment**	**Variance**	**Actual Treated**	**Variance**
Admitted Patient Care					
Elective	6,933	6,664	269	6,853	80
Non-Elective	499	600	(101)	498	1
Day Cases	8,493	9,336	(843)	9,208	(715)
Total Admitted Patient Care	**15,925**	**16,600**	**(675)**	**16,559**	**(634)**
Outpatients					
First Appointment	17,462	17,168	294	18,209	(747)
Follow Up Appointment	45,755	52,471	(6,716)	54,896	(9,141)
Outpatients with Procedures	8,961	4,232	4,729	0	8,961
Total Outpatients	**72,178**	**73,871**	**(1,693)**	**73,105**	**(927)**

The Trust has increased the number of elective inpatients by increasing the number of theatres available to eleven having entered in to a partnership with a private provider, and also routinely operates in Worcestershire to support the need for patients to be treated closer to home wherever possible.

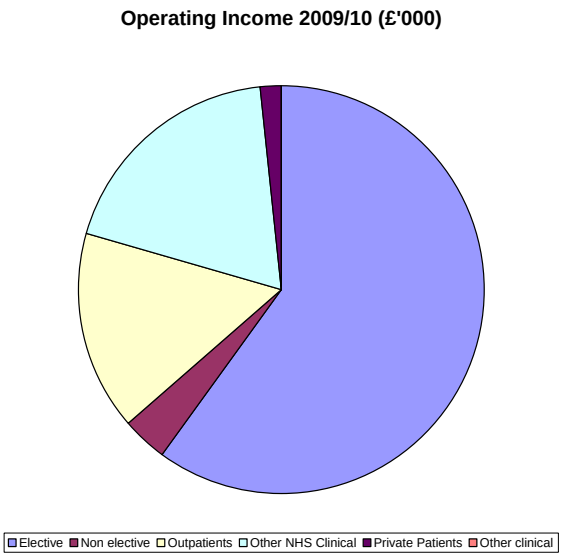
Comprehensive Income

Despite the loss on tariff the trust has continued to grow its income base and from that has produced a material operating surplus, which will act as a firm base for revenue and capital investment in quality, growth and facilities in the future uncertain financial climate.

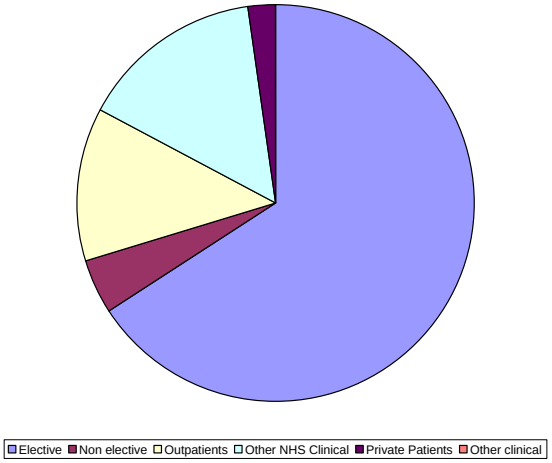
	2009/10 £'m	**2008/09 £'m**
Operating Income	67.29	65.48
Operating Expenses	(63.96)	(62.14)
Operating Surplus	3.38	3.33
Net Finance Costs	(1.18)	(0.73)
Net Operating Surplus	**2.16**	**2.6**

* Operating expenses include a write off for the lowering of market value of the site due to the current economic conditions of £0.68m (£0.94m 08/09), which is excluded from the operating surplus measured by Monitor as it is a technical valuation adjustment. The Trust therefore exceeded its target for the independent regulator of £2.5m by achieving £2.56m.

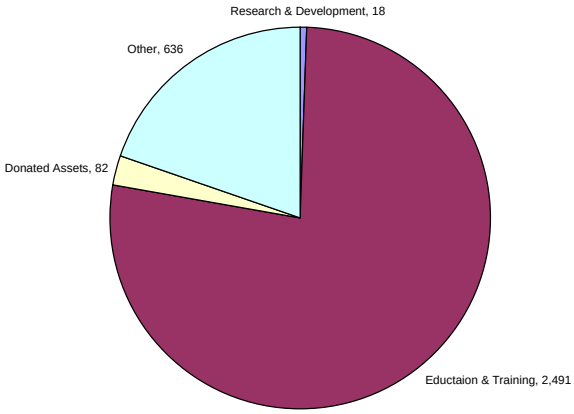
Sources of Income



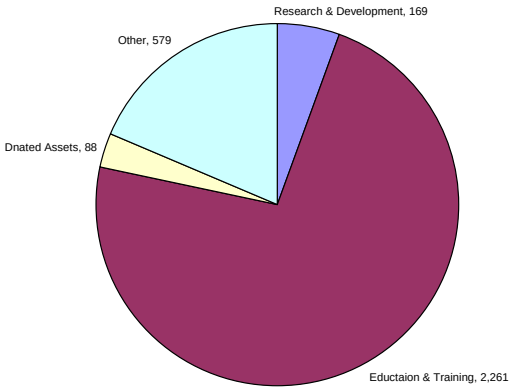
Healthcare Income 2008/09 (£'000)



Other Income 2009/10 (£'000)



Other 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 2009/10 the Trust percentage of private patient was 1.6% (2% 08/09).

Improving efficiency and ensuring continued value for money

The Trust continually strives to work efficiently and demonstrate value for money in all that it does. All staff are involved in waste cutting initiatives and in doing so ensure that all available resources are used to add value to patient care and the patient experience.

To support challenge we have committed to an Excellent Health Programme which during the year has identified a number of process changes and new ways of working to deliver more effective and safer healthcare at a lower cost in the Theatre and Ward areas. This work is continuing across the Trust and in 2010/11 the Trust is introducing a Lean Academy where trained ROH staff will lead change across the Trust. These schemes are led by clinical and medical staff with full involvement of our staff side representatives.

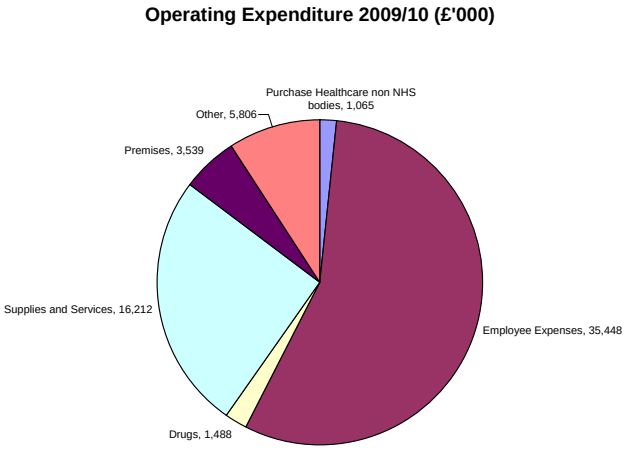
In 2009/10 the Trust delivered in excess of £3m in cost improvements without reducing the headcount of staffing or impacting upon patient care. This represents a concerted effort by all staff with increased clinical engagement to highlight areas where safe improvements and cost reduction could be achieved.

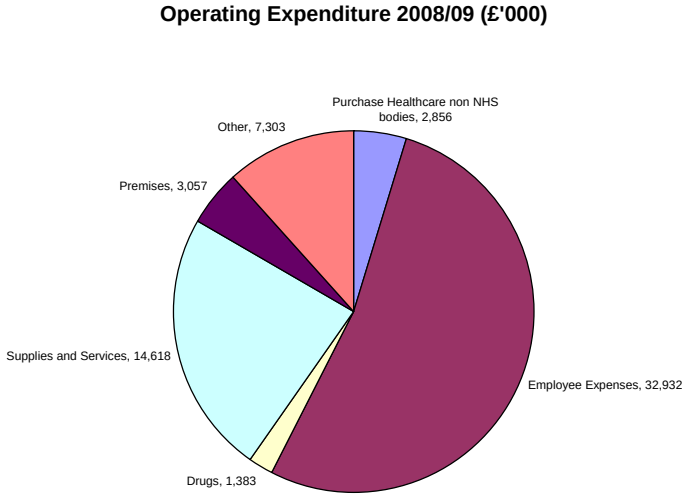
For the foreseeable future the Trust will need to reduce its costs by in excess of 5% per annum. The focus for this work will be through the Lean Academy, quality initiatives and partnership working with our commissioners and other Trusts.

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 is within its allocated budget. The Trust Board and the Executive Management team monitor this.

Analysis of Trust Expenditure 2008/09





The largest element of expenditure for the Trust is staffing which accounts for 55% of expenditure. The cost of staffing increased proportionally from 52% in 2008/09 as the Trust invested in the provision of an additional theatre and ward ensuring that all patients were treated at regular ROH managed facilities . The cost of purchased healthcare reduced from 5% to 2% of Trust expenditure in the same period.

Capital Investment

Having achieved foundation status ,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 (£3.5m)
- Improving the Trust estate (£0.4m)
- Elimination of Mixed Sex Wards (£0.3m)

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 31st March 2010 the Charitable Funds have a Balance of £690,800. During 2008/09 the Trust raised £118,200 whilst spending £172,500. The main schemes supported were:

1. Supporting the oncology service £7,000
2. Supporting the anaesthetic service £4,000
3. Supporting the Children's Ward £8,000
4. Purchase of medical equipment £53,000
5. Touch screens and IT equipment for physiotherapy £3,000

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

Regulator Risk Ratings

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

A financial risk rating of 5 denotes a Trust with the lowest level of financial risk and one being the highest.
[1]

2009/10	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	5	5	5	5	5
Governance risk rating	Green	Green	Green	Amber	Not known
Mandatory services	Green	Green	Green	Green	Green

[1] [1] The outpatients development programme has a total value of £8m and will be completed in the financial year 2010/11 where the remaining spend will be accounted for.

2008/09	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	5	5	5	5	5
Governance risk rating	Amber	Amber	Amber	Green	Not known
Mandatory services	Green	Green	Green	Green	Green

4. Quality Report and Account 2009/10

Our commitment to quality improvement

PART ONE

The View from the top – developed by listening to others

In late 2009 the Trust board adopted a new strategy for the hospital that would put our aspiration for quality at the heart of everything we do. As part of the process of developing the strategy the Board sought the views of patients and carers, its Members' Council and its Patient Council. This Quality Report and Account has been compiled to reflect these views and those of our commissioners and to clearly reflect the work of the past year and identify how we propose to take forward measurable initiatives in support of our work.

Our Vision is:

'To be the first choice for orthopaedic services for patients, carers and commissioners'.

We will continue to be an organisation with:

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

We will:

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

As an organisation with an enviable reputation for what we do, we recognise that the way we provide services is of real value to our patients. To be perceived as delivering excellence we must have values that clearly define what we mean. We have set these as follows:

Quality

- We will treat everyone with dignity
- We will listen to patients and understand their individual needs
- We will strive to get the basics of care right every time
- We will provide comfort to those in need
- We will provide a safe environment for patients and staff
- We will learn from our mistakes and adopt a fair blame culture

Integrity

- We will be honest and deliver on our promises to patients, carers and each other
- We will do our job and expect others to do theirs in a competent manner
- We will manage our finances effectively
- We will tackle inequality in delivery of services and employment

Leadership

- We will influence orthopaedic practice nationally
- We will set challenging goals for ourselves and others
- We will involve staff in improving the services we provide
- Our leaders will provide opportunities for staff to learn and develop
- We will tackle underperformance
- We will communicate clearly with staff and listen to their opinion

Innovation

- We will seek new and better ways to care for patients today and in the future
- We will challenge conventions to improve what we do and become more effective
- We will actively search for opportunities to further develop sustainable services

Partnerships

- We will collaborate with other organisations to build a sustainable future
- We will seek to reduce our impact on the environment
- We will work across professional boundaries to provide flexible services for patients
- We will involve people for the benefit of our communities

Our top priority throughout the organisation continues to be to deliver safe, high quality care for our patients. We were proud to see this acknowledged during 2009/10 with the achievement of an excellent rating for quality of services awarded by the Care Quality Commission.

Actively listening to others

During the course of the year the Board held a quality workshop with valuable input from our patients, carers, staff and our commissioners. This enabled the board members to hear first hand what mattered to these important groups and to ensure that as we developed our strategy these issues were recognised and incorporated.

Quality has also been integral to our discussions with our Members' Council and our newly established Patient Experience sub-committee is driving a number of improvements in our administrative processes. We are also working closely with colleagues at the University of Birmingham using experience based-design methodology to involve patients, carers, volunteers and staff in influencing the development of our new outpatients department.

Actively involving our staff

We have seen major quality improvements during the year supported by the introduction of new ways of working. The Excellent Health programme and Productive Ward both encourage staff to step back, look at how they do things and make improvements that save time and resource and improve efficiency and effectiveness. Both these programmes have demonstrated improvements for staff as well as patients and have empowered staff to lead and implement quality improvements. They also identify and allow the release of additional time for direct patient care by adopting a lean approach to all activity.

Visibility of the top team

The senior management team undertake 'patient safety walkabouts' where, by visiting wards and service areas, they can see for themselves the standards of the working environment and hear from staff at all levels, what issues they feel need to be addressed. Quality rounds are undertaken by the Director of Nursing and Governance and her team of Senior Nurses (Matrons). Each non-executive director has been involved in visiting clinical areas and departments and the Chairman is regularly seen on independent walkabout throughout the organisation.

Putting systems in place to give assurance

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

Thanks to those who have helped undertake this work in the last year

We would like to take this opportunity to thank all of our staff for their contribution in delivering a quality service over the past year and we look forward to continuing to ensure that this remains at the top of our agenda in the future.

We would also like to thank those groups that have helped us in the development of our Quality Account. These include our Clinical Directors, senior management team and the IGC. Discussions have also been held with the Members Council Patient Experience sub-committee and representatives from the Birmingham LINk.

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

CEO signature.....

PART TWO

Our performance against the quality improvement priorities we set for 2009/2010 and statements of assurance from the Board

We set a range of priorities in 2009/10 that were agreed by the board following discussion with commissioners.

The table below (Table 1) outlines these priorities and our performance against them. There are three key areas of quality performance; safety, effectiveness and experience. These are called 'domains' by health organisations when they look at quality.

Safety is about getting those important things that have the potential to do harm to patients right every time.

Effectiveness looks at issues that impact on the clinical outcome of patient care.

Experience covers matters that have an effect on how patients feel about their treatment or stay in hospital.

NHS service providers work with commissioners of care to agree how to embed national, local and regional priorities through the Commissioning for Quality and Innovation arrangements (CQUINS).

Table 1 – Performance against quality improvement priorities during 2009/10

In 2010/11 the Trust will continue to monitor the 2009/2010 priorities to ensure that standards are maintained or improved upon still further.

SAFETY AIM	RESULTS 2009/10	ONGOING METHOD OF MONITORING for 2010/11
To improve staff survey results on incident reporting (*The staff survey takes place once a year and is independently completed and analysed for all Trusts)*	The 2009 staff survey demonstrates that the number of staff witnessing incidents/errors has reduced by 3% and those reporting them has increased by 2% ☒	National staff survey and associated action plan reported bi-annually to the Board.
To have zero 'never' events (*These events are described by the National Patient Safety Agency as those things that should never happen and include, for example,*	Achieved – there were zero 'never' events ☑	Incident reporting system with monthly reports to the

leaving instruments or swabs in patients during operations ; injecting neat potassium chloride,; feeding patients through tubes that are placed incorrectly or operating on the wrong area.		Board
To halve the number of drug errors (*This means reducing mistakes about prescribing or administering patient medication)*	Not achieved – there were 135 drug errors reported in 2009/10 compared to 119 in 08/09. None of these caused serious harm. ☒ The increased focus on safety has encouraged greater reporting . Work will continue to encourage reporting of errors and identify improvements that ensure patients receive prescribed medicines.	Incident reporting system with monthly reports to the Board

EFFECTIVENESS AIM	**RESULTS** **2009/10**	**ONGOING METHOD OF MONITORING for 2010/11**
To improve surveillance of wound infections (*It's never possible to prevent all infections after surgery, but these can cause real misery to patients, so the hospital keeps a watchful eye on follow-up)*	Achieved for all hip and knee replacements – surgical site infection data is now collected for 30 days post surgery. ☑ (Previously this data had only been collected whilst patients were in hospital)	Via surveillance systems, CQUIN and quarterly reports to Infection Control Committee and the Board
To reduce urinary tract infections (*It had been identified that there were more*	Achieved – reduced from 32% in October	Via surveillance systems, CQUIN and quarterly

than expected incidences of these infections the previous year which the Trust looked into and identified improved ways of caring for patients)	2008 to 4% in May 09. ☑	reports to Infection Control Committee and the Board
To benchmark the following indicators against other specialist orthopaedic Trusts and identify areas for improvement: **1. Above expected length of stay** **2. Readmission rates** **3. In-hospital mortality** (*It is better for patients to get back home as soon as possible after surgery. It's also not good for patients to have to come back in again. Any patient death while in hospital is of concern, even though some surgery has potential high risks of which our patients are made aware)*	Achieved- benchmarking has been undertaken across all 3 areas using Dr Foster data. ☑ This has demonstrated that above average length of stay and in-hospital mortality rates are better than the comparison group. Readmission rates appear higher and further work is being undertaken to understand the reasons for this**.**	Via information systems and quarterly reports to Clinical Outcomes and Effectiveness Committee and the Board

PATIENT EXPERIENCE AIM	**RESULTS** **2009/10**	**ONGOING METHOD OF MONITORING for 2010/11**
To reduce the numbers of patients saying in the National Patient Survey that: **1. They shared sleeping accommodation with the opposite sex (from 8.7% to 7%)** **2. They shared toilet facilities with the opposite sex (from 9.6% to 8%)** (*The National Patient Survey is independently conducted across all Trusts and it is acknowledged as undesirable that different*	The scores in the 2009 patient survey were as follows: 6.3% said they shared sleeping accommodation (achieved) ☑ 8.7% said they shared toilet facilities (improved but not achieved) ⌃	National Inpatient Survey and associated action plan reported bi-annually to the Board.

genders share accommodation or facilities)		
To reduce complaints by 5% (*Complaints are a key indicator of dissatisfaction and the Trust looks for themes in order to tackle common issues and reduce future complaints)*	Achieved – complaints reduced from 172 to 147, a reduction of 15% In 2010/11 We aim to further reduce by 5% ☑	Complaints monitoring system with monthly reports to the Board
To reduce the percentage of patients who rated hospital food as poor in the national survey from 16.6% to 12% (*The National Patient Survey is independently conducted and the Trust benchmarks itself against others. Food quality was seen to be a recurrent issue)*	Improved but not achieved - 15.2% of patients rated the hospital food as poor. 🡅	National Inpatient Survey and associated action plan bi-annually to the Board. In-house patient survey reports quarterly to the Board.

These areas continue to be priorities in 2010/11 and Table 2 reflects this.

Quality improvement priorities for 2010/11

The table below (Table 2) outlines the quality improvement priorities for 2010/11. These have been chosen with the help and involvement of the Clinical Directors, the senior management team, the Integrated Governance Committee, the Members' Council Patient Experience sub-committee and representatives from the Birmingham LINk . The table also explains why these were chosen and how they will be monitored and reported on. Commissioning for Quality and Innovations (CQUINs) are monitored through the Trust's contract and reflect national, regional and local priorities.

Table 2 - Quality improvement priorities for 2010/11

SAFETY PRIORITIES	RATIONALE	**Monitoring and Reporting** (*A system has been developed with the agreement of the PCT for Board and commissioners to assess performance against CQUIN targets.)*
90% of patients will be assessed for risk of	National	Via CQUIN

venous thrombo-embolism (*This is also sometimes known as deep vein thrombosis or DVT and there are national guidelines on how to reduce this risk)*	requirement CQUIN Audit work demonstrates that this is an area for improvement	monitoring reports Quarterly to the Board
Reduction in falls by 10% from 09/10 baseline (*Patients may cause themselves further injury by falling and the Trust recognises that orthopaedic patients are particularly at risk, but that this risk must be balanced with the need to encourage mobility after surgery)*	Local priority CQUIN To reduce potential harm to patients	Via CQUIN monitoring reports Quarterly to the Board
Reduction in missed doses of medication determined from baseline audit (*This will take place in May 2010)*	Local priority CQUIN To reduce potential harm to patients	Via CQUIN monitoring reports Quarterly to the Board

CLINICAL EFFECTIVENESS PRIORITIES	**RATIONALE**	**Monitoring and Reporting**
Reduction in non-MRSA bacteraemia by 50% from 2008/9 baseline of 32 cases	Local priority CQUIN To reduce potential harm to patients	Via CQUIN monitoring reports Quarterly to the Board
Reduction in pressure ulcers from 2009/10 baseline (*The baseline will be confirmed early in 2010/11)*	CQUIN To reduce potential harm to patients	Via CQUIN monitoring reports Quarterly to the Board
To examine re-admission data identifying, implementing and monitoring actions as necessary	To better understand causes of readmission and	Analysis of Dr Foster information presented to

(*this work is to look at why patients are returning to hospital and to identify ways to reduce this)*	to take action to reduce these	Clinical Outcomes Committee Quarterly to the Board

PATIENT EXPERIENCE PRIORITIES	**RATIONALE**	**Monitoring and Reporting**
To increase the number of questions in the National Patient Survey where ROH scores in the top 20% of all Trusts from 67% to more than 75% (*This gives us an independent view of our overall quality and will provide evidence to support the achievement of our ambition to become the first choice hospital for orthopaedic care)*	To ensure there is a continuous focus on improving the patient experience	Annual national patient survey and in-house real time survey Quarterly to the Board
To reduce the % of patients who rated hospital food as poor in the national survey from 15.2% to 12%	Local priority To ensure improvement in the quality of the food provided	Annual national patient survey and in-house real time survey Quarterly to the Board
To reduce the numbers of patients saying in the national patient survey that they shared toilet facilities with the opposite sex from 8.7% to 8%	To deliver the improvements set out previously	Annual national patient survey and in-house real time survey. Delivering Same Sex Accommodation action plan Quarterly to the Board

STATEMENTS OF ASSURANCE FROM THE BOARD

This section of the report includes statements of assurance from the Board (in bold italics) together with additional commentary and information from the Trust.

During 2009/2010 the Royal Orthopaedic NHS Foundation Trust provided trauma and orthopaedic, neurosurgery, pain management and general medicine services.

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

The income generated by the NHS services reviewed in 2009/10 represents 95% of the total income generated from the provision of NHS services by the Royal Orthopaedic Hospital NHS Foundation Trust.

Patient Safety Walkabouts

"All members of the senior team make visits to different wards and services within the Trust to talk with staff, face-to-face, about the issues that concern them. This means that leadership is visible and accessible and that Board members can see what's going on. These visits have cast light on local issues, identified unnecessary blocks to change and allowed obstacles to be overcome quickly. This has engendered a real feeling of empowerment in staff to initiate change and reinforced the collective responsibility we all have for patient safety."

Lindsey Webb, Director of Nursing and Governance.

Clinical audits allow clinical staff to review the quality and effectiveness of their services to patients through an established and independent process of auditing.

During 2009/2010 two national clinical audits and one national confidential enquiry covered NHS services that the Royal Orthopaedic Hospital NHS Foundation Trust provides.

During the period The Royal Orthopaedic Hospital NHS Foundation Trust participated in 100% of the available national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

The national clinical audits and the national confidential enquiries that the Royal Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during the reporting period were:

1. National Joint Registry – hip and knee replacement
   – on average, for the period April-September 2009 97.5% of NJR-relevant operations were submitted. The NJR required a compliance rate of 80%.

2. Patient Reported Outcome Measures – hip and knee replacement
   – on average, during the period Oct 09-Feb 10 (during which PROMS has been monitored at the ROH) 91.8% of hip replacements had a PROMS form completed, and 94.02% of knees. The PROMS scheme requires a compliance percentage of 60%.

3. National Confidential Enquiry into Peri-operative Deaths
   – this was led by the interim Clinical Director of Anaesthetics who has responsibility for reviewing all peri-operative deaths.

Learning lessons from clinical audits

The reports of these 2 national clinical audits were reviewed by the Trust in 2009/2010 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The ROH has increased their efforts to monitor metal on metal hip resurfacings as a result of reviewing the data collected by the National Joint Registry.
- The PROMS audit builds on work already done at the ROH, and when the first feedback report is received the Trust will compare its findings to our currently collected data.
- The National Confidential Enquiry into Peri-operative Deaths was a piece of work that had already been woven into the fabric of the organisation over the last ten years or so. Thanks to this, systems were set in place for on-call anaesthetic cover and it also helped inform the design of our emergency service.

In addition to national clinical audits, the Trust undertakes its own clinical audits.

Such audits are frequently undertaken by the surgical and anaesthetic teams and staff are encouraged to draw up action plans as a result to ensure that learning is captured and best practice shared.

The reports of 64 local audits were reviewed by the Trust in 2009/10 and the Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

The reports of the 64 local clinical audits (including rolling audits as well as one-off audits) were reviewed by the trust in 2009/2010. Examples from two anaesthetic audits in late 2009 are as follows: one related to IV cannula quality control and one HDU bed allocation. From the cannula audit it was agreed that the department would move toward a better quality of safety needle. The HDU bed allocation audit has been sent to the relevant Clinical Service Manager for action that involved training for ward staff to enable more effective management of post operative monitoring of patients.

The importance of clinical audits

"Clinical audit is not a new idea but it is evolving. We have always looked at our results and tried to learn from our outcomes how to do better in the future. What we are learning is that this responsibility is shared across the organisation and across all disciplines and specialities.

Matt Revell, Clinical Director, Clinical Outcomes

National Patient Safety Agency alert and medication audits are frequently undertaken. A 2009 NPSA enteral feeding audit showed that there were some gaps in staff knowledge so an action plan was formulated, including feedback of results to nutrition and medicines links, ward

managers and senior nurses. Enteral guidelines were then developed and additional training arranged.

Example

The Trust has a robust medicines audit schedule, with six monthly drug chart audits being undertaken, and quarterly 'snap shot' audits of medication charts. Following these audits, actions are agreed with ward managers and results and actions fed back to the area team. Reporting of serious or potentially serious non compliance via the Trust's incident reporting system is encouraged, and the issues raised are discussed in monthly medicines link meetings. Recent audits showed that there needed to be better compliance with expected prescribing and administration requirements, improved documentation relating to omissions, and further training, updates and assessments to ensure awareness of safe medicines prescribing and administration. A plan is currently being followed through to ensure these actions take place

.

Future Audit Plans

An audit programme for the forthcoming 12 months has been put together, the results from which will be presented at each surgical audit meeting so that actions can be identified and followed through as necessary. This will include Trust-wide topics such as consent, venous thrombo embolism, and patient records.

Our Infection Prevention and Control Team (IPCT) have a strong audit system which all wards and theatres must participate in. All areas continue to audit the environment and hand hygiene every month in conjunction with one other specific audit according to the IPCT audit calendar. A specific audit tool has also been designed to meet the needs of theatres and recovery. Some changes recently been made to the audits ensure that an action plan is now required once the audit is completed, in order to help track the resolution of issues along with assisting the chasing of outstanding problems.

The trust's Pain Management Programme is reviewed every six months using evaluation forms. The programme is monitored to make sure it is at the right level and the information given to patients is appropriate and in sufficient detail.

The Therapies department has a dedicated audit and research lead who chairs frequent meetings to discuss ongoing and prospective projects. She also attends Clinical Outcomes and Effectiveness meetings to ensure actions are taken as appropriate.

The Trust will continue to participate in all relevant national audits. The national audit on diabetes, and also dementia, were sent to the organisation in the last financial year, but it was deemed not necessary for us to participate, being a specialist Trust. The Trust will be participating in the national falls and bone health audit from September 2010.

Participation in clinical research

The number of patients receiving NHS services provided by The Royal Orthopaedic Hospital NHS Foundation Trust in 2009/2010 that were recruited during that period to participate in research approved by a research ethics committee was 34.

Participation in clinical research is growing and this demonstrates The Royal Orthopaedic NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

The Trust was involved in conducting 12 clinical research studies during 2009/10. All of these were completed as designed within the agreed time and at the agreed level of patient participation. The Trust used national systems to ensure that studies were managed appropriately for the degree of risk involved.

In line with best practice, five of the studies were given permission to start by an authorised person less than 30 days from receipt of valid complete application. Four of the studies were established and managed under national model agreements and none of the 12 eligible research projects involved the use of a research passport (This is a document which has details about the accredited competence of the individual and allows them to work in different organisations). In 2009/2010 the National Institute for Health research (NIHR) supported six of these studies through its research networks.

In the last three years no publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

Other Publications

As a specialist hospital, many of the Trust's consultants use their skills to develop new services and to support colleagues across the world in understanding orthopaedic issues. They share this learning through publications in medical journals and at major conferences where they give presentations on their work.

An example of a long-term study was that of a patient who had a very rare tumour in a part of the body where it was also rare for this type of tumour to occur. The Trust's oncology consultants followed this case for 16 years and reported on the difficulty of diagnosis and management of such a rare, slow growing and low grade tumour. Their publication explains how such a tumour could be confused with something more common. Theirs was the first publication on this condition and will help others understand how to improve their diagnosis and support better patient care.

A case study was also published which considered the use of total hip replacement and revision for hyatid disease (a type of cyst) involving the bony pelvis. The patient had a large recurrent cyst and this was probably the first time such treatment was used to help overcome the problem.

Financial, Contracting, Data and Regulatory Information Related to Quality

Commissioning for Quality and innovation – CQUIN funding

CQUIN funding is made available to the Trust on the basis that agreed improvements are made in specific areas of performance. This money is not guaranteed income for a Trust, but is paid according to agreed levels of achievement. There are national, regional and local priorities for investment of this money and the tables earlier in part two identify some of these.

A proportion of The Royal Orthopaedic Hospital NHS Foundation Trust's income in 2009/2010 was conditional on achieving quality improvement and innovation goals agreed between The Royal Orthopaedic Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

(Further details of the agreed goals for 2009/2010 and for the following 12 month period are available on request from the Trust's Head of Commissioning, Gareth Hyland, Gareth.hyland@roh.nhs.uk)

Statements from the Care Quality Commission

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

The Royal Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered.

The Care Quality Commission has not taken any enforcement action against The Royal Orthopaedic NHS Foundation Trust during 2009/2010.

The Royal Orthopaedic Hospital NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission and the last review was in October 2009. The CQC's assessment of The Royal Orthopaedic Hospital NHS Foundation Trust identified the Trust as having no areas for concern in the healthcare associated infection inspection undertaken in October 2009.

The Royal Orthopaedic Hospital NHS Foundation Trust has not participated in any special reviews or investigations by CQC during the reporting period.

Data Quality

All NHS organisations must keep data on the treatment of patients. This data is, of course, highly sensitive and also allows Trusts to be accountable for the quality of the service they provide in comparison to others.

Much of the data provided is gathered in an agreed way and must meet exacting standards. The standard of our information management is assessed using an Information Governance Toolkit.

The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 2009/2010 Secondary Uses Service for inclusion in Hospital Episode Statistics which are included in the latest published national data.

The percentages of records in the published data which included the patient's valid NHS number were:

98.70% for admitted care

99.57% for outpatient care

N/A % for accident and emergency care (as this Trust does not offer an accident and emergency service)

The percentages of records in the published data which included the patient's valid General Medical Practice Code were:

97.84% for admitted care

98.83% for outpatient care

N/A % for accident and emergency care (as this Trust does not offer an accident and emergency service)

The Royal Orthopaedic Hospital NHS Foundation Trust's score for 2009/2010 Information Quality and Records Management, assessed using the Information Governance Toolkit was 94.42%.

Payment by results is a system which protects the public purse by ensuring that providers are only paid for work done. Every time a patient visits hospital and is seen by a consultant or their team, and where a diagnosis is made or a surgical procedure undertaken, this will be given a nationally determined code. Each code has a standard payment tariff associated with it. Trusts match the code to each procedure and to make sure Trusts provide accurate information, this matching is independently audited and the percentage accuracy of the Trust's submissions is quoted in the statement below.

The Royal Orthopaedic Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the 2009/10 reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Primary diagnosis incorrect 10%

Secondary diagnosis incorrect 13.6%

Primary procedures incorrect 3.6%

Secondary procedures incorrect 3.9%

The above audit results were taken from a sample for procedures carried out between April 09 –June 09 and for the following types of procedures only:

- ***Trauma and orthopaedics***
- ***Spinal surgery***
- ***HRG4 activity for HB99Z***

Therefore, the above clinical coding error rates should not be extrapolated further than this sample.

PART THREE

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

In Part Two the Trust demonstrated its agreed targets for quality 2009/10, identified how well we performed and looked forward to 2010/11.

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

2009/10 could be described as the Trust's 'lift-off' in its quest for excellence in patient care.

As we developed our new Trust strategy (highlighted in Part One), there was a very real imperative to think about financial consequences and this could have steered us away from thinking about the root of our business – patient care. Similarly, performance targets can always drive behaviour and grab our attention.

At Board level, and this has also been evident throughout the organisation, we have come back every time to underpin our decisions with a view of what is right for the patient.

The Board has met with patients and had feedback on where our services fell down against patient expectations. The Board also considered how it could avoid the pitfalls of trying to balance the books and tipping over the boundary, away from great patient care. The Board has also considered how to make positive use of the benefits of Foundation Trust membership, its strong group of volunteers and its early steps in terms of public engagement.

These interests can sometimes compete, but the challenge was to make them complementary to one another.

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

Excellent Health – our key quality improvement programme

This is a programme of investment which the Trust Board approved for implementation early in 2009/10 and which will continue throughout 2010/11 using external help to support an ongoing pro-active approach adopted by our staff.

The project is all about improving the way we do things so that patients benefit. The project begins in theatres which are at the core of what we do and yet are areas that patients really don't see, but from which they derive such benefit.

Our clinicians and their teams are our most vital resource in terms of quality of clinical outcome for patients and supporting them to work effectively is essential. Having the right patient at the right time, in the right theatre, with all the correct instruments, anaesthetics and theatre team seems like a simple enough formula, but there is always the potential for an overrun, for staff sickness, or for a patient to pull out at the last minute, and these things have a huge impact on the work of everyone else and on patients themselves. The project team supports theatre staff in identifying how to plan to cope with these things and to make sure that theatres are fully staffed

and fully used and that patients have their operations on time and in as calm and safe an environment as possible.

One of the biggest differences is having information clearly visible and shared by everyone across all ten theatres - this highlights urgent problems and facilitates rapid solutions.

Steve Bloomer, Director of Finance

"For us, quality is a corporate responsibility. My key responsibility is finance, and I recognise that great quality gives great value for money. In the last year, through major investment in our Excellent Health programme, this Trust has been able to change the way we do things in theatres to the benefit of our patients. Thinking in a lean way is a continuous process that only works if all those involved feel they can have a say and 'own' any changes.

"Starting in theatres, which is the hub of our activity, has meant that we can get the right processes in place to ensure patients have as good an experience as possible during a time which is, for them, quite frightening. This means that their transfer from wards will be more timely and they should never suffer unnecessary delays that might increase their anxiety.

"As this work rolls out along the patient journey in the organisation, we will see even more benefits. Yes, this will save money, but what it really liberates is our freedom to invest in additional work that makes a real difference."

Productive Ward – Releasing Time to Care

This is a programme developed by the NHS Institute for Improvement and Innovation that helps wards look at the way they do things to improve care for patients by releasing nursing time. The key to its success is that it is owned and implemented at ward level and involves everyone.

Two of our wards were showcase wards and have implemented a number of changes with all of the other wards now starting this work. Changes have included better organisation of ward areas, improving the way in which meals are delivered and improving information for all staff on the ward about what is happening with each patient. All of these have released nurses time and staff and patient satisfaction surveys have reported increased levels of satisfaction for both groups. The programme has also helped to reduce complaints and staff sickness.

Sister Louise Turley – Ward 1

"Productive Ward has really helped us to make improvements in our ward area. I was a bit sceptical at the beginning but can now really see the benefits that it has had for patients and staff and I am now its biggest fan! The ward is much better organised and the nurses have more time to spend with patients and are less stressed. This in turn has meant our patients are happier and feel well cared for."

Building for the Future

Over several years, since the opening of our newest wards in the Treatment Centre and due to the location of our imaging department diagonally across the site from our outpatients department, patients have had to walk over a third of a mile between outpatients and x-ray. The last stretch of the walk was supported by a buggy operated by our volunteers and supported by the League of Friends, but everyone recognised the deep irony of making orthopaedic patients travel great distances across the site and back again, when mobility was likely to be a core problem. Until we became a Foundation Trust, our hands were tied. To build a new outpatient department was our dream but not a priority in competition for funds with other trusts, nor of sufficient scale to merit a private finance initiative.

This year, we have been able to literally build the foundations to make the dream real by using our own money to fund this new space.

The building design will be simple, environmentally friendly and fit for patients. It directly addresses a long-standing patient concern about their experience when they come for their diagnostic appointments.

Dr Elizabeth Hensel, Non Executive Director

"As a clinician and academic researcher, I have responsibility at the Board for championing the patients' perspective. One of our major opportunities to do things differently came this year with the design of our new outpatient department.

"We wanted to make sure that we used our patients' experience of current services as a key part of the design and planning of the new service, so we decided to use the Experience Based Design (EBD) approach promoted by the NHS Institute for Innovation and Improvement. The Trust has worked with researchers from the University of Birmingham to pilot the approach and adapt it for our further use. The researchers have worked with patients and carers to identify their stories and journeys, and also with staff. Currently staff and patients are working together to jointly design the new service. Changes will be implemented by both staff and patients and evaluated by the University.

"As a Foundation Trust we have funded this development entirely from our own resources. It is an investment that must really work across all fronts and key to this is the patient. Whatever design we could have came up with would have improved some things, for example the current long walk between the outpatients department and x-ray. However we realised it would have been all too easy to be complacent. Our Board seeks to go that extra mile for the patient and we have now embedded this approach into any future re-design of our facilities."

Putting Patients First

Professor Andrew Stevens, Non-Executive Director "As chair of the Integrated Governance Committee I have seen huge strides made by the Trust this year to understand exactly what quality means to the organisation.

"The Board held a whole-day workshop and invited patients to tell their story and there can be no denying that this was a seminal moment in our corporate thinking – sitting face-to-face with people telling us what we got right and what we occasionally or persistently got wrong.

"The statistics we received tell an impressive story. There is, almost without exception, praise for our clinical work, cleanliness and staff. It seems that we struggle with some of the ostensibly simpler things – communication, food, and keeping to schedule.

"We recognise that in terms of patient experience, until these things meet the standards we aim for, we cannot be complacent.

"I am pleased that we have shone a spotlight on these and will be reviewing progress in these key areas as part of our drive to be the hospital of choice for orthopaedic services."

The Board has certainly wanted to put patients first this year, but wanted to make sure we continued to listen to what they had to say rather than just making assumptions about what we thought they'd say.

As a Foundation Trust we have a unique opportunity to use our Members' Council and our membership to help us continually challenge ourselves to improve.

The Council was instrumental in supporting our strategic ambitions and re-structured its own committees to take account of the future direction of the organisation. It established a Patient Experience Committee that would add to the work of the Patient Council and seek to ensure that the patient perspective was taken into account.

Val Doyle, Director of Operations

"In my role I have overall responsibility for how we deliver services to patients. It's all too easy to be driven by targets and lose sight of the little things that patients find so important.

"Our Members' Council re-focused its committee structure this year with a major committee looking at patient experience. One of the first things they did was bring examples of some of the confusing correspondence we sent out. I was genuinely shocked and went off to investigate a problem that they felt had been persistent since way before my time, but had never previously been crystallised with a file of examples.

"In my review I found a myriad letters of varying quality and clarity. With colleagues we agreed to simplify things and it was satisfying to all concerned to have finally cracked a problem that had rumbled on for some time.

"By working with this committee, I believe we can quickly iron out some of the minor glitches in our processes that irritate patients. In doing this we will save time, resource and money and be able to re-utilise that efficiency saving to provide an even better service."

Training our future clinicians

We are proud to be a specialist teaching hospital, able to offer students the chance to rub shoulders with and learn from some of the best orthopaedic surgeons in the world. We were concerned that the training of undergraduate doctors in our specialty was a very brief period of time and that it made sense to adopt a new approach that enhanced their diagnostic skills in orthopaedics.

One of our Clinical Directors developed a simple and possibly unique 'simulated patient' approach to support the 5 week teaching programme. Mindful of the strong band of volunteers at the hospital, and aware that many of them had been or still were orthopaedic patients, he sought to devise a programme which would bring them and the trainee doctors together.

As a result, working with other clinical practitioners, a programme was devised where volunteers learnt roles and 'acted' as patients. The student doctors had access to guinea pigs on whom to try their interviewing, interpersonal and examining skills. The pilot has proved extremely successful with students feeling it to be of real value and with volunteers who feel they've made a real contribution to the style and patient focus of our future workforce.

Volunteer and 'simulated patient', Ron Greenwood:

"I have been a patient at a local hospital for some time and also an active volunteer at ROH, so it has been a real delight to participate in the simulated patient programme devised this year by the Trust.

"Volunteers are trained to 'act' as patients – we're given advice on the sort of symptoms we would have and we take on different roles each week.

"Over a few weeks, trainee doctors examine us and take histories in a safe environment. We play our roles, then give direct feedback on 'how it was for us'. Over the weeks, with support of the clinical staff we see them grow in skill and confidence. They engage with us more effectively, find ways of asking us to move so that they can carry out examinations better and their feedback suggests it really brings their learning alive.

"Healthcare is a people business and our doctors undoubtedly have the brainpower to learn the science, but there's no substitute for human interaction to really test understanding and communication.

"It's given us an insight into how little trainees sometimes see of real patients before they 'go live' and this sort of work is yet another reason why I am so committed to this hospital."

It all starts with our staff and the little things – it's these that make the difference

We believe that this hospital has quality running all the way through and really seeks to improve all the time. There is no room for complacency and so we begin at induction with an emphasis on high quality patient care. We know patients fear infections and we know it's the vigilance of our staff that will prevent these. Our infection control team has won awards for its work.

Claire Kettle, Personal Assistant

"One of the best things about mandatory training is the section on infection control. It's no wonder we win awards and have such a low rate of infection because the only bug that survives here is the cleanliness bug!

"I defy anyone who finds out about the number of germs on the human body; the unmentionable things we women carry on the bottom of our handbags and the residual dirt we can see under the purple glow of the detection machine after we've inadequately washed our hands to ever again fail to observe and obey the handwashing and gel dispensing facilities as they go round the wards!"

All staff are made aware of the NHS Constitution and we have included a full module on this in our internal bespoke management development programme. This underpins the role and responsibilities of staff as well as the rights of patients.

Our workforce is supported with ongoing training that encourages individuals to be responsible for updating their skills.and for personal achievement. Working with a neighbouring acute trust we have developed a leadership programme for clinical managers and team leaders that covers customer excellence, dignity and safety. There will also be a interactive module on handling and safeguarding vulnerable adults which is designed to embed best practice.

Emily Harris, Healthcare Assistant and apprentice

"The Trust encouraged me to attend some training on improving patient care at the local college. They really encouraged me and my hard work paid off when I won an award from Bournville College – The Exceptional Customer Care Award for Healthcare Assistants."

"I enjoy working with people, but the course reminds me to think about how what I do affects them. I know that makes a real difference."

The trust welcomes students on placement and many school students return after work experience as volunteers. The Trust makes best use of apprenticeships, undergraduate and post-graduate internship and because of the size of the Trust, many students comment on the breadth of the experience they are able to gain while with us.

All staff in the organisation are subject to annual appraisal and this offers the chance to talk about performance. In future this will be supplemented with discussion about their understanding of the values of the organisation and what these mean in the context of their individual jobs. The Board has asked that the executive team find ways to make better connections between the appraisal process and the Trust Business Plan and align individual training with the organisation's overall training needs analysis. This should result in an improvement in the percentage of employees receiving and recording proper appraisal.

Alongside the development of its strategy, the Trust will develop a full training needs analysis for its staff and has already undertaken a skill mix review of nursing. These processes help the Trust identify what gaps it has in terms of skill and behaviours as well as providing benchmark information to assure the Board that staffing levels and competencies are sufficient to deliver excellent patient care.

The Trust has completed the AMQUAR self assessment which has identified the priority actions for the Trust and our doctors in preparation for Medical Revalidation. We have taken the first step by appointing a Clinical Director for Medical Workforce and Regulation, Mr Andre Jackowski, who will lead on the Trust's preparation in this important area. We have already commenced work by ensuring all of our Clinical Directors are trained to undertake enhanced appraisals that will be required to support the revalidation process.

The Trust Board regularly reviews the rates of sickness absence in the organisation as these can be an indicator of areas where management attention is needed or where service levels might be adversely hit. During 2009/10 there was concern at high levels of sickness in a couple of departments and this was reviewed and correlated to unavoidable long-term sickness of individuals or to areas under sever operational pressure. Using data to trigger intervention, the trust was able to meet teams and identify ways to improve the situation. This has meant that any adverse impact has been minimised.

Leadership

2009/10 was the first full year of the Trust's new Clinical Director structure. As the Clinical Directors' management and corporate responsibilities represent a new feature in their roles, the Trust devised a development programme for them and delivered workshops specifically focusing on the emerging strategy. The visibility of their leadership among clinical peers and colleagues has already begun to see improvements in working practice and innovation. As a result the sub-specialties, research and clinical outcomes activities have each been able to stand back and consider how best to improve what they do.

Andrew Thomas, Medical Director

"Until 18 months ago, my role was the single identified focus of corporate medical leadership in the Trust. As a practising surgeon, my time away from clinical work was limited so a solution had to be found that would add value, allow a range of talented individuals to make a clear contribution and to underpin the development of Medical Directors of the future."

"Already they have used the scope of their empowerment to build their teams and agree processes that are right for them. At the same time, they can learn from colleagues, share best practice and pilot new approaches with support of the whole consultant body."

The senior management team of the trust has identified its own learning needs and has worked with the Board and external organisations to challenge its paradigms and ways of thinking. The economic circumstances of 2009/10 meant that nothing could be taken for granted and so the team deliberately counterbalanced the need to revisit financial considerations with heightened focus on clinical outcomes and patient care issues.

For 2010/11, the Trust will disseminate the strategy and use high level indicators of patient and staff satisfaction as key measures of engagement and perception. There is a real recognition that communication is fundamental to staff feeling well led and part of a strong team and this will be a major area for the trust to evolve over the coming months.

Maintaining standards across the board - national targets and regulatory requirements

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

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

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

Many members of the public are familiar with the 18 week target and this gives patients the right to expect that from their initial referral to the necessary treatment (such as an operation or

physiotherapy), they have to wait no more than 18 weeks. There will always be exceptions – sometimes for clinical reasons and sometimes because of the sheer level of demand on the surgeons and the absence of colleagues elsewhere with the skills to offer treatment. For us, this is particularly true in spinal surgery and paediatric spinal deformity where we have now influenced a national review of the sub-specialty.

The table below shows our track record against these targets. When we benchmark ourselves against other orthopaedic departments we believe our achievements are significantly better than most.

National target	08/9	09/10	Comment
Fully meet all 24 core standards	Achieved	Achieved	
MRSA	Achieved	Achieved	
C diff	Achieved	National target – achieved Local target – not achieved	Local target of 7 breached – 9 cases in total (5 of which were hospital acquired)
31day subsequent treatment all cancers	NA	Achieved	
31 diagnosis to treatment all cancers	Achieved	Achieved	
62 day referral to treatment of all cancers	Achieved	Achieved	
2 week cancer wait	Achieved	Achieved	
18 week referral to treatment admitted	Achieved	Achieved	
18week referral to treatment non admitted	Achieved	Achieved	
Screening all elective admissions for MRSA	NA	Achieved	

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Measuring quality as we move forward

The Trust has achieved good performance in its data quality and successfully measures against national targets.

What is recognised, however, is that the measurement of quality requires more than quantitative date sets, it requires data analysis and the accumulation of qualitative data.

The quality observatory will help provide minimum data sets, but the internal drawing together and analysis of information is crucial to us really understanding how several parts of the organisation work together to provide the patient pathway.

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

For 2010/11 the Trust is introducing and piloting a consultation toolkit that will allow any part of the organisation to gather feedback from internal or external customers using a wide variety of techniques. This was inspired by the Board session on quality where an external speaker outlined how many service improvements came from listening to internal customers. This had particular resonance as the Trust recognised that whilst clinical practice was strong, some of the administrative and support functions were perceived as less effective. Using a rigorous and non-subjective method of gathering information would make it hard to fail to respond to feedback.

Laurence James, Chairman

"In conclusion – quality is central. Without it, our reputation will be damaged irrevocably and in a people business, reputation is everything."

"This report is written at the start of our journey to be the first choice provider of orthopaedic services, combining clinical excellence with great customer care in every situation. We are building on almost two centuries of orthopaedic tradition, 100 years of surgery on the Woodlands site and an ongoing sense of purposeful ambition".

"There is no room for complacency. Patients cannot fail to compare us with the shiny new buildings of major hospitals nearby, or the cosy familiarity of their local community clinic. My Board and my team are committed to building on the strength of having a relatively small, committed workforce, a fantastically loyal and proud membership and patients who do not hesitate to recommend us to others. Our quality agenda cannot be fully described in so few words as there are in this report, but I hope it gives a flavour of what we do and a clear indication of our commitment to continue to do still more."

Annex to the ROH Quality Report and Account: Statements from Local Involvement Networks, Overview and Scrutiny Committees and Primary Care Trusts

Statement of Birmingham LINk

The Trust has a clear 'vision' statement which has been informed by a consideration of the views of Commissioners and those of patients and careers which it has actively sought in developing a new strategy. The strategy aims to put quality at the heart of all its activities.

The vision statement focuses clearly on:

- Quality
- Integrity
- Leadership
- Innovation
- Partnership

During 2009/10, the Trust achieved a rating of 'excellence in quality' from the Care Quality Commission.

The Trust has reported a number of initiatives which involve actively listening to the public, service users, carers and staff.

There have been innovations reported relating to working practices and Senior Management are engaging in 'high visibility', allowing opportunities for interaction with service users, clinical staff and the monitoring of standards of care. This, in conjunction with the development of quality assurance mechanisms, indicates a positive move towards transparency and clear accountability and should enable the Trust to respond quickly to identified needs and priorities.

The Royal Orthopaedic Hospital NHS Foundation Trust has reported improved quality against a number of performance indicators / targets. It has been open about areas in which targets have not been met e.g. the aim of reduction of patients sharing toilet facilities with the opposite sex by 1.6% was not achieved although improved.

The Trust has clearly identified its priorities for 2010/11 in order to drive up quality. It has identified a number of monitoring mechanisms and also a range of activities undertaken.

Up to March 2010, the Trust has not had a direct relationship with Birmingham LINk, but in March, initiated contact with the LINk. This resulted in useful initial contact during which LINk representatives had a preliminary discussion with the Chief Executive and Director of Nursing about how the Trust might work with LINk. Apparent goodwill and enthusiasm by the Trust was demonstrated, and a further meeting has been requested by them in order to develop a future partnership and further explore suggestions made at the March meeting.

The comments in this report by LINk are based on the Trust's report on the quality of its activities and LINk has not seen any of the primary data related to this. However, if current Patient Council Members, volunteers, Governors of the Trust and members of the public were to join LINk and form a ROH NHS FT Action Group, the Trust could provide this group with timely data throughout the year. This would facilitate public involvement in shaping care provision in a consultative process, and enable the group to provide an informed report on the Annual Quality Account of the Trust.

Overview and Scrutiny Committee

The Birmingham Overview and Scrutiny Committee has received the Quality Report and Account but has decided not to make comment in 2009/10 due to the calling of a general election during the period in which such a review would have been made.

Statement of South Birmingham Primary Care Trust (NHS South Birmingham)

NHS South Birmingham welcomes the opportunity to contribute to the Quality Account through this corroborated statement with regards to the existing contracts it holds with the Trust and any associated information. The whole commissioning organisation has had an opportunity to provide feedback, including the Public Involvement Action Group.

The Trust has clearly engaged with patients, staff, volunteers and user groups to produce the Quality Account, the contributions from staff in particular provide good evidence of the priority placed on improving quality.

We have an on-going quality monitoring process with the Trust which includes monthly contract meetings and quarterly performance and quality meetings. This provides the PCT with a good understanding of the issues facing the Trust, its internal systems and processes that are in place to provide assurance.

The Trust sets out clear organisation values to deliver excellence and has clearly described its achievements around quality, safety and clinical effectiveness and commitment to a number of quality improvement programmes for 2010-11. There is evidence of participation in clinical audits and examples of how this has led to service improvements.

NHS South Birmingham can verify the low incidence of MRSA and Clostridium Difficile infection rates within the Trust and the reported level of performance against the 4 elements of the CQUIN.

The Account reflects the considerable number of activities that have been undertaken to improve the patient experience, including responding to feedback having recognised areas of concern. We acknowledge the work planned for 2010-11, to use feedback more in improving patient experience.

In summary, the Quality Account provides a balanced view of both the Trust's achievements throughout 2009-10 and has set clear priorities for quality improvement in 2010-11.

We will continue to work in partnership with Royal Orthopaedic Hospital Foundation Trust during the coming year in commissioning quality services on behalf of patients.

How to provide feedback on the account

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

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

Email: Lindsey.Webb@roh.nhs.uk
Telephone: 0121 685 4233
Address: The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham B31 2AP

5. Sustainability/Climate Change report 2009/10

On 30th September 2009 the Trust Board set out the organisation's intentions for its carbon reduction commitment and agreed with the target set for the NHS based upon a reduction from the 2007 carbon footprint of 10% by 2015. This commitment requires:

- Every organisation to review its energy and carbon management at Board level.
- Measure and monitor as a whole life cycle cost basis.
- Ensure appropriate behaviours are encouraged in individuals as well as across the organisation.

The Trust needed to establish a baseline from which it could measure its progress and is using information from the year 2006/07.

Sustainability and climate change cover a range of topics that come together to show how much energy the organisation uses to do its work. This doesn't just cover gas, water and electricity, but also includes transport, travel and waste. By including better ways to design buildings, encouraging staff to think more about the energy they use and by encouraging recycling and tree planting, the Trust helps to balance its energy use with making efforts to undertake positive actions which reduce the effects of greenhouse gases on the environment.

The ROH NHS Foundation Trust routinely gathers information on its use of energy and production of waste through its Estates Return Information Collection (ERIC), submissions to the Department of Health.

The Trust Board is committed in 2010/11 to publish a strategy which will help its staff contribute to effectively move towards the achievement of the 10% reduction by 2015.

This will be an important milestone and will take account of the significant change of facilities on site with the completion of a new, energy-efficient outpatient department. The Trust is mindful of the additional high-tech facilities in that unit as well as the design improvements which will help ensure that general consumption is as low as possible. Nonetheless, the hospital still provides many of its services from older, less energy-efficient buildings and the strategy must recognise this. So, for example, while metering will enable departments to measure their consumption more accurately, it will be staff behaviour that will really make the difference.

Already the Trust has worked to improve its recycling with highly visible recycling points around the site and staff are actively encouraged to use public transport, cycle or walk to work through regular incentive programmes, competitions and reminders.

There has been a major initiative for staff to encourage tree planting as part of a national scheme and this involves our community partners.

The Trust takes seriously its role as a good corporate citizen and works with partners wherever possible to make improvements. Recently it has begun to work with Northfield Eco Centre, a local voluntary organisation that can help the trust develop ideas and schemes that will engage and motivate staff and patients to think and act more responsibly about the environment.

The Trust reviews the data it collects through ERIC and seeks to identify trends and act on any negative results. It can be seen, for example, that usage of energy and production of waste actually rose from the 2006/7 baseline year, which might, on the face of it, seem disappointing, but this was due to significantly higher levels of activity and movement from 5 to 6 (and sometimes 7) day working to meet 18 week targets for patient care.

Key actions that underpin our strategy:

- Establish and confirm a database of 2006/7 for carbon usage in the areas of energy usage of gas and electricity and waste
- Establish a database in2010/11, when the information is available for travel and procurement
- Inform and engage all the staff in the Trust about the commitment to achieve a reduction of 10% of our carbon usage by 2015
- Support staff by installing metering within hospital departments for the usage of energy and water consumption to give them relevant information
- Agree targets for each department to reduce its carbon usage in terms of gas, electricity and water
- Set targets across the hospital to reduce its carbon usage concerning waste and travel
- The Trust will survey its estate to identify which areas can produce savings through investment for energy consumption.

Making sure things happen and getting external assurance

The Trust has established a Good Corporate Citizen Group (GCCG) which has broad representation from across the organisation. This group actively reviews the data available on energy consumption, waste and travel and reports quarterly to the Executive Management Team and provides an annual report to the Trust Board.
In order to secure external assurance for the Trust that the GCCG were moving in the right direction, the Trust asked its internal auditors to review the plans of the group and received the report in March 2010.

The internal auditors advised that the Trust was well placed to provide assurance through its Statement on Internal Control regarding the progress it had made on the carbon management agenda.

The Trust has confirmed to its auditors that it will develop an action plan using the GCCG which will address accountability, timescales, monitoring processes and resource allocation.

It was identified that greater collaboration with suppliers could potentially enhance results and that really specific measurable targets would drive performance.

The auditors suggested that the Trust Board consider payback on investment when considering any capital projects designed to reduce emissions and identify how long it might take to recoup financial savings sufficient to merit the initial spend.

The auditors recognised that the Trust cannot do everything and must seek to prioritise and secure value for money and so the strategy will set clear and evaluated priorities that have real impact.

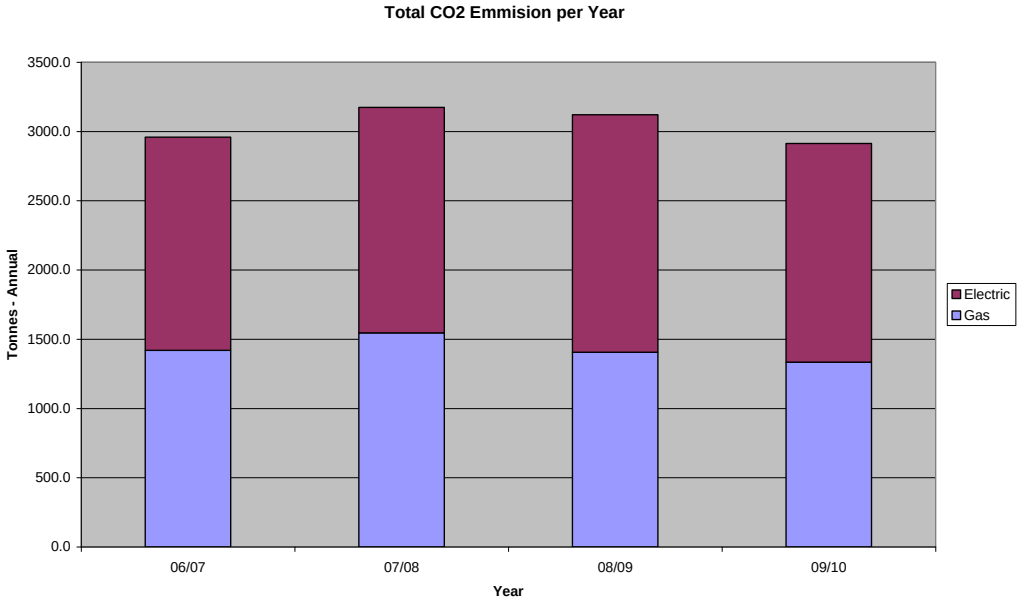
Our performance to date

In setting the database for energy and water at 2006/7, the Trust reviewed and updated its data for electricity, gas, water and waste as follows:

	Non-Financial–Tonnes per annum					Financial £/000		
	6/7	7/8	8/9	9/10	% Saving	8/9	9/10	% Saving
Electricity	1539	1629	1714	1529	1	359	354	1
Gas	1420	1546	1406	1333	-7	244	115	53
Water M^3	29374	24737	26950	22800	24	49	44	10
Waste	0	0	139	152	49	49	56	+14.
Transport	0	0	1.1	1.07	3	0	0	0

No data is available for waste in 2006/7 or 2007/8

The graph below shows total CO2 Emission per year between 2006/7 and 2009/10



What the table tells us as at March 2010

During 2009/10 the Trust reversed an upward trend in the consumption of electricity by staff 'good housekeeping' efforts, resulting in a small saving on cost to the Trust. The 2007/8 data gave a rogue reading for gas consumption caused by a faulty meter and now corrected, shows a steadyreduction. The Trust has invested in new energy efficient boilers in the administration building during 2009/10 and this should show a saving in carbon usage in future. The fall in the price of gas gave the Trust a financial saving. The Trust reduced its water consumption when it transferred its decontamination of theatre instruments 'off site' to BBraun and this has resulted in

a financial saving in water usage. The Trust's waste has increased during the last two years despite recycling measures and segregation of its domestic and clinical waste. This increase is in part due to the increased use of disposable clinical and non-clinical products in areas such as infection control and catering.

Investing to save

In order for the Trust to move forward with its strategy and to be able to set targets for future sustainability, the ROH has undertaken a survey of the estate to establish an 'Invest to Save' programme.

A carbon footprint is usually stated in terms of kilograms of carbon (Kg) being used. There are two main fuels normally considered when reviewing the carbon footprint of a building, these being either electricity or gas fuel. The carbon footprint of a Trust can be calculated for each building by establishing the amount of electricity or gas that has been consumed, in terms of kilowatt hours and converting to an equivalent in kilograms of carbon, using published carbon emissions factors.

Electricity has a higher carbon emission factor than gas due to its production inefficiencies so targeting a reduction in electrical consumption would have a greater effect on the carbon footprint of a building than gas. By targeting electrical services, the Trust would secure a greater return.

Investment in improving lighting luminaries and controls will be:

Capital Cost:	£83800
Potential saving:	£10900
Pay-back (years):	8.6
CO_2 saving (Kgc):	10190

Investment in energy consumption meters in order to set department targets requires an investment of £6000 across the trust.

Gas

Targeting a reduction in the use of gas fuelled services, the ROH would undertake boiler and ventilation plant replacement:

Capital Cost:	£215,000
Potential saving:	£12,500
Pay-back (years):	17
CO_2 saving (Kgc):	22,718

Ventilation Plant:	
Capital Cost:	£50000
Potential saving:	£6787
Pay-back (years):	7.5
CO_2 saving (Kgc):	11,993

The ROH will be investing though the capital programme in a three year 'Invest to Save' strategy to achieve these CO_2 savings.

Through the Trust's investment programme for 2010/11, a further 10190 (Kgc) will be saved on the Trust's footprint reducing the electricity to 1519 - a total saving of 2%.

Energy	6/7 (baseline year)	9/10 (annual report year)	2010/11 (target for next financial year)	% Saving
Electricity	1539	1529	1519	2
Gas	1420	1233	1300 To be confirmed	8
Water	29374	22308	22000 To be confirmed	25
Waste	0	152	140 To be confirmed	0
Transport	0	1.07	1.0 To be confirmed	9

Over the next 12 months, the GCCG will be considering recently published data by the Sustainable Development Unit which some of the carbon saving measures the ROH could target, these include reducing drug wastage; using teleconferencing to save travel on business miles; improving heating and lighting controls; insulation and reducing thermostat-controlled temperatures by one degree. Taken together we estimate that these steps could save over £100k per year, (though each initiative must be assessed against any cost of implementation for payback) but the potential exists to save up to 400,000 kilograms of carbon.

How we benchmark ourselves

In order to provide an insight into the carbon reduction performance of the ROH NHS Foundation Trust compared to others, the Trust uses the West Midlands Carbon Indicator Performance tool. This will give information to assess our carbon use and develop carbon rating.

Carbon indicator scores are based upon emissions for water use and disposal of waste and a standardised Trust score is developed (similar to the efficiency ratings we are familiar with on fridges and dishwashers). Depending upon the score, the Trust is then rated between 'A' and 'G' ('A' being more efficient). A typical Trust is calibrated to score 100 which is equivalent to a 'D' rating.

Despite its older and scattered buildings across the site, the ROH NHS Foundation Trust scored a carbon indicator of 62 which is equivalent to a 'C' rating. To further improve the Trust's rating, the Trust must continue to examine ways of improving its levels of waste recovery and recycling and continue to reduce its water consumption. If these measures are robustly acted upon, the Trust may succeed in its ambition to be 'A' rated.

Being innovative and leading the field

The NHS is realising that sustainability is part of the core business of the health service rather than a green add-on. In addition, the NHS is one of the biggest resource users and carbon generators in the UK and there are many efforts underway both nationally and locally to reduce the carbon footprint. A new initiative is the NHS Forest which aims to plant a tree for every NHS Employee. There are 1.3 million employees in the NHS and the NHS Forest will have 1.3 million mature trees in twenty years' time. In forty years' time, the centenary of the birth of the NHS, the forest will play a significant part in offsetting the reduced carbon footprint of the health service, and could account for as much as ten percent of its carbon footprint if we start now.

The ROH NHS Foundation Trust, or 'The Woodlands' as it is also known, has agreed to become a pilot scheme for the NHS Forest initiative. It has a long history of outdoor convalescence for its patients and makes good use of the existing open spaces. The target for the Trust is to plant in excess of 800 trees and the Trust aims to plant not only trees on site to ensure that young trees are growing to replace the mature trees in due course, but also to forge closer links with the community by involving them in tree planting initiatives off site. The first of what is hoped to be many such occasions, was the visit by Northfield Manor Primary School before Christmas 2009. The students collected acorns and beechnuts with the aim of growing these as a school project. It is hoped that in future the students can return to the Trust and plant their trees in the hospital grounds. The Trust also participated in the BBC 'Breathing Spaces' event and planted a number of young oak samplings by the Nurses home. The Trust has also commenced the planting of a more natural hedgerow which will follow the boundary of our site. Further initiatives will include an opportunity for patients and visitors to plant a commemorative tree in the grounds, and further encouragement for Trust employees to plant trees at home or in public spaces. Currently the Trust is responsible for the planting of 122 trees towards its target.

Finally, the planting of trees is forming part of the Trust's carbon reduction strategy as every tree planted helps to offset the CO^2 emissions by the Trust. Each tree planted 'offsets' your environmental impact by 'breathing' in about 1 tonne of CO^2 emissions over its lifetime of 100 years.

Summary performance sustainability and climate change

Energy
We have established our database for gas and electricity at 2006/07.

We have reduced our carbon footprint at March 2010 by:

Electricity: 1%
Gas: 7%

We are going to target further reductions in 2010/11 in electricity consumption through an investment of £50,000 which will provide a further saving totalling 2% for electricity.

Water
We have reduced water consumption by outsourcing decontamination of instruments.

We have implemented an action plan for further saving measures.

Transport
We have a Travel Plan with targets for reduction in CO^2.

We have a database for:

- Car travel by staff and targets for reduction in our carbon footprint
- Car sharing
- Cycling
- Public Transport
- Walking to work
- We are working on our business travel carbon footprint

We are working on our non-emergency ambulance transport carbon footprint with our contractor.

Waste
We have established our database at 2006/07.

We need to segregate and recycle more waste, i.e. plastics, batteries and fridges.

We need to reduce waste through IT usage.

Procurement and Food

We are in discussions with the Healthcare Purchasing Consortium concerning the need to establish a database and targets for sourcing products locally.

6. Valuing People, Diversity and Staff Engagement Report 2009/10

Staff Engagement

The Executive team engages with staff about what matters to them in a number of ways. Each executive director meets with staff, outside of their own area of responsibility to discuss and address both patient safety and staff issues.

In the latter part of the year in developing the new Strategy for the Trust, staff have been engaged in its development and by the end of May 2010 over 80% of staff will have been briefed personally by a member of the executive team about the new strategy and values.

In addition staff have been able to contribute to changes that affect their work through improvement work embracing Lean methodologies. Each of our wards are now embracing the national Productive Ward project and our theatres have embarked on a significant change programme, 'Excellent Health' with support from a partner organisation.

Our staff took part in the national staff opinion survey. This year our response rate was 57% which is above average for acute specialist trusts in England and a 10% improvement on last year.

Overall, the results demonstrate improvement in the majority of key areas with improvement in 20 of the 36 key factor areas, compared to 2008. The key areas of improvement were in:

- appraisal
- staff satisfaction with the quality of work and patient care delivered
- satisfaction with job content, feedback and staff involvement
- working in well-structured teams

Our top four rankings scores, compared to other Acute Specialist Trusts, were:

Key Factor	This Year's Score	National Average	Improvement Since 2008
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	99%	95%	2%
Percentage of staff working in a well structured team environment	52%	42%	8%
Percentage of staff having well structured appraisals in last 12 months	41%	35%	11%
Quality of job design (clear job content, feedback and staff involvement)	3.5	3.44	0.08

Our bottom four ranking scores were:

Key Factor	This Year's Score	National Average	Deterioration Since 2008
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	**22%**	**18%**	**7%**
Percentage of staff using flexible working options	**62%**	**70%**	**4%**
Percentage of staff experiencing physical violence from staff in last 12 months	**2%**	**1%**	**1%**
Percentage of staff experiencing discrimination at work in last 12 months	**10%**	**7%**	**3%**

In light of these results, the priorities for action in 2010/11 will be to engage with staff about their own behaviour in the workplace and organisational culture. We will work collaboratively with trade union representatives and staff governors to embed the Trust's commitment to ensuring staff are able to attend work without experiencing bullying and harassment. Our progress against these priorities will be monitored by the Director of Workforce and Organisational Development and then reported formally to the Workforce and Organisational Development committee every six months.

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 recognised trade union representatives through our day to day work and 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, is chaired by the Chief Executive and involves a number of Executive Directors. 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, including performance and 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. Trade Union colleagues have been fully engaged in these processes.

Equality and Diversity

The Trust continues to make progress on diversity matters. Diversity is now lead by the new Director of Workforce and OD and this agenda is monitored by the Workforce and OD Committee.

During the year senior managers received training in Equality Impact Assessments and the assessment of the impact of diversity on service provision commenced and was published. The importance of dignity in care for all patients irrespective of their background was a feature of all mandatory training for staff.

The Single Equality Scheme was published on the Trust's website and reviewed in the last quarter of the year incorporating the views of internal and external stakeholders. Employment monitoring statistics were considered by the Equalities Committee and the Workforce Committee, a sub-committee of the Trust Board.

Workforce Statistics

	Staff 2008/9	%	Staff 2009/10	%	Membership 2008/9	%	Membership 2009/10	%
Age								
0-16	2	0.14	4	0.13	7	0.1	16	0.3
17-21	61	0.98	74	1.90	160	3.4	175	3.0
22+	1280	98.88	1241	97.97	4268	89.5	5087	88.1
					333	7	495	8.6
Ethnicity								
White	927	63.53	973	67.19	3392	71.1	4017	69.6
Mixed	25	1.72	24	1.66	80	1.7	108	1.9
Asian or Asian	155	10.65	149	10.29				
British					277	5.8	357	6.1
Black or Black								
British	58	3.98	58	4.01	205	4.3	292	5.1
Other	294	20.16	244	16.86	814	17.1	999	17.3
Gender								
Not Stated					1944	40.8	2253	39.0
Male	419	28.2	446	30.80	2786	58.4	3486	60.0
Female	1040	71.28	1002	69.20	38	0.8	34	1.0
Recorded Disability								
No	173	11.86	160	11.05				
Not Declared	2	0.14	-	-			5118	88.7
Undefined	1283	87.94	1287	88.88				
Yes	1	0.07	1	0.07	n/a		655	11.3

The key priorities for the Trust in relation to Diversity for 2010/11 are to:

- Embed equality impact assessment of services across the organisation to ensure all services have been assessed by the end of the year.

- engage staff from minority groups, including staff with a disability about their experience as employees to improve their experience
- To improve the extent of diversity data captured from staff particularly in relation to disability and ethnic origin
- Publish our employment monitoring statistics

Performance in these areas will be monitored by the Workforce and OD Committee.

Sickness absence

We have continued to make improvements in sickness absence levels in the Trust with the annual average levels improving to 3.67%. Our endeavours to reduce sickness and improve the health and well-being of our staff have been supported by our Occupational Health provider University of Birmingham Hospitals NHS Foundation Trust. This service is open to all staff and will be re-tendered during 2010/11.

Retirements due to ill health

During the year to 31 March 2010 there was 1 early retirement from the Trust agreed on the grounds of ill-health at a cost of £149,018 (31 March 2009 - £0).

7. The Board of Directors' Report on Activity and Obligations 2009/10

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

The Royal Orthopaedic Hospital was established as an NHS Trust in 1995 and founded under the National Health Services Act 2006 as the Royal Orthopaedic Hospital NHS Foundation Trust on the 1 February 2007. The Trust is located within the South Birmingham Primary Care Trust health economy area. Its main hospital location is 5 miles from Birmingham City Centre and 2 miles from the University of Birmingham. It is one of a number of acute trusts in Birmingham and primarily serves patients from the West Midlands.

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

The Board of Directors' activity 2009/10

The Board of Directors is a unitary body accountable for decisions on the running of the organisation, its direction and fiduciary control. The Board regularly reviews its governance role and capability and in early 2010 agreed in principle to work with the Members' Council to recruit an additional non-executive director and appoint substantively to the new executive director post of Strategic and Business Development during the year.

The Board of Directors is chaired by Mr Laurence James 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 2009/10 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.

NEDs have attended seminars organised by the SHA, workshops organised by the Trust bringing in external speakers and discussing important issues in depth and have also attended a range of external events organised by Monitor, the Audit Commission, the FTN and NHS Confederation. In addition, NEDs and the Chairman invited an external facilitator to work with them on a review of their effectiveness as NEDs in challenging times.

Members and Governors have direct access to all members of the Board. In addition to having direct access on request, all the members of the Board are invited to attend every 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.

Information made available to the Board has been improved with a re-vamped and more targeted corporate performance report and better use made of the reporting committee structure to evidence assurance. The Chairman has worked with the executives to secure more focus presentation of information supporting targeted decision-making.

The Board considers that all Non-Executive Directors (with the exception of the Trust

Chairman, to whose office Provision A.3.1 of the Foundation Trust Code of Governance does not apply) are independent in character and judgment and there are no relationships or circumstances which are likely to affect, or appear to affect, their judgment.

Directors holding office during 2009/10

The following Directors held office throughout the period of this report unless otherwise indicated:
Mr Laurence James - Chair (term of office expires 31/10/11)
Professor Andrew Stevens - Senior Independent Director and Deputy Chair (term of office expires 31/01/11)
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)
Mr Chris Monk - Non-Executive Director (term of office expires 31/12/10)
Mr Roger Otto - Non-Executive Director (term of office expires 31/12/10)
Ms Penny Venables - Chief Executive Officer
Mr Graham Bragg - Deputy Chief Executive and Director of Finance (also Director of Strategy and Business Development)
Mrs Valerie Doyle - Director of Operations interim and then substantive from October 2009)
Mr Andrew Thomas - Medical Director
Mrs Lindsey Webb - Director of Nursing and Governance

The Five Board Committees

The Board has five committees – Audit as the key scrutinising committee; Integrated Governance as its progress review committee; Nominations and Remuneration Committee to address Board capability, terms of employment for executive directors and staff pay awards; and Charitable Funds of which the Trust Board is a corporate trustee. In autumn 2009 the Board created an additional committee, the Investment Committee to consider major strategic investments that have major corporate, reputational or financial implications for the Trust.

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

Audit Committee

Membership:
Mr R Otto (Chair)
Mr C Monk
Dr E Hensel
Mr R Millinship
(Mr S Bloomer as Finance Director has attended while Mr Bragg assumed an 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.

Integrated Governance Committee

Membership:
Professor A Stevens (Chair)
Mr L James
Dr E Hensel
Ms P Venables
Mr G Bragg
Mrs V Doyle
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

The Committee has an annual work plan that ensures it receives effective reporting from appropriate executive sub-groups The committee chairman gives a written or verbal report on every IGC meeting at the next available Trust Board.

Nominations and Remuneration Committee

Membership:
Mr L James (Chair)
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
- Agrees Executive Directors' remuneration, terms and conditions
- (Executive Director salary levels are informed by benchmark salary information derived from established national NHS pay surveys. All Executive Directors are employed on permanent contracts of employment with a six month notice period. No executive Directors have provision for other payments over and above their statutory entitlement, to be made on termination of employment. In determining whether or not to agree an annual uplift of salary for Executive Directors, the Committee had due regard to the national pay awards made to other staff groups.)

In the case of Non-Executive Director vacancies including the Chair, the relevant information is passed to the Remuneration and Nominations Committee of the 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. The committee benchmarks remuneration annually.
In late 2009 the committee drew up revised contracts for executives which will be agreed in 2010/11.

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.

Investment Committee (from November 2009)

Membership:
Mr C Monk (Chair)

Mr R Millinship
Mr L James
Mrs P Venables
Mr G Bragg

Purpose
The work of the committee is:

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

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

Evaluation of Board Performance

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

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

The Trust does not have a formal process for evaluating the performance of the Members' Council or its members, but will consider this early in 2010/11 as part of the evaluation of effectiveness for its work and that of its new committees.

Non-Executive Directors' attendance at meetings
Brief synopsis of major areas of responsibility of the Board and its committees:

Trust Board **12 meetings**	**Audit Committee** **6 meetings**	**Integrated Governance Committee** **9 meetings**	**Remuneration and Nomination Committee** **6 meetings**	**Charitable Funds Committee** **3 meetings**	**Investment committee** (from October 2009) **2 meetings**
Development of long term strategy Monthly performance review; Key national target review; Strategic planning; Capital project development	Review of overall assurance with internal and external auditors; major project reviews.	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; Prioritisation of fund allocation	Considers early stage investment proposals and then makes recommend-ations to trust board about major strategic investments of corporate, financial or reputational risk.

Laurence James Chairman (from 1st November 2009)	Trust Board	Integrated Governance Committee	Remuneration & Nomination Committee	Charitable Funds	Investment committee (
Mr James is also Chairman of Stroud and Swindon Building Society	**Chairman**12/12	6/6 (joined Committee from August 09)	**Chairman** 6/6	**Chairman** 2/3	2/2

Professor Andrew Stevens Deputy Chairman and Senior Independent Director	**Trust Board**	**Integrated Governance Committee**	**Remuneration and Nomination Committee**	**Charitable Funds Committee**
Mr Stevens is a professor at Birmingham University and also works with NICE	(Deputy Chairman) 10/12 Undertaking chair appraisal and feedback to Members' Council	**Chairman** 7/9 Chairman Focus on clinical guidance and outcomes	6/6 Acts as interface with Members' Council	3/3

Chris Monk	**Trust Board**	**Audit Committee**	**Charitable Funds Committee**	**Investment committee**
Mr Monk is retired as a Partner in King Sturge, a firm of property agents and also serves on Advantage West Midlands and several other bodies	12/12 Leading on capital development and estates	6/6 Particular focus on best practice HR & OD	3/3	**Chairman** 2/2

Roger Otto	**Trust Board**	**Audit Committee**	**Remuneration and Nomination Committee**	**Charitable Funds Committee**
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	10/12 Reporting on work of audit and annual report to Members' Council	**Chairman** 6/6 Acts independently of Trust Chairman in holding the organisation to account.	6/6	2/3

Dr Elizabeth Hensel	Trust Board	Audit Committee	Integrated Governance Committee	Charitable Funds Committee
Dr Hensel is a clinical psychologist and has been a non-executive director of an NHS ambulance trust	10/12 Leading on information systems and patient flows	5/6 Acts as link person with integrated governance	(Deputy Chairman) 9/9 Acts as link person with audit; particular focus on governance structures	2/3

Robert Millinship	Trust Board	Audit Committee	Charitable Funds Committee	Investment committee
Mr Millinship has a background in manufacturing and production businesses and acts as an interim director or consultant	9/12 Leading on 18 weeks project delivery	6/6 Key focus on performance criteria	2/3	1/2

Executive Directors attended all meetings of the Board and Committees, 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.

Board of Directors' Discharge of Obligations 2009/10

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 with in the financial statements.

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

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 2009/10 was £65,000.

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

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

Property is measured at fair value. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent asset valuations were undertaken on 31 March 2010 by GVA Grimley international property advisers.

Following revaluation of Property as at 31 March 2010, the Trust has recognised a loss on the revaluation of £400k in the Income and Expenditure Accounts with a total write down of assets of £1.896m.

Political and Charitable Donations

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

Post Balance Sheet Events

In June 2009 the Trust entered into a contract to construct a new outpatient department with a value of approximately £8 million of which only £3.5 million is included within these accounts. The project is due to be completed in September 2010, with an estimated final value for the department of £7 million. This will result in a £1 million impairment which the Trust has already included within its financial projections reported to the board.

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

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

Health and Safety at Work
The Trust takes its responsibilities for the health and safety of its staff and patients very seriously. 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.

Health and Safety Executive (HSE)
The Trust has received two visits from the HSE during this period;
The first in September/October 2009 looked at the Trust's manual handling training, procedures, policies, risk assessments, incidents, training records and workplace. Several remedial actions needed to be completed following the visit:

- Intravenous fluids should be delivered and stored correctly to reduce high-level manual handling. (This action is completed)
- Ward and department managers should check their own staff training records and ensure they attend mandatory training (This action is completed)
- Communication between wards and departments should improve in relation to patients' mobility and handling needs. (This remains on-going)

A second visit in December 2009 looked at the histopathology laboratory and in particular the ventilation systems. A further visit was scheduled for April 2010 – this review is ongoing and options for long-term solutions are under discussion.

Risk Assessment Training
There were six Health and Safety/Risk Assessment training course run by the Trust's Health and Safety Advisor and a further three are scheduled in 2010. All clinical areas now have ward mangers/Head Of Department or a nominated member of staff trained in carrying out risk assessments.
Audits have been carried out of the wards' risk assessment status and this will continue to be monitored over 2010/2011

Policies
Various health and safety policies have been updated and implemented including:

- Sharps Policy
- Manual Handling Policy
- Stress Policy
- Slip, trip, and falls Policy

Each of these has been discussed at relevant committees by users and then by the executive management team and Integrated Governance Committee as part of routine governance processes within the trust.

Orthotics
This department was assessed by Health and Safety in 2009 and the reports indicated some necessary changes to ventilation. The department has installed a new local exhaust ventilation (LEV) equipment following the recommendations of the report.

COSHH (control of substances hazard to health)
COSHH assessments have been completed for all clinical areas via the Sypol system that used by the trust's Governance department.

Theatres
The role of the local health and safety area representative for Theatres has been strongly supported this year by the Trust's Health &Safety advisor. This has facilitated the department in carrying out its risk assessments and training in a more locally focused way. Risk assessment

folders and COSHH folders have been produced for the area by a members of the theatre's team alongside the implementation of new procedures developed as part of the Excellent Health programme.

Mandatory Training

Annual mandatory training for all trust staff continues to be provided by the Health and Safety Advisor. This includes patient/load handling, Health and Safety Policies and issues. This element of training also includes the e-vac chair which is the Trust's emergency patient evacuation equipment for use during afire.

Fire

Health & Safety staff supported the trust in its review of a fire incident in October 2009 which resulted in the destruction of the main kitchen and server areas at the hospital. The resulting plan is being monitored through Health and Safety Group.

Central Alerting System (CAS)

The Health & Safety Advisor continues to monitor the Medicine Healthcare Regulatory Authority (MHRA) Alerts the Trust receives and disseminates information to relevant staff/depts. The status of all CAS alerts are reported at SPEC meetings

West Midlands Health & Safety Advisors Association (WMHSAA)

The Trust's Health &Safety Advisor continues to attend this meeting, representing the hospital. This facilitates the discussion of health and safety issues with similar organizations throughout the West Midlands and as the meeting is also attended by the Health and Safety Executive, allows direct communication with the regulatory body.

External Consultations

The Trust has actively contributed responses to a range of consultations from the Department of Health, Monitor and the Care Quality Commission. In most cases the Trust makes comment to the Foundation Trust Network and NHS Confederation (for inclusion in their aggregate response) and in its own right so that the specific impact of any proposals on a specialist orthopaedic service can be registered. The Trust has keenly assessed any governance and legal implications of changes and endeavoured to prepare for the implementation of changes well in advance.

The trust has not undertaken any formal external consultations on its own services during 2009/10.

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 focuses on reducing its environmental impact by using less, recycling more and disposing of waste sensitively and remains committed to reducing its 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 excellence 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. Full detail can be found in Chapter 5 of this Annual Report.

Better Payment Practice

The Trust has adopted the Public Sector Better Payments Practice Code to ensure that it pays 95% of suppliers within 30 days of the receipt of invoice. The Trust paid 97% of invoices within 30 days against the target of 95%. The Trust did not incur any late payment penalties during 2009/10 under the Late Payment of Commercial Debts (Interest) Act 1998.
The Trust did not adopt any other payment policy.

Compliance with the cost allocation and charging requirements

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

Freedom of Information (FOI) Act

The Trust continued to meet the requirements of the act and responded to requests in a compliant fashion. During the year one FOI request was referred to the Information Commissioner for adjudication. The Commissioner found in favour of the Trust and requested the complainant to withdraw. This resulted in publication of the Information Commissioner's findings in support of the Royal Orthopaedic Hospital NHS Foundation Trust. The Trust has seen a rise in FOI enquiries year on year and has also received a number of enquiries as a result of media stories on other organisations stimulating comparative data requests. The cost of staff time in responding to these requests continues to rise commensurately with their volume and complexity, though it has not been routinely necessary to seek financial compensation from the enquirer for time spent by the trust.

Use of Information Technology

The Trust continues to use products developed under Connecting for Health where its offerings meet the Trust's requirements. During 2009/10 the Trust has focused on the development of clinical systems and the strengthening of the IT infrastructure.

In developing its Strategic Plan the Trust recognises the need for accurate and timely information on which to make decisions whether they be patient or business related. The Trust is

therefore considering investing heavily in the development of a data warehouse designed to bring all the data sources together in one repository to facilitate the analysis of data to provide consistent and accurate information

The Trust continued to achieve level 2 or above against the requirements of the Information Governance toolkit during 2009/10.

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

During 2009/10 the Trust had four serious untoward incidents relating to Information Governance .Two incidents involved the theft/loss of an encrypted laptops. No confidential data was held on either machine. There was no risk of data loss. The other two incidents involved the loss of patient data on pieces of paper. New procedures were implemented in response to these occurrences.

Policies and procedures relating to counter-fraud

The Trust engages the services of its local counter-fraud specialist. Regular audits of counter-fraud activities are undertaken, and the Trust is active in promoting the work of the counter-fraud team to all staff. A joint communication strategy and action plan has been developed to ensure that all staff are aware of their responsibilities and where they can seek help. Regular updates are provided to the Audit Committee on the work of the local counter fraud specialist and the Board received a presentation on the work of counter-fraud at the end of 2009/10.

Remuneration and Pensions Disclosures
Details of senior employees' remuneration can be found in the Remuneration Report on pages xxx and accounting policies for pensions can be found on pages xxx.

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

Going concern SB
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.

8. The Members' Council report on its work, elections and membership

The work of the Members' Council 2009/10

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 revised its committee structure during 2009/10 in support of the emerging strategy for the organisation. There are now three committees – Nominations and Remuneration, Patient Experience and Member Engagement.

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. During 2009, the Council supported the selection and appointment of Trust auditors from the financial year 2010/11.

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. Council committees are attended by executive directors and non-executive directors and 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 at which it is fully engaged in discussions, although any decisions taken remain the sole responsibility of the Board.

Doing its job – as a whole Council

In 2009/10 the Members' Council discharged its responsibilities by agreeing the appointment of auditors for the financial year 2010/11.

The Members' Council fully discussed the Trust's Annual Plan and also worked closely with the Board on the development of a revised strategy for the Trust. This strategy was discussed at its AGM and at the joint meetings with the Board. Informal evaluation of the effectiveness of performance of the Members' Council in mid 2009 resulted in changes to the committee structure supporting the full council. This reflected the need to maintain strategic discussions at full council meetings which were open to the public.and to provide scope for detailed discussion of membership activities in other committee meetings.

Members' Council involvement in strategy

The Council 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. The Council approved a long-term strategy for the Trust in late 2009 for publication and dissemination with its support during 2010.

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

In committees
Following the review of effectiveness, members agreed to a change in the committee structure so that there are now three committees within the Members' Council, reflecting key strategic areas within the Trust. Each committee reports its work at each of the public Members' Council meetings.

The Patient Experience Committee has responsibility for ensuring that the trust keeps patient needs at the heart of its work and responds to issues identified by patients and service users through the Patient Council, from survey feedback or through patient and carer membership. The committee is attended by the Director of Nursing and Governance and the Director of Operations, giving direct access to executive action and also by a designated NED who can maintain a strong link with the board. This alleviates any potential problems of disconnection and ignorance of customer issues.

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

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

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

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

There are five public constituencies within Public membership:

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

There are two constituencies within Staff membership:

- Clinical
- Non-clinical

All election boundaries for public members (including patients) are co-terminus with either PCT or local authority boundaries. Public membership eligibility is restricted to those persons living within the relevant boundary and being over 16 years of age. In addition to those representatives on the 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.

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

Elections

Elections to our Members' Council for vacancies arising in 2009/10 have been overseen by the Electoral Reform Society.

Results of **2008/2009** Election, (results delayed to April 2010, due to an election re-run):

Public: Rest of West Midlands

Number of eligible voters:			**1219**
Total number of votes cast:			**397**
Turnout:			**32.6%**
Number of votes found to be invalid:			**4**
Blank or Spoilt	No	3	
Declaration form received		1	
Total number of valid votes to be counted:			**393**

Result (two to elect):

The following candidates were elected (in order of election):
GILL, Judy
SCOTT, Yvonne

Public: South Birmingham

Number of eligible voters:			**1624**
Total number of votes cast:			**502**
Turnout:			**30.9%**
Number of votes found to be invalid:			**7**
Blank or Spoilt	No	7	
		1	
Total number of valid votes to be counted:			**495**

Result (two to elect):

The following candidates were elected (in order of election):
RICHMOND, Isobel
LAST, Alan

Results of **2009/2010** Election – February 2010

Public: Rest of England and Wales

Number of eligible voters:		**339**
Total number of votes cast:		**77**
Turnout:		**22.7%**
Number of votes found to be invalid:		**0**
Blank or Spoilt	0	
	0	
No declaration form received		
Total number of valid votes to be counted:		**77**

Result (one to elect):

The following candidate was elected: TALBOYS, Robert

Public: South Birmingham

Number of eligible voters:		**2,070**
Total number of votes cast:		**580**
Turnout:		**28.0%**
Number of votes found to be invalid:		**0**
Blank or Spoilt	7	
	0	
No declaration form received		
Total number of valid votes to be counted:		**573**

Result (three to elect):

The following candidates were elected (in order of election):
HART, Neil
MULLINEX, David George
ROSKELL, Gary

Uncontested Election Seats were also filled:

Public: Rest of West Midlands

NOON, Stella
DOHERTY, John

Election nominations were also sought for East and North Birmingham (two vacancies) No eligible nominations were received by the due date and so a further election is to be held in early 2010.The Trust received a resignation from a Heart of Birmingham Governor in March 2010, so this vacant post will form part of the election too.

Elected Members serving during the year 2009/10
(Names in bold held office at March 2010)

South Birmingham (5 seats)
1. ROSKELL, Gary - appointed March 08 until end January 2010 and re-elected for 3 years until end January 2013
Attended 3 Council meetings (of 6) and serves on the Membership Engagement Committee (1 of 1)

2. COOKE, Carole Ann - appointed for 3 years until end January 2010. Did not stand for-re-election
Attended 4 Council meetings (of 5) and served on the Remuneration Committee(no meetings attended)
3. HART, Neil - appointed for 3 years until end January 2010, re-elected for 3 years until end January 2013
Attended 5 Council meetings (of 6) and serves on the Remuneration Committee (Chair) attended 2 of 2 meetings
4. MULLINEX, David, appointed for 3 years until end January2013
Attended 1 Council meeting (of1) and serves on eth Membership Engagement Committee
5. RICHMOND, Isobel Ingrid – re-elected for 3 years to15th April 2012) Attended 5 Council meetings (of6) and served on the Environment Committee
6. LAST Alan, appointed for 3 years to end 15th April 2012 and serves on the Attended 4 Council meetings (of 6) and serves on the Membership Engagement Committee (Chair) (1 of 1)

Heart of Birmingham (1 seat)
1. GATES, Shirley (from September 2008 until end August 2011; resigned March 2010)
Attended 2 Council meetings (of 6) and served on no committees

Rest of the West Midlands (4 seats)
1. BARWICK, Joan Margaret appointed for 3 years) until end January 2010, did not stand for re-election
Attended 2 Council meetings (of 5) and served on the Environment Committee
2. NOON, Stella - appointed for 3 years until end January2010, re-elected for 3 years until end January 2013
Attended 6 Council meetings (of 6) and serves on the Patient Experience Committee (Chair) (1 of 1)
3. GILL, Judy – appointed on re-election, for 3 years until 15th April 2012. Attended 4 Council meetings (of 6) and serves on the Patient Experience Committee
4. SCOTT, Yvonne - appointed on re-election, for 3 years until 15th April 2012
Attended 6 Council meetings (of 6) and serves on the Patient Experience Committee (1of1)
5. DOHERTY, John appointed for 3 years until end January 2013

East and North Birmingham (2 seats)
1. CASWELL, Rita Ann – appointed for 3 years until end January 2010. Did not stand for-re-election
Attended 5 Council meetings (of 5) and served on the Remuneration Committee (1of 2)and was Environment Committee (Chair)
(Currently carrying 2 vacancies pending elections._
2. MERRY, Christina Mary (appointed for 3 years until end January 2010. Did not stand for-re-election
Attended 3 Council meetings (of 5) and served on the Membership Committee

Rest of England (1 seat)
1. SMITH, Anne Hartland –appointed for 3 years until end January 2010.) Failed to re-gain seat at election. Attended 5 Council meetings (of 5) and served on no committee

TALBOYS, Robert – appointed for 3 years to end January 2013
Attended 1 meeting (of 1)

Clinical Staff Representatives
1. CHURCHMAN, John re-elected for 3 years until end March 2012
Attended 6 Council meetings (of 6) and serves on the Member Engagement Committee
2. GRIMER Robert – appointed for 3 years until end March 2012
Attended 3 Council meetings (of 6) and serves on the Patient Experience Committee

Non-Clinical Staff Representatives

GILMARTIN, Tracy Anne re-elected for 3 years until end March 2012, resigned March 2010 Attended 4 Council meetings (of 6) and served on the Remuneration Committee (2 of 2)

Partner Nominees

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

South Birmingham PCT
Sandra Cooper Attended 2 (of 6) Council meeting and served on the Governance committee

Heart of Birmingham PCT
Jacqui Francis Attended 5 Council meetings (of 6)

Birmingham City Council
Cllr. Keith Barton Attended 6 Council meetings (of 6) and served on the Governance Committee

University of Birmingham
Jean Broadfield (until December 2009) Attended 1 Council meeting (of 4)
Professor Catherine Sackley (from end February 2010). Attended no Council meetings (of 0)

Birmingham City University
Marion Thompson Attended 3 Council meetings (of 6) and serves on the Remuneration Committee (2 of 2)

Bournville Village Trust
Roger Wilson Attended 1Council meeting (of 6) and served on the Environment Committee

Patient Support Groups
Sue Arnott Attended 4 Council meetings (of 6) and serves on the Patient Experience Committee

Member of Parliament
Richard Burden MP Attended 3 Council meetings (of 6) and serves on the Membership Engagement Committee

Birmingham Council of Faiths
Parwez Hussain
Attended no Council meetings and served on the Remuneration and Membership Committee but attended no meetings.

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

The 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.

Engaging Our Membership

Membership has continued to grow during 2009/10 and now stands at over 5,500. The profile of our membership remains representative of our community and we recognise the ongoing need to maintain a real relationship with our members.

During 2009/10, building on the Members' Council ambition to become better rooted in our community and more accessible to young people, the Public Engagement department has undertaken a range of underpinning development work.

This work has become embedded within the Trust within the last year. The merging of the Membership and Volunteering departments has successfully created a more integrated approach to our interaction with the public and has strengthened and increased the capacity to trial and develop new opportunities for engagement. Our volunteers are some of our most active members and play a key role in adding value to the life of the hospital.

With an established membership, the new Membership Involvement and Engagement Sub-Group and the Membership Manager have agreed that the primary focus in the coming year will be one of improving interaction and engagement rather than significant growth. There have been a number of targeted engagement schemes within the Trust, aimed at improving diversity of members with particular regard for those under 25 and those with disabilities.

As a member of the local Constituency Strategic Partnership, we have also attempted to respond positively to the specific challenges of our local community, particularly unemployment and young people classified as NEET (Not in Education, Employment or Training). The Trust has been acutely aware that the economic downturn, giving rise to 10% unemployment across Birmingham has hit very hard in the Northfield area, compounding the already high levels of unemployment. We have been pleased to offer membership the chance to join us as volunteers and use this to maintain skills and, in some cases, help people secure jobs in a climate of stiff competition.

The trust appointed a Young Volunteer Co-ordinator to specifically focus on the needs of volunteers under the age of 25. This is delivering promising results. In the first five months since commencing employment, the post-holder has placed and supported 28 (aged 16 & 17) young people into voluntary work on site. Of the four young people classified as NEET, three have secured apprenticeships as a result. We have also helped seven into further education and offered additional training to all. The outcomes of this project are being shared with the other Foundation Trusts in the locality with a view to developing a cross-network service to increase the opportunities available to our members. Some young people have actively participated in our scheme to help aspiring health professionals (doctors, nurses, physiotherapists) and they have been actively supported by our clinical staff and mentored by older volunteers.

Our Community Liaison Officer has developed working with Birmingham Disability Employment Service, Mencap, Community Options, Mind and Work Directions to offer opportunities for people who would traditionally have been excluded from becoming involved with the NHS. We have developed a programme for volunteers to mentor volunteers with disabilities to allow inclusion and diversity to increase. We have also created partnership with local Secondary

Schools and offer educational resources, careers advice and opportunities to interact with patients and staff.

We have also worked with our Clinical Director for Research and Development and created a simulated patient programme. Members have been invited to training sessions to learn to simulate the signs and symptoms of orthopaedic conditions for 4th year medical students. They then have the opportunity to offer feedback on the students' examination and interactions. Members involved with this have been extremely positive, as they feel that they are genuinely influencing clinicians of the future. Students have also felt that this has had a major impact upon their learning and interpersonal skills. We intend to look at ways of improving and expanding this project over the next year.

Over the next twelve months, the Trust will be looking closely at the role of the Governors (our Members' Council), particularly with respect to the part that they play in engagement with the Trust. We will also be looking at the process of consultation and making it accessible for all departments and areas within the Trust. This process has begun with the development of a consultation toolkit, which will be disseminated throughout the Trust, but we will also look at how this can be encouraged and supported to ensure that consultation becomes an effective toolkit for service improvement, delivery and efficiency.

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

Membership size and movements

Public constituency	**2009-10**	**2010-11 (estimated)**
At year start (April 1)	4768	5773
New members	1367	350
Members leaving	362	123
At year end (March 31)	5773	6000
Staff constituency	**2009-10**	**2010-11 (estimated)**
At year start (April 1)	821	821
New members	82	82
Members leaving	82	82
At year end (March 31)	821	821

Analysis of current membership

At the end of 2009/10 the Trust had grown its membership to over 5,500 and maintained it as representative to the population as a whole. The trust will continue to develop its membership base in 2010/11 but will not seek significant growth. Staff numbers are expected to remain broadly static for the period.

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	16	
17-21	175	5,690, 271
22+	5087	
Not stated	495	
Ethnicity		
White	4017	1,138,054
Mixed	108	16,501
Asian or Asian British	357	83,078
Black or Black British	292	44,384
Other	97	4,408,252
Not Stated/Do not wish to state	902	

Public constituency	Number of members	% of membership
Socio-economic Category		
ABC1	3043	52.7
C2	1076	18.6
D	1223	21.3
E	395	6.8
Data not available	36	0.6
Gender		
Male	2253	39
Female	3486	60
Unspecified	34	1

Remuneration Report

Salary and Pension Entitlements of Senior Managers

A) Salaries *						
	2009-10 (12 months to 31st March 2010)			2008-09 (12 months to 31st March 2009)		
Name and Title	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
Mr. L Lawrence-Chairman (left 31st October 2008)	0	**0**	0	10-15	**0**	0
Mr. L James – Chairman (from 1st November 2008)	35-40	**0**	0	10-15	**0**	0
Mrs. P Venables – Chief Executive	120-125	**0**	0	110-115	**0**	0
Mr. G Bragg-Director of Strategic and Business Development	100-105	**0**	0	90-95	**0**	0
Mr. A Thomas-Medical Director	20-25	**110-115**	0	15-20	**100-105**	0
Mr. A Crawshaw-Director of Operations (left 20th March 2009)	0	**0**	0	75-80	**0**	0
Mrs. L Webb – Director of Nursing & Governance	80-85	**0**	0	75-80	**0**	0
Mrs. V Doyle – Director of Operations (from 1st July 2009)	95-100	**0**	0	130-135	**0**	0
Professor A Stevens-Non Executive Director	10-15	**0**	0	5-10	**0**	0
Dr. E. Hensel-Non Executive Director	10-15	**0**	0	5-10	**0**	0
Mr. R. Otto–Non Executive Director	10-15	**0**	0	5-10	**0**	0
Mr. R. Millinship -Non Executive Director	10-15	**0**	0	5-10	**0**	0

Mr. C. Monk -Non Executive Director	10-15	**0**	0	5-10	**0**	0

*This element of the annual report has been audited

Executive Director Salaries are determined by the Remuneration and Terms of Service Committee of the Trust Board, informed by benchmark salary derived from established national NHS pay surveys. All Executive Directors are employed on permanent contracts of employment with a six month notice period. No Executive Directors have provision for other payments over and above their statutory entitlement, to be made on termination of employment. All Executive Directors were employed for the whole year 2009/10, except for Mrs V Doyle who joined the Trust in July 2009. In determining whether or not to agree an annual uplift of salary for Executive Directors, the Committee had due regard to the national pay awards made to other staff groups.

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

B) Pension Benefits *

Name and title	**Real increase in pension and related lump sum at age 60** **(bands of £2500) £000**	**Total accrued pension and related lump sum at age 60 at 31 March 2010** **(bands of £5000) £000**	**Cash Equivalent Transfer Value at 31 March 2010** **£000**	**Cash Equivalent Transfer Value at 31 March 2009** **£000**	**Real Increase in Cash Equivalent Transfer Value** **£000**	**Employers Contribution to Stakeholder Pension** **To nearest £100**
Mrs. P Venables - Chief Executive	7.5 - 10	160 - 165	771	657	81	0
Mr. G Bragg – Director Of Finance	-	155 - 160	954	869	42	0
Mr. A Thomas - Medical Director	20 – 22.5	190 - 195	1,096	894	157	0
Mr. A Crawshaw –Director of Operations (left 20th March 2009)	-	-	-	350	-	0
Mrs. V Doyle – Director of Operations (from 1st July 2009)	-	55 - 60	227	541	-	0
Mrs. L Webb - Director Of Nursing and Governance	5 – 7.5	75 - 80	306	255	37	0

Salary and Pension Entitlements of Senior Managers

*This element of the annual report has been audited.

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 2008-09 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: Date: 01 June 2010

Chief Executive

The Royal Orthopaedic Hospital NHS Foundation Trust

Accounts for the Year Ended 31st March 2009

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

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the 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 The Royal Orthopaedic Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual have been followed, 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: 1st June 2010

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 2010 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 ten times a year 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 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 July 2009 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. The quarterly Corporate Performance Report includes details of all red risks on the Board Assurance Framework and the Corporate Risk Register and tracks changes made during the last quarter.

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 Trust Board Assurance Framework provides a framework for reporting key information to the Board. It identifies which of the Trust’s objectives are at risk because of inadequacies in the operation of controls and at the same time it provides structured assurances about where risks are being managed effectively and objectives are being delivered. The 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 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 that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently but noted a weaker process relating to Data Security.

The key control weaknesses highlighted were:

- Data management procedures for other confidential or sensitive data were not as well defined as those for patient identifiable data

- Management do not formally monitor compliance with the security and data management policies

- Not all users have migrated to NHS.net email accounts, so emails are being sent that are not automatically encrypted

- The Trust have not undertaken a follow up exercise to update the Data Mapping exercise carried out in January 2008 for all departments and wards to determine whether the insecure high risk inbound and out bound flows of information for the Trust identified in the original mapping exercise have been discontinued or a more secure means adopted.

The implementation of a number of good practice control procedures was highlighted, principally:

- An Information Security Management Governance framework has been established by the Trust, with appropriately identified security officers, a management forum and clearly documented security policies and procedures, including a Trust-wide security incident reporting procedure.

- The Trust has implemented USB port management and encryption of mobile device hard disks to prevent the loss of data through these channels.

- Password policy controls are enforced at the network level, to help prevent unauthorised access to systems and data.

A focused piece of internal audit work has been commissioned in 2010/11 to resolve the issues highlighted in the data security audit. In addition, the Board monitors compliance with IG Toolkit Statement of Compliance criteria each quarter and confirms that is satisfied that the Trust meets the required standard.

Specific controls include:

- Trust portable devices i.e. laptops, data sticks and PDAs, have encryption software installed and no personal devices can operate on the trust network

- Information flows containing personal/sensitive data in and out of the Trust have been identified and risk assessed, and transfer methods changed where required

- Imaging have implemented image sharing software so increasing the number of trusts they can share images with electronically

- An information security and confidentiality Code of Conduct is issued at mandatory training along with specific data security training as part of the Information Governance training session

- A Corporate Records management procedure has been implemented introducing good practice for managing and securing corporate information

The Information Governance Group is chaired by the Director of Strategic and Business Development who is also the Trust's Senior Information Risk Owner at Board level. This group maintains a Risk Register, Issues Log and Incident Log which is reviewed and actioned bi-monthly. The Trust had 4 SUIs during 2009/10 relating to actual or potential loss of data. Two laptops were stolen but these contained no patient data and were encrypted anyway. 2 incidents involved the loss of paper patient lists each containing less than 20 patients. These were investigated and as a result procedures changed, mandatory training reinforced and communications sent out via Core Brief.

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 LINKS), patients, the local community and the Local Authority Overview and Scrutiny Committee.

General public awareness of the Trust's Strategy is achieved through its presentation to the 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.

The Trust successfully passed a level 1 NHSLA Risk Management Standards Assessment in March 2010.

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

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

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

Annual Quality Report

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

Indicators included within the Quality Accounts are reported regularly internally and externally through the Corporate Performance Report and Quarterly Quality Report and the Trust Board is satisfied that the messages within the quality report reflect the regular information received throughout the year. The Members Council assessed and reviewed the document and also felt it was representative of their views and experiences. The report was shared with the Oversight and Scrutiny Committee, Birmingham LINkS and NHS South Birmingham. NHS South Birmingham confirmed the report was representative of their views and experiences.

The Board have taken assurance on quality of data included in the report from the following sources:

- The internal audit report "Reporting Performance – Validation of Data" which gave substantial Assurance
- The Audit Commission Reports on Payments by Results where data quality and governance was assessed
- The Information Toolkit Assessment
- The Internal Audit report "High Level Assessment of the Information Toolkit" which offered substantial assurance.

The Quality Accounts Process is led by the executive Director of Nursing and Governance.

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

correct unacceptable variances are agreed with the responsible managers and monitored in 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. More detailed monitoring, with a particular emphasis on financial controls, is reported on a quarterly basis

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

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 has been supported in 2009/10 by the introduction of a Patient Level Costing and Information system, which provides managers and clinicians with information about key cost drivers and performance metrics, and allows benchmarking between sub-specialties and peer comparison at a consultant level. This information will be used as the basis for service line reporting and management, which will be introduced in 2010/11 as a tool for reviewing contribution and profitability alongside traditional cost control reporting.

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

The Healthcare Commission assessments in 2009 awarded the Trust a scoring of “excellent” for Quality of Services and "excellent" for value for money.

The financial risk rating of 5 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 its Patient Forum and other specialist patient care groups to

ensure it takes account of any concerns or recommendations for service improvement. A meeting has also been held to develop relationships with the Birmingham LINKS and two sub-committees of the Members Council have been established to look at member engagement and patient experience.

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.

- 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 Standards for Better Health final declaration
- the Care Quality Commission inspection, resulting in an unconditional registration
- 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 Care Quality Commission
- the review meetings held with the Trust's host commissioner and quarterly meetings with associate Primary Care Trusts
- the concordat review
- NHSLA Assessment
- The Fire Group and Improvement Action Plan
- Process reviews as part of the Excellent Health programme

Signed

Penny Venables
Chief Executive Date: 1st June 2010

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 2010 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows 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 commentary on the financial performance included within the Directors' Report [and (list other elements if appropriate)II], 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 Annual Reporting Manual 2009/10. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I am 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 Chair's Statement, the Chief Executive's Statement, Background Information, Directors' Report, the sections on the Board of Governors, the Board of Directors, Independent Auditor's Report to the Members' Council of The Royal Orthopaedic Hospital NHS Foundation Trust membership and public interest disclosures and the un-audited part of the Remuneration Report] III. 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 Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust;

• the financial statements and 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 commentary on the financial performance included within the Directors' Report [and (list other elements if appropriate)I], 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
07-June-10

Foreword to the Accounts

These accounts for the year ended 31 March 2010 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

1st June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

	Notes	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Operating Income from continuing operations	**3**	67,298	65,482
Operating Expenses of continuing operations	**4**	(63,960)	(62,149)
Operating Surplus		**3,338**	3,333
Finance Costs			
Finance income		151	643
Finance expense - financial liabilities		(30)	(30)
Finance expense - unwinding of discount on provisions		(18)	(21)
PDC Dividends payable		(1,284)	(1,325)
Net Finance Costs		**(1,181)**	(733)
SURPLUS FOR THE YEAR		**2,157**	2,600
Other comprehensive income			
Revaluation gains/(losses) on property, plant and equipment		(1,496)	(1,419)
Increase in the donated asset reserve due to receipt of donated assets		93	0
Reduction in the donated asset reserve in respect of depreciation, impairment and/or disposal		(82)	(88)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**672**	1,093

The notes on pages 103 to 140 form part of these accounts.

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

	Notes	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Intangible assets	**7**	92	82	0
Property, Plant and Equipment	**8**	37,679	37,228	41,449
Trade and other receivables	**10**	36	35	48
Total non-current assets		**37,807**	37,345	41,497
Current assets				
Inventories	**9**	2,583	2,089	1,870
Trade and other receivables	**10**	4,651	4,475	5,351
Other current assets	**10**	815	545	356
Cash and cash equivalents	**12**	18,704	16,305	9,486
Total current assets		**26,753**	23,414	17,063
Current liabilities				
Trade and other payables	**13**	(7,474)	(4,599)	(4,397)
Borrowings	**13.2**	(80)	(80)	(80)
Provisions	**15**	(100)	(39)	(44)
Tax payable	**13**	(767)	(769)	(19)
Other liabilities	**13.1**	(468)	(414)	(184)
Total current liabilities		**(8,889)**	(5,901)	(4,724)
Non-current liabilities				
Borrowings	**13.3**	(101)	(181)	(261)
Provisions	**15**	(242)	(236)	(227)
Other liabilities	**13.1**	(215)	0	0
Total non-current liabilities		**(558)**	(417)	(488)
Total assets employed		**55,113**	54,441	53,348
Financed by (taxpayers' equity)				
Public Dividend Capital		38,905	38,905	38,905
Revaluation reserve		3,156	4,761	6,165
Donated asset reserve		2,416	2,296	1,976
Income and expenditure reserve		10,636	8,479	6,302
Total taxpayers' equity		**55,113**	54,441	53,348

The financial statements were approved by the Audit Committee on behalf of the Board of Directors on 01 June 2010 and are signed on its behalf by:

Penny Venables – Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Total	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2009	**54,441**	38,905	4,761	2,296	8,479
Surplus for the year	2,157	0	0	0	2,157
Revaluation and impairment gains/(losses) on property, plant and equipment	(1,496)	0	(1,496)	0	0
Increase in respect of receipt of donated assets	93	0	0	93	0
Reduction in respect of donated assets depreciation, impairment or disposal	(82)	0	0	(82)	0
Public Dividend Capital received	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0
Public Dividend Capital repayable (creditor)	0	0	0	0	0
Public Dividend Capital written off	0	0	0	0	0
Other transfers between reserves	0	0	(109)	109	0
Taxpayers' Equity at 31 March 2010	**55,113**	38,905	3,156	2,416	10,636

	Total	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2008	**53,348**	38,905	6,165	1,976	6,302
Surplus for the year	2,600	0	0	0	2,600
Revaluation and impairment gains/(losses) on property, plant and equipment	(1,419)	0	(1,419)	0	0
Reduction in respect of donated assets depreciation, impairment or disposal	(88)	0	0	(88)	0
Public Dividend Capital received	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0
Public Dividend Capital repayable (creditor)	0	0	0	0	0
Public Dividend Capital written off	0	0	0	0	0
Other transfers between reserves	0	0	(408)	408	0
Movements on reserves	0	0	423	0	(423)
Taxpayers' Equity at 31 March 2009	**54,441**	38,905	4,761	2,296	8,479

STATEMENT OF CASH FLOWS AS AT 31 MARCH 2010

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Cash flows from operating activities		
Operating surplus from continuing operations	3,338	3,333
Non-cash income and expense		
Depreciation and amortisation	2,573	3,118
Impairments	683	1,379
Reversal of impairments	(283)	0
Transfer from the donated asset reserve	(82)	(88)
Amortisation of government grants	30	0
(Increase)/Decrease in Trade and Other Receivables	(447)	659
(Increase)/Decrease in Other Assets	0	0
(Increase)/Decrease in Inventories	(494)	(219)
Increase/(Decrease) in Trade and Other Payables	2,480	1,839
Increase/(Decrease) in Other Liabilities	(80)	(80)
Increase/(Decrease) in Provisions	67	4
Other movements in operating cash flow	1	(4)
NET CASH GENERATED FROM OPERATING ACTIVITIES	**7,786**	9,941
Cash flows from investing activities		
Interest received	151	684
Purchase of intangible assets	(56)	(96)
Purchase of Property, Plant and Equipment	(4,142)	(2,276)
Sale of Property, Plant and Equipment	54	1
NET CASH GENERATED FROM INVESTING ACTIVITIES	**(3,993)**	(1,687)
Cash flows from financing activities		
Interest element of finance leases	(30)	(30)
Capital element of finance lease rental payments	(80)	(80)
PDC Dividend paid	(1,284)	(1,325)
NET CASH GENERATED FROM FINANCING ACTIVITIES	**(1,394)**	(1,435)
Increase in cash and cash equivalents	**2,399**	6,819
Cash and Cash equivalents at 1 April 2009	**16,305**	9,486
Cash and Cash equivalents at 31 March 2010	**18,704**	16,305

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 *NHS Foundation Trust Financial Reporting Manual 2009/10* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) 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 Transition to International Reporting Standards

The financial statements have been prepared in accordance with International Financial Reporting Standards (IFRS) and interpretations from the International Financial Reporting Interpretations Committee (IFRIC) that have been adopted by the European Union. The effective date of transition to IFRS is 1 April 2008, being the beginning of the earliest comparative year reported in the financial statements. The financial statements for 2008/09 prepared under UK GAAP have been restated to comply with IFRS, therefore being the comparative period for the year to 31 March 2010.

1.3 Consolidation

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

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

HM Treasury has granted dispensation to the application if IAS 27 by NHS Foundation Trusts in relation to the consolidation of NHS charitable funds for 2009/10 and 2010/11. The disclosure requirements of the standard will, however, apply from 2009/10 should be the NHS charitable fund to be considered to be a subsidiary of the NHS Foundation Trust.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.4 Income

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

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.

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

1.5 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs
NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment. The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and an IAS19 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) IAS19 Accounting valuation

In accordance with IAS19, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

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

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

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

Scheme provisions as at 31 March 2008

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money

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

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

Local Government Superannuation Scheme

Some employees are members of the Local Government Superannuation Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations. The Trust does not have any employees that are members of this pension scheme.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the pensions reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.6 Expenditure on other goods and services

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

1.7 Property, Plant and equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.
- individually have a cost of at least £5,000;
- 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.

Measurement

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

Property is measured at fair value. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent asset valuations were undertaken on 31 March 2010 by GVA Grimley international property advisers. The revaluation undertaken at that date has been accounted for in these accounts on 31 March 2010 as follows:

- Land £3,131,258
- Buildings and Dwellings £27,159,480

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

All land and buildings are revalued using professional valuations in accordance with IAS 16.

Assets in the course of construction are valued at cost and are valued on completion by professional valuers as part of the land and buildings revaluation required by IAS 16.
Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure

In the absence of a valuation, 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

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

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. 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.

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

- Buildings – as per GVA Grimley's estimate

- Plant and Machinery:
    - Engineering Plant and Equipment – short life 5 years
    - Engineering Plant and Equipment – medium life 10 years
    - Engineering Plant and Equipment – long life 15 years
    - Medical Equipment – short life 5 years
    - Medical Equipment – medium life 10 years
    - Medical Equipment – long life 15 years
    - Decontamination Equipment – short life 2 years

- Transport Equipment – 7 years
- Information Technology – 3 years

- Furniture and Fittings:
    - Furniture – short life 3 years
    - Furniture – medium life 5 years
    - Furniture – long life 10 years

Future Useful Economic Life

GVA Grimley's has adopted the remaining economic life for modern equivalent buildings at 60 years. The economic life of the service engineering component within these buildings is 20 years. In previous valuations the age and remaining lives of buildings and their elements have been assessed as at the valuation date by the valuer. The reduction in life of the service engineering component will result in an increased depreciation charge over the life of those assets.

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

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

De-recognition

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

- the sale must be highly probable i.e.:

    - management are committed to a plan to sell the asset;

- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs, it is removed from the fixed asset register and shown as a disposal when the Trust has no further use for it.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;

- how the intangible asset will generate probable future economic or service delivery

- benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and

- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Intangible fixed assets are capitalised when:

- Intangible fixed assets are capitalised when they are capable of being used in a trust's activities for more than one year

- they can be reliably valued;

- they have a cost of at least £5,000

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

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

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

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Donated assets

Donated assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated 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 Statement of Comprehensive Income. Similarly, any impairment on donated assets charged to the Statement of Comprehensive Income 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 retained earnings.

1.10 Private Finance Initiative (PFI) transactions

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

1.11 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.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value. Work in progress comprises goods and services in intermediate stages of production.

1.13 Cash and cash equivalents

Cash and cash equivalents comprise of cash in hand and demand deposits, together with short-term highly liquid investments with maturities of 90 days or less and bank overdrafts. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases bank overdrafts are shown within borrowings in ‘current liabilities’ on the Statement of Financial Position. In the Statement of Cash Flows, bank overdrafts which are repayable on demand and which form an integral part of an entity’s cash management are also included as a component of cash and cash equivalents with the equivalent items reported in the Statement of Financial Position.

1.14 Finance income and costs

Interest earned on bank accounts and interest charged on overdrafts is recorded as ‘interest

receivable' and 'interest payable' in the periods to which they relate, and shown on the Statement of Cash Flows. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.15 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 2010. The trust has not entered into any regular way purchases or sales in the year to 31 March 2010.

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

De-recognition

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

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

Classification and Measurement

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

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

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

The Trust does not hold any assets in this category.

Loans and receivables

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

The Trust's loans and receivables comprise: cash 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. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the balance sheet date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

The Trust does not hold any assets in this category.

Other financial liabilities

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

They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the 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 cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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 annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.17 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.

1.18 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.

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 15 on page 43.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of

claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises. The Trust has also taken out additional insurance to cover claims in excess of £1 million.

1.19 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 17 on page 43 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 17 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.

1.20 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

1.21 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.

1.22 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.

1.23 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;

- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and

- Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.24 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*.

1.25 Significant accounting policies, judgments and sources of estimation uncertainty

Accounting policies that have been selected during the process of applying International Reporting Standards have been considered by management, assisting users in understanding financial performance and financial position. Management is required to make various judgements and assumptions about the carrying amounts of assets and liabilities which require estimation of the effects of uncertain future events. Estimates and assumptions are based on historical experience and other factors that are considered to be relevant, all estimates and underlying assumptions are continually reviewed. Any revisions to accounting estimates are recognised in the period in which the revision relates to.

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

Leases

Leases have been reclassified from operating leases to finance leases if the lease transfers substantially all the risks and rewards incidental to ownership of an asset. Title may or may not eventually be transferred. An asset and a liability will be recognised on the balance sheet.
Judgements and sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

Determination of useful lives for Property, Plant and Equipment

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

Partially completed spells

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

Impaired receivables

The Trust has a policy to provide a standard provision of 5% for impaired receivables against the total of all non NHS receivables.

1.26 Application of International Financial Reporting Standards

The following standards and interpretations have been adopted by the European Union but are not required to be followed by the Foundation Trust until a future accounting period. None of them are expected to impact upon the Trust's financial statements. The following standards will be adopted by the Foundation Trust as follows:

2010/11

- IAS 27 consolidated and separate financial statements and IFRS 3 business combinations
- IAS 39 financial instruments: recognition and measurement
- IFRS 5 assets for disposal

2011/12

- IAS 24 related party disclosures
- IAS 32 financial instruments: presentation

2 Segmental Reporting

The Trust considers that all of its activities fall within one material segment, which is the provision of healthcare services. The segmental reporting format applied to these accounts reflects the Trust's management and internal reporting structure.
The provision of healthcare is within one main geographical segment being the United Kingdom, and materially from Departments of HM Government in England. Income from within the whole of HM Government is disclosed below:

		Year Ended 31 March 2010		Year Ended 31 March 2009
	£000	%	£000	%
Income from whole HM Government	65,729	97.67%	63,801	97.43%
Income from non HM Government	1,569	2.33%	1,681	2.57%
	67,298	100.00%	65,482	100.00%

All business activities of the Trust are continually reviewed for material segments.

3 Income from Activities

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Acute Trusts		
Elective income	38,453	41,041
Non elective income	2,370	2,837
Outpatient income	10,148	7,766
Other NHS clinical income	12,013	9,425
All Trusts		
Private patient income	1,052	1,240
Other non-protected clinical income	35	76
Total income from activities	**64,071**	62,385
Other operating income		
Research and development	18	169
Education and training	2,491	2,261
Transfer from donated asset reserve in respect of depreciation on donated assets	82	88
Profit on disposal of other tangible assets	45	0
Other	591	579
Total other operating income	**3,227**	3,097
TOTAL OPERATING INCOME	**67,298**	65,482

Other income includes £157,203 from on site catering services (2008/09 - £180,271); staff accommodation rentals of £69,156 (2008/09 - £72,635); and staff recharges of £8,153 (2008/09 - £27,584).

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.

3.1 Private Patient Income

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000	Base Year £'000
Private patient income	1,052	1,240	1,446
Total patient related Income	64,071	62,385	33,956
Proportion (as percentage)	**1.64%**	1.99%	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 2010. In December 2009, the High Court ruled that changes in the base year calculation will be brought into effect for the accounts year ending 31 March 2011.

4 Operating Expenditure

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Purchase of healthcare from non NHS bodies	1,065	2,856
Employee Expenses - Executive directors	512	469
Employee Expenses - Non-executive directors	94	85
Employee Expenses - Staff	34,842	32,378
Drug costs	1,488	1,383
Supplies and services - clinical	15,149	13,625
Supplies and services - general	793	993
Establishment	738	784
Transport	200	183
Premises	3,582	3,057
Increase/(decrease) in bad debt provision	13	3
Depreciation on property, plant and equipment	2,557	3,104
Amortisation on intangible assets	46	14
Impairments of property, plant and equipment	683	1,379
Reversals of impairments of plant, property and equipment	(283)	0
Audit fees - statutory audit services	65	55
Other auditors remuneration - further assurance services	7	8
Other auditors remuneration - other services	122	106
Clinical negligence	721	350
Loss on disposal of other property, plant and equipment	0	16
Legal fees	69	79
Consultancy costs	563	205
Training courses and conferences	169	134
Patient travel	10	11
Redundancy	0	7
Hospitality	8	5
Insurance	112	41
Other services eg external payroll	266	542
Losses, ex gratia & special payments	94	15
Other	275	262
TOTAL OPERATING EXPENDITURE	**63,960**	62,149

Impairment of property, plant and equipment includes an amount of £478,995 which relates to an impairment (due to market revaluation) of Ward Block 1 (2008/09 - £940,053), situated on the existing premises.

5 Operating leases

5.1 Payments recognised as an expense

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Minimum lease payments	1,979	37
Contingent rents	0	0
Less sublease payments received	0	0
TOTAL PAYMENTS	**1,979**	37

The Trust is engaged in providing a range of orthopaedic and other procedures to patients. BMI Healthcare limited has granted a lease to the Trust for the use of facilities at the BMI Edgbaston Hospital, for the provision of orthopaedic services to patients.

At the end of each calendar month BMI Healthcare will invoice the Trust for a sum equal to the charges payable in respect of that calendar month.

There is nothing in the agreement intended to, or shall operate to, create a partnership between the Trust or BMI Healthcare, or to authorise either party to act as an agent for each other, and neither party shall have authority to act in the name or on behalf of, or otherwise to bind the other in any way.

5.2 Total future minimum lease payments

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
- not later than one year;	2,180	31
- later than one year and not later than five years;	6,451	76
- later than five years.	0	0
TOTAL FUTURE PAYMENTS	**8,631**	107

6 Employee costs and numbers

	2009/10			2008/09		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	30,093	27,559	2534	27,820	26,500	1,320
Social security Costs	2,369	2,369	0	2,289	2,289	0
Employers contributions to NHS Pensions	2,892	2,892	0	2,738	2,738	0
TOTAL EMPLOYEE COSTS	**35,354**	32,820	2,534	32,847	31,527	1,320

6.1 Employee costs

The total Employer Pension contribution payable for the period is £2,892,411 (31 March 2009: £2,738,165).

6.2 Average number of persons employed

	2009/10			2008/09		
	Total Number	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number
Medical and dental	104	96	8	104	99	5
Administration and estates	228	226	2	219	213	6
Healthcare assistants and other support staff	82	82	0	74	74	0
Nursing, midwifery and health visiting staff	304	303	1	311	311	0
Nursing, midwifery and health visiting learners	2	2	0	0	0	0
Scientific, therapeutic and technical staff	120	111	9	111	105	6
Other	5	5	0	5	5	0
TOTAL PERSONS EMPLOYED	**845**	825	20	824	807	17

6.3 Retirements due to ill health

During the year to 31 March 2010 there was 1 early retirement from the Trust agreed on the grounds of ill-health at a cost of £149,018 (31 March 2009 – £0).

7 Intangible assets

	Software licences (purchased) £000	Other (purchased) £000	Total £000
Gross cost at 1 April 2009	96	0	96
Additions - purchased	56	0	56
Additions - donated	0	0	0
Disposals	0	0	0
Gross cost at 31 March 2010	**152**	0	152
Amortisation at 1 April 2009	14	0	14
Provided during the year	46	0	46
Disposals	0	0	0
Amortisation at 31 March 2010	**60**	0	60
Net book value			
NBV - Purchased at 31 March 2010	92	0	92
NBV - Donated at 31 March 2010	0	0	0
NBV total at 31 March 2010	**92**	0	92

	Software licences (purchased) £000	Other (purchased) £000	Total £000
Gross cost at 1 April 2008	0	0	0
Additions - purchased	96	0	96
Additions - donated	0	0	0
Disposals	0	0	0
Gross cost at 31 March 2009	**96**	0	96
Amortisation at 1 April 2008	0	0	0
Provided during the year	14	0	14
Disposals	0	0	0
Amortisation at 31 March 2009	**14**	0	14
Net book value			
NBV - Purchased at 31 March 2009	82	0	82
NBV - Donated at 31 March 2009	0	0	0
NBV total at 31 March 2009	**82**	0	82

There is no active market for the Trust's intangible assets and there is no revaluation reserve.

8 Property, plant and equipment for year ended 31 March 2010

	Total	Land	Buildings excl dwellings	Dwellings	Assets under construction & POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	45,333	5,202	26,495	1,053	713	8,965	51	2,708	146
Additions - purchased	4,820	0	730	37	3,469	488	0	96	0
Additions - donated	93	0	0	0	0	93	0	0	0
Impairments charged to revaluation reserve	(2,694)	(2,069)	(629)	4	0	0	0	0	0
Reclassifications	0	0	313	(60)	(253)	0	0	0	0
Net impairments charged to income and expenditure	(400)	0	(400)	0	0	0	0	0	0
Disposals	(265)	0	0	0	0	(224)	(32)	0	(9)
Cost or Valuation at 31 March 2010	**46,887**	3,133	26,509	1,034	3,929	9,322	19	2,804	137
Accumulated depreciation at 1 April 2009	8,105	0	12	126	0	6,355	35	1,431	146
Provided during the year	2,557	0	1,074	31	0	724	3	725	0
Reversal of depreciation following asset impairment	(1,881)	0	(1,724)	(157)	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Disposals	(256)	0	0	0	0	(215)	(32)	0	(9)
Accumulated depreciation at 31 March 2010	**9,208**	0	45	0	0	6,864	6	2,156	137
Net book value									
NBV - Purchased at 31 March 2010	35,082	3,133	24,173	1,034	3,929	2,152	13	648	0
NBV - Finance lease at 31 March 2010	181	0	0	0	0	181	0	0	0
NBV - Donated at 31 March 2010	2,416	0	2,291	0	0	125	0	0	0
NBV total at 31 March 2010	**37,679**	3,133	26,464	1,034	3,929	2,458	13	648	0
Analysis of Property, plant and equipment									
NBV - Protected assets at 31 March 2010	30,631	3,133	26,464	1,034	0	0	0	0	0
NBV - Unprotected assets at 31 March 2010	7,048	0	0	0	3,929	2,458	13	648	0
Total at 31 March 2010	**37,679**	3,133	26,464	1,034	3,929	2,458	13	648	0
Asset financing									
Owned	37,498	3,133	26,464	1,034	3,929	2,277	13	648	0
NBV - Finance leased	181	0	0	0	0	181	0	0	0
Total at 31 March 2010	**37,679**	3,133	26,464	1,034	3,929	2,458	13	648	0

8.1 Property, plant and equipment for year ended 31 March 2009

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	51,113	6,502	31,242	903	603	8,588	51	2,902	322
Additions - purchased	1,699	0	352	46	600	599	0	102	0
Impairments charged to revaluation reserve	(5,406)	(1,300)	(4,106)	0	0	0	0	0	0
Reclassifications	0	0	212	278	(490)	0	0	0	0
Net impairments charged to income and expenditure	(1,379)	0	(1,205)	(174)	0	0	0	0	0
Disposals	(694)	0	0	0	0	(222)	0	(296)	(176)
Cost or Valuation at 31 March 2009	**45,333**	5,202	26,495	1,053	713	8,965	51	2,708	146
Accumulated depreciation at 1 April 2008	9,664	0	2,946	91	0	5,287	27	991	322
Provided during the year	3,104	0	1,053	35	0	1,278	8	730	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reversal of depreciation following asset impairment	(3,987)	0	(3,987)	0	0	0	0	0	0
Disposals	(676)	0	0	0	0	(210)	0	(290)	(176)
Accumulated depreciation at 31 March 2009	**8,105**	0	12	126	0	6,355	35	1,431	146
Net book value									
NBV - Purchased at 31 March 2009	34,932	5,202	24,218	927	713	2,579	16	1,277	0
NBV - Donated at 31 March 2009	2,296	0	2,265	0	0	31	0	0	0
NBV total at 31 March 2009	**37,228**	5,202	26,483	927	713	2,610	16	1,277	0
Analysis of Property, plant and equipment									
NBV - Protected assets at 31 March 2009	32,612	5,202	26,483	927	0	0	0	0	0
NBV - Unprotected assets at 31 March 2009	4,616	0	0	0	713	2,610	16	1,277	0
Total at 31 March 2009	**37,228**	5,202	26,483	927	713	2,610	16	1,277	0
Asset financing									
Owned	36,967	5,202	26,483	927	713	2,349	16	1,277	0
NBV - Finance leased	261	0	0	0	0	261	0	0	0
Total at 31 March 2009	**37,228**	5,202	26,483	927	713	2,610	16	1,277	0

9 Inventories

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Materials	2,583	2,089	1,870
Work in progress	0	0	0
Finished goods	0	0	0
TOTAL INVENTORIES	**2,583**	2,089	1,870

	31 March 2010 £000	31 March 2009 £000
Inventories recognised in expenses	10,689	9,839
Write-down of inventories recognised as an expense	8	10
Reversal of any write down of inventories resulting in a reduction of recognised expenses	0	0
TOTAL	**10,697**	**9,849**

10 Trade receivables and other receivables

	Financial Assets			Non Financial Assets		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current financial assets						
NHS Receivables	4,075	3,914	4,771	0	0	0
Provision for impaired receivables	(40)	(27)	(24)	0	0	0
	4,035	3,887	4,747	**0**	0	0
Prepayments	0	0	0	519	493	538
Accrued income	2	2	43	0	0	0
Other receivables	813	543	313	97	95	66
	815	545	356	**616**	588	604
Total Current Financial Assets	**4,850**	**4,432**	**5,103**	**616**	**588**	**604**
Non Current Financial Assets						
Trade and other receivables	36	35	48	0	0	0
TOTAL TRADE AND OTHER RECEIVABLES	**4,886**	4,467	5,151	**616**	588	604

10.1 Provision for impairment of receivables

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Balance at 1 April	27	24	365
Increase in provision	13	3	0
Amounts utilised	0	0	0
Unused amounts reversed	0	0	(341)
Balance at 31 March	**40**	27	24

A provision has been made as at 31 March 2010 for impairment of receivables in the amount of £40,000 (31 March 2009: £27,000 and 1 April 2008: £24,000). The provision relates to Non NHS debts. There is no recent history of default with NHS non-impaired debts. The ageing analysis of these non-impaired debts is as follows:

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Up to three months	337	793	1,093
In three to six months	490	398	499
Over six months	0	0	0
TOTAL AGEING OF NON IMPAIRED RECEIVABLES	**827**	1,191	1,592

11 Other current assets

11.1 Current and Non Current asset investments

The Trust did not hold any current asset investments or non-current asset investments in the period to 31 March 2010 (£nil – 31 March 2009).

12 Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Cash and cash equivalents at 1 April	16,305	9,486	8,624
Net change in year	2,399	6,819	862
Cash and cash equivalents at 31 March	18,704	16,305	9,486
Broken down into:			
Cash at commercial banks and in bank	90	83	4,136
Cash at OPG (Office of Paymaster General)	18,614	16,222	5,350
Other current investments	0	0	0
Cash and cash equivalents as in Statement of financial position	**18,704**	16,305	9,486
Bank overdraft	0	0	0
Cash and cash equivalents as in Statement of cash flows	**18,704**	16,305	9,486

13 Trade and other payables

	Current			Non Current		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
NHS Payables	2,805	1,354	612	0	0	0
Trade payables - capital	918	176	753	0	0	0
Taxes payable	0	0	0	767	769	19
Other trade payables	3,110	2,681	2,869	0	0	0
Accruals	641	388	163	0	0	0
TOTAL TRADE AND OTHER PAYABLES	**7,474**	4,599	4,397	**767**	769	19

Other Trade Payables include £373,213 outstanding pension contributions at 31st March 2010 (31 March 2009: £348,129 and 1 April 2008: £324,149). There are no payments due in future years under arrangements to buy out the liability for early retirements over five years.

13.1 Other liabilities

	Current			Non Current		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Deferred income	407	414	184	0	0	0
Deferred government grant	61	0	0	215	0	0
TOTAL OTHER LIABILITIES	**468**	414	184	**215**	0	0

Other liabilities include a deferred government grant for single sex wards in the amount of £276,704. This will be written off over a 5 year period with 6 months written off in the year to 31 March 2010. Fixed assets relating to this Grant will also be written off over 5 years and are included within buildings excluding dwellings.

13.2 Borrowings

	Current			Non Current		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Bank overdrafts	0	0	0	0	0	0
Obligations under finance leases	80	80	80	101	181	261
TOTAL BORROWINGS	**80**	80	80	**101**	181	261

13.3 Finance lease obligations

	Net lease liabilities			Gross lease liabilities		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Within one year	80	80	80	110	110	110
Between one and five years	101	181	261	139	249	359
After five years	0	0	0	0	0	0
	181	261	341	**249**	359	469
Included in :						
Current borrowings	80	80	80	0	0	0
Non-Current borrowings	101	181	261	0	0	0
	181	261	341	**0**	0	0

14 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 £17,400,000 in 2009/10 (£17,900,000 in 2008/9). The trust borrowed/repaid a net £0 in 2009/10 (£0 in 2008/9) and at 31 March 2010 had £0 of outstanding borrowing (£0 at 31 March 2009).

The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £13.4m (£13.9m – 31 March 2009), and
(ii) Approved working capital facility of: not to exceed £4.0m

Financial Ratio	Actual 2008/09	Plan 2008/09
Maximum Debt / Capital Ratio	0%	0%
Maximum Dividend Cover	2x	2x
Maximum Interest Cover	0%	0%
Maximum Debt Service Cover	0%	0%
Maximum Debt Service to Revenue	0%	0%

The trust has an approved working capital facility of £4.0m (£4.0m in 2008/9). The Trust had drawn down £0 of its working capital facility at 31 March 2010 (£0 at 31 March 2009). 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.

15 Provisions for liabilities and charges

	Current			Non Current		
	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Legal claims	81	20	26	0	0	0
Other	19	19	18	242	236	227
TOTAL PROVISIONS	**100**	39	44	**242**	236	227

	Pensions relating to former directors £'000	Pensions relating to other staff £'000	Legal claims £'000	Other £'000	Total £'000
At 1 April 2009	0	0	20	255	275
Change in discount rate	0	0	0	0	0
Arising during the year	0	0	69	0	69
Utilised during the year	0	0	(9)	(11)	(20)
Reversed unused	0	0	0	0	0
Unwinding of discount	0	0	0	18	18
At 31 March 2010	0	0	80	262	**342**
Expected timing of cash flows:					
Within one year	0	0	80	20	100
Between one and five years	0	0	0	43	43
After five years	0	0	0	199	199
Total expected timing of cash flows	0	0	80	262	**342**

The provisions included under legal claims are for Employee and Public Liability, and are subject to changes in value and timing by either third party insurers or the NHS Litigation Authority depending on the incident date.

Other claims relate to injury benefit provisions which are discounted using the real discount rate set by HM Treasury. 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 2010 has £1,233,687 (£2,561,076 – 31 March 2009 and £652,514 – 1 April 2008) in respect of clinical negligence liabilities of the trust included in its accounts.

16 Contractual Capital Commitments	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Property, plant and equipment	5,446	150	214
Purchase of investment properties	0	0	0
TOTAL CONTRACTUAL CAPITAL COMMITMENTS	**5,446**	150	214

17 Contingent (Liabilities)/Assets

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Gross value of contingent liabilities	20	17	17
Amounts recoverable against liabilities	0	0	0
NET VALUE OF CONTINGENT LIABILITIES	**20**	17	17

The contingent liabilities relate to two employee liability claims. The Trust does not have any contingent assets at 31st March 2010.

18 Post Balance Sheet Events

In June 2009 the Trust entered into a contract to construct a new outpatient department with a value of approximately £8 million of which only £3.5 million is included within these accounts. The project is due to be completed in September 2010, with an estimated final value for the department of £7 million. This will result in a £1 million impairment which the Trust has already included within its financial projections reported to the board.

19 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:

	Receivables £000	Payables £000	Revenue £000	Expenditure £000
London Strategic Health Authority	546	0	6,557	0
Birmingham East and North PCT	0	438	5,992	0
Dudley PCT	0	381	4,002	0
Heart of Birmingham PCT	0	138	3,156	0
South Birmingham PCT	251	0	19,066	0

	Receivables £000	Payables £000	Revenue £000	Expenditure £000
Sandwell PCT	0	0	3,797	0
Solihull Care PCT	0	153	1,908	0
Sandwell and West Birmingham Hospitals NHS Trust	0	47	0	204
South Staffordshire PCT	341	0	2,344	0
Warwickshire PCT	271	0	1,509	0
Walsall PCT	361	0	1,990	0
Worcestershire PCT	319	0	6,084	0
Birmingham Children's Hospital NHS Foundation Trust	0	265	0	903
Heart of England NHS Foundation Trust	38	34	3	25
University Hospital Birmingham NHS Foundation Trust	993	964	941	2,543
University Hospitals Coventry and Warwickshire NHS Trust	0	31	0	77

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

	Receivables £000	Payables £000	Revenue £000	Expenditure £000
National Blood Authority	0	0	0	118
NHS Litigation Authority	20	0	0	726
National Health Service Logistics Authority	0	0	0	1,405
Birmingham City Council	0	0	0	38
NHS Purchasing and Supply Agency	0	243	0	0

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 £13,107 during the year (£12,756 – 31 March 2009).

20 Private Finance Initiatives

The Trust did not have any Private Finance Initiative schemes as at 31 March 2010.

21 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. Trust treasury activity is subject to review by the Trust's internal auditors.

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

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

Credit risk
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 2010 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 Trust's £4,000,000 working capital facility. The Trust aims to fund capital schemes by internally generated funds. In addition the Trust can borrow from the Department of Health's financing facility or commercially. The Trust is therefore not exposed to significant liquidity risk.

Set out below is an analysis, by category, of the Trust's financial assets and liabilities as at 31 March 2010. Fair value approximates to the book value because of the short maturity of these instruments.

21.1 Financial Assets

	Carrying value 31 March 2010 £000	Fair value 31 March 2010 £000	Carrying value 31 March 2009 £000	Fair value 31 March 2009 £000	Carrying value 1 April 2008 £000	Fair value 1 April 2008 £000
Current financial assets						
Trade and other receivables	4,035	4,035	3,887	3,887	4,747	4,747
Other current assets	815	815	545	545	356	356
Cash and cash equivalents	18,704	18,704	16,305	16,305	9,486	9,486
	23,554	23,554	20,737	20,737	14,589	14,589
Non current financial assets						
Trade and other receivables	36	36	35	35	48	48
TOTAL FINANCIAL ASSETS	**23,590**	**23,590**	20,772	20,772	14,637	14,637

21.2 Financial Liabilities

	Carrying value 31 March 2010 £000	Fair value 31 March 2010 £000	Carrying value 31 March 2009 £000	Fair value 31 March 2009 £000	Carrying value 1 April 2008 £000	Fair value 1 April 2008 £000
Current financial liabilities						
Measured at amortised cost:						
Finance leases	181	181	261	261	341	341
Trade and other payables	7,474	7,474	4,599	4,599	4,397	4,397
Provisions under contract	100	100	39	39	44	44
	7,755	7,755	4,899	4,899	4,782	4,782
Non current financial liabilities						
Provisions under contract	242	242	236	236	227	227
TOTAL FINANCIAL LIABILITIES	**7,997**	**7,997**	5,135	5,135	5,009	5,009

22 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 2009/10 the Trust had 41 (31 March 2009: 26) separate losses and special payments, totaling £68,440 (31 March 2009: £27,374). These were in relation to cash losses and ex-gratia payments to patients.

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

These amounts are reported on an accruals basis but excluding provisions for future losses.

23 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.

24 Transition to IFRS

The financial statements for the year ending 31 March 2009 were prepared in accordance with UK GAAP. The Trust has adopted International Financial Reporting Standards (IFRS) for these financial statements year ending 31 March 2010.

Impact on Financial statements

The main impact of IFRS on the financial statements of the Trust is within Finance leases (IAS17). A finance lease previously categorised as an operating lease has been reclassified as a finance lease, where the Trust has substantially all the risks and rewards incidental to ownership.

24.1 Reconciliation of total tax payers' equity (total assets employed) at 31 March 2009 and 1 April 2008 (date of transition to IFRS).

		UK GAAP 31 March 2009	IFRS 31 March 2009	Difference	UK GAAP 1 April 2008	IFRS 1 April 2008	Difference
Non-Current Assets	**Ref**	£000	£000	£000	£000	£000	£000
Intangible assets		82	82	0	0	0	0
Property, Plant and Equipment	**24.2**	36,967	37,228	261	41,108	41,449	341
Trade and other receivables	**24.3**	0	35	35	0	48	48
		37,049	**37,345**	**296**	**41,108**	**41,497**	**389**
Current Assets							
Inventories		2,089	2,089	0	1,870	1,870	0
Trade and other receivables	**24.4**	5,055	4,475	(580)	5,755	5,351	(404)
Other current assets	**24.5**	0	545	545	0	356	356
Cash and cash equivalents		16,305	16,305	0	9,486	9,486	0
		23,449	**23,414**	**(35)**	**17,111**	**17,063**	**(48)**
Current Liabilities							
Trade and other payables	**24.6**	(5,013)	(4,599)	414	(4,581)	(4,397)	184
Borrowings	**24.7**	0	(80)	(80)	0	(80)	(80)
Provisions	**24.8**	0	(39)	(39)	0	(44)	(44)
Tax payable		(769)	(769)	0	(19)	(19)	0
Other liabilities	**24.6**	0	(414)	(414)	0	(184)	(184)
		(5,782)	**(5,901)**	**(119)**	**(4,600)**	**(4,724)**	**(124)**
Non-Current Liabilities							
Borrowings	**24.7**	0	(181)	(181)	0	(261)	(261)
Provisions	**24.8**	(275)	(236)	39	(271)	(227)	44
		(275)	**(417)**	**(142)**	**(271)**	**(488)**	**(217)**
Total assets employed		**54,441**	**54,441**	**0**	**53,348**	**53,348**	0
Financed by Taxpayers' Equity							
Public dividend capital		38,905	38,905	0	38,905	38,905	0
Revaluation reserve		5,169	5,169	0	6,165	6,165	0
Donated asset reserve		1,888	1,888	0	1,976	1,976	0
Income and Expenditure reserve		8,479	8,479	0	6,302	6,302	0
Total taxpayers' equity		**54,441**	**54,441**		**53,348**	**53,348**	

Reference 24.2
Property, plant and equipment

	31 March 2009 £000	1 April 2008 £000
Finance leases (IAS 17) requires leases of equipment previously categorised as operating leases to be reclassified as finance leases, where the Trust has substantially all the risks and rewards incidental to ownership.	261	341
	261	341

Reference 24.3
Non-current other assets

	31 March 2009 £000	1 April 2008 £000
Presentation of Financial Statements (IAS 1) requires current assets to be realised within 12 months after the statement of financial position date and therefore balances over 12 months have been split out into 'trade and other receivables' as part of 'non-current assets'.	35	48
	35	48

Reference 24.4
Trade and other receivables

	31 March 2009 £000	1 April 2008 £000
Presentation of Financial Statements (IAS 1) requires accrued income and other debtors to be reclassified as 'other current assets'. Therefore they have been separated from 'Trade and other receivables'.	(545)	(356)
Trade receivables over 12 months have been shown as 'trade and other receivables' as part of 'non-current assets'.	(35)	(48)
	(580)	(404)

Reference 24.5
Other current assets

	31 March 2009 £000	1 April 2008 £000
Presentation of Financial Statements (IAS 1) requires accrued income and other debtors to be classified as 'other current assets'.	545	356
	545	356

Reference 24.6
Trade and other payables

	31 March 2009 £000	1 April 2008 £000
Presentation of Financial Statements (IAS 1) requires 'deferred income'	414	184
To be shown as 'other liabilities'.	**414**	184

Reference 24.7
Borrowings

	31 March 2009 £000	1 April 2008 £000
Finance leases (IAS 17) requires operating leases that transfer substantially all risks and rewards to the Trust to be reclassified.	(80)	(80)
Liability due within one year – 'current liabilities'	(181)	(261)
Liability due over one year – 'non-current liabilities'	**(261)**	(341)

Reference 24.8
Provisions

	31 March 2009 £000	1 April 2008 £000
Presentation of Financial Statements (IAS 1) requires provisions to be Split between 'current' and 'non-current assets'.	39	44
Liability due within one year – 'current liabilities'	**39**	44

The analysis below shows a reconciliation of comprehensive income reported under UK GAAP for the year to 31 March 2009 to the revised statement of income under IFRS as reported in these financial statements.

24.9 Total comprehensive income

	31 March 2009 £000
Retained surplus for the year under UK GAAP	2,600
Impairment losses on property, plant and equipment	(1,419)
Reduction on donated asset reserve	(88)
Total comprehensive income for the year	**1,093**

24.10 Reconciliation of the statement of cash flows for the year ended 31 March 2010

There is no change in the cash and cash equivalents of the Trust due to the adoption of International Reporting Standards.