The Royal Orthopaedic NHS Foundation Trust

Annual Report and Accounts 2010/11

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

Contents 2010/11

1. Chairman's Message

In a year that has been dominated by the proposed changes to the National Healthcare system and cuts in Public Spending I am pleased to be able to report that, although we are very cognisant of these external pressures, the main focus for the Royal Orthopaedic Hospital remains unchanged and delivering excellent standards of care to all our patients remains our top priority. It is therefore pleasing to note that in the Care Quality Commission's Inpatient Survey 2010 we were one of the best performing Trusts for the care received by patients. Of the nine categories within the survey our results were about the same as other Trusts in three and better in six. Although the results are reassuring we are not complacent as there are areas where we can improve and we are already tackling these as part of our quality improvement programme.

The Board takes patient safety and experience very seriously and this is reflected in the importance and time devoted to the subject at our monthly meetings. Non- Executive Directors also sit on committees that look more closely at clinical and patient safety matters and they carry out regular visits to patient areas to see first-hand how the Trust is performing. We gain further feedback through our Patient's Council which is a committee chaired by a representative of the Member's Council and any feedback is given to the Trust for action.

We have worked closely with the Members' Council over the past year and our relationship remains very positive and productive. Apart from the normal meetings Members' Council has been involved in two joint Board meetings, the selection process for new external auditors and the recruitment of two new Non-Executive Directors. In what has been a busy year, the Council has also seen a number of its members change as a result of planned and unforeseen circumstances. Despite all of these challenges the Members' Council has remained as committed, enthusiastic and supportive of the Trust as ever.

Visitors to the Woodlands site over the past year will have seen the new outpatients department be developed and it is pleasing to be able to report that from May all of our outpatients will be using the new facility. It is a splendid building that incorporates all the up to date features expected of a hospital of our standing. Apart from being very stylish and practical the new building is also very energy efficient and incorporates all the latest energy saving devices. Most importantly patients will no longer have to negotiate the long walk to the imaging department, sit in very confined and crowded waiting rooms or be seen in out-dated consulting areas.

In January we officially opened the Teenager Cancer Trust unit on one of our wards. It is a dedicated area in which teenagers can relax and take their

minds off some of the more worrying aspects of their treatment while they are with us. It is a wonderful facility which really has made a difference to the teenagers that we look after in the Trust. It is a fabulous project that is the culmination of an idea that emanated from one of our staff and made possible by the Teenage Cancer Trust.

Reference was made to the external pressures that the Trust faces earlier it would seem appropriate to consider this in the light of our performance of the last year and the challenges that we will inevitably encounter going forward. You will see later in the report that the Trust had another successful financial year and we were able to record a surplus. Our performance, although in line with our expectations, resulted in our Monitor rating reducing by one point although at this level we are still considered to be low risk. To achieve this performance we initiated an efficiency programme called 'Excellent Health' which presented us with opportunities to improve our efficiency and patient safety. This programme along with other initiatives has enabled the Trust to make productivity improvements without compromising patient safety and created a foundation upon which further improvements can be made.

Although we are confident about our performance in the year ahead we realise that the proposed changes in the healthcare system may have a financial impact upon us longer term and therefore we are continuing to explore new methods of working that will result in more streamlined activities and improved care.

The success that we have enjoyed over the past year can be attributed to the commitment and dedication of all staff. There are inevitably more demands being placed upon staff to adapt and change and this is not always easy. It is credit to them that we have achieved so much and more importantly it has been accomplished without compromising patient care in any way whatsoever. We are also grateful for all the help that we receive from our loyal and hard working group of volunteers. They provide a valuable support service within the hospital and this undoubtedly accounts for the positive experience that patients report having when they visit us.

In February we saw some changes on the Board when Professor Andrew Stevens retired after ten years' service. I am grateful for the contribution that Andrew made while he served on the Board particularly in the area of clinical governance. In the interests of good governance we also decided to recruit an additional non-executive thereby ensuring that there is always a clear majority of non-executives on the Board. I am delighted to be able to report that we have been able to appoint two outstanding individuals, Professor Taunton Southwood and Frances Kirkham; both bring considerable expertise and experience to the Board.

The success of the Royal Orthopaedic Hospital is dependent upon a team made up of very different but essential parts. We have found that the very best results come when we blend all the different elements together and our permanent staff work alongside volunteers and we have a Board and Members Council that have a common goal - to provide the very best orthopaedic care in a safe, clean and friendly environment. In these difficult times we will remain focussed on this goal and never forget that patients must be at the heart of everything we do.

Laurence James

2. Chief Executive's Report

2010/11 has been a year of success coupled with increasing challenge. It has been pleasing to see the work of our staff and Chairman recognised in several external awards and to receive so many compliments from patients and their relatives.

The Trust has seen the first full year effect of developing its service improvement processes and this has meant that in many key areas staff have had to adapt to new ways of working. This will be a continuous improvement programme for the organisation and I wish to place on record my thanks for those who have trailblazed these new ways of working.

Delivering our strategy and taking forward developments in outreach have begun to come to fruition and the advantages of robust forward planning have helped us weather some of the difficulties more easily than others.

Our new outpatients department, although sadly much delayed, was opened for business in May 2011 and this is an example of a project stimulated by patients and their advocates who felt the configuration of our old site and buildings presented an unacceptable 'long walk' for patients with mobility problems. Using our freedoms as a Foundation Trust, we have been able to fund the new build entirely from our own resources and have involved patients in the design every step of the way.

We continue to work in partnership with others and in the last year, particularly with universities to increase the Trust's focus on both the academic and research agendas. We even found a way to involve students in our outpatient department and have used charitable funds to commission bespoke artwork that both tells the story of some of our patients and staff but also provides a focal point for those waiting for their clinic appointments.

Over the coming year, we know things may be even more challenging and I have been pleased to hear first-hand how staff want to meet these challenges head-on. Regular staff briefing sessions have been held to consider the impact of financial pressures and to elicit ideas for ways to make positive changes. This feedback, coupled with that from a major survey of our members has given us food for thought and the confidence to tackle some issues we had previously felt might be a step too far for our patients and users.

Using so many of the techniques applied so often in industry, we are able to have confidence in our decisions and retain a strong position in a competitive market-place.

This annual report reflects the work of a Trust wholly committed to putting patients first and to involving them in decisions of significance.

Penny Venables

3. Operating and Financial Review 2009/10

Summary of Financial Performance

Moving in to 2010/11 it was clear that the year would be challenging for the health service nationally and also the health economy locally. It was known that the NHS along with other public sector organisations needed to reduce costs as part of the government initiative to reduce public debt which created a fundamental challenge to all Boards - how do you increase the quality of your service and the patient experience whilst reducing your cost base?

With this in mind the following 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 £1.25m net of the revaluation of the new outpatient building	Operating Surplus £1.33m Overall trust including the write off of project costs upon the handover of the new outpatient department (£0.3m).
Achieve a Monitor Risk rating of 4	Achieved a 4
Deliver £3.2m in cost reduction	Achieved £2.8m
Deliver a capital programme of £6.3m	Delivered £5.2m

The financial environment saw further falls in the tariff income which reduced the price per patients along with commissioning intentions to reduce the volume of patients meant that the Trust required a challenging cost improvement programme to remain a going concern.

The Trust exceeded its target operational surplus target by £80,000 generating a full year operating surplus of £1.33m. This is excludes a write-off of project costs for the new outpatient building and once these are included, the Trust recorded a loss of £0.3m. The Trust's regulator Monitor excludes one-off exceptional costs such as this and therefore rated the Trust as with a risk rating of 4 which shows a low financial risk.

The surplus was achieved by increasing the number of elective patients treated within the Trust but doing it within the resource allocated therefore creating a more efficient environment. This was achieved by the continued commitment to the Trust's Excellent Health programme which has introduced a number of lean thinking techniques in the ward, theatre and administrative areas. We will continue to invest in this initiative.

There were on-going cost control pressures in scarce resource areas particularly with junior doctors and anaesthetists but overall the Trust was able to control other areas of expenditure to ensure that the effect of these pressures did not stop us achieving our target.

We failed to achieve our cost improvement target achieving 88% but the lessons learned have been taken forward into the coming financial year and we have invested in a Programme Management Office and robust programme structure to make sure that we make the 22% savings missed in 2010/11 in 2011/12.

The Trust finished the year with a strong liquidity position £14.8m against a plan of £13.6m which will enable us to continue to invest in improving property, plant and equipment.

The final Monitor financial metrics were as follows:

Monitor Financial Metric	**Actual**	**Plan**
EBITDA margin	7.3%	7.6%
EBITDA Achieved (%)	99.8%	100%
Return on Assets	4.8%	4.6%
I&E Margin	2.0%	1.9%
Liquidity Risk (days)	97.9	77.3

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 15,400 inpatients and saw in excess of 72,000 outpatients throughout the year including 3,300 patients who received a procedure within the outpatient setting.

	2010/11			**2009/10**	
	Actual Treated	**Plan Treatment**	**Variance**	**Actual Treated**	**Variance**
Admitted Patient Care					
Elective	7,573	6,910	663	6,933	640
Non-Elective	502	526	(24)	499	3
Day Cases	7,344	8,446	(1,102)	8,493	(1,149)
Total Admitted Patient Care	**15,419**	**15,882**	**(463)**	**15,925**	**(506)**
Outpatients					
First Appointment	17,781	18,169	(388)	17,462	319
Follow Up Appointment	51,103	51,210	(107)	45,755	5,348
Outpatients with Procedures	3,331	1,853	1,478	8,961	(5,630)
Total Outpatients	**72,215**	**71,232**	**983**	**72,178**	**37**

The Trust increased the number of elective patients it treated without providing additional physical resources or additional staffing. This was possible by adopting the new lean methodologies introduced in the Excellent Health Programme. The programme is seen as vital in creating a safe cost effective environment with high quality patient care going forward.

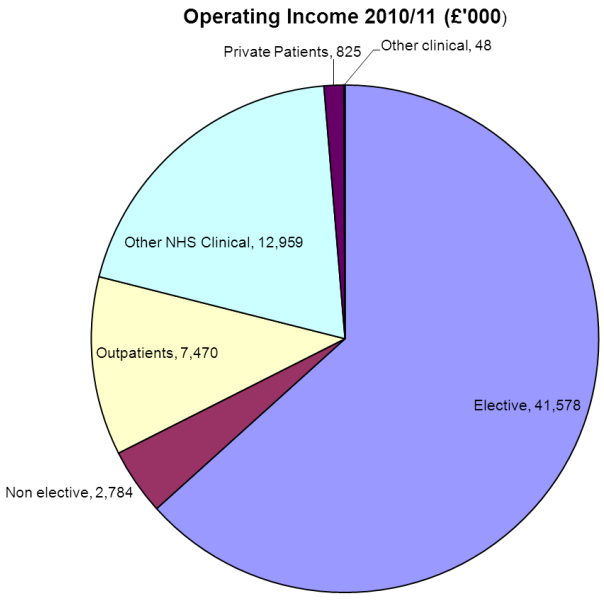
Comprehensive Income

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.

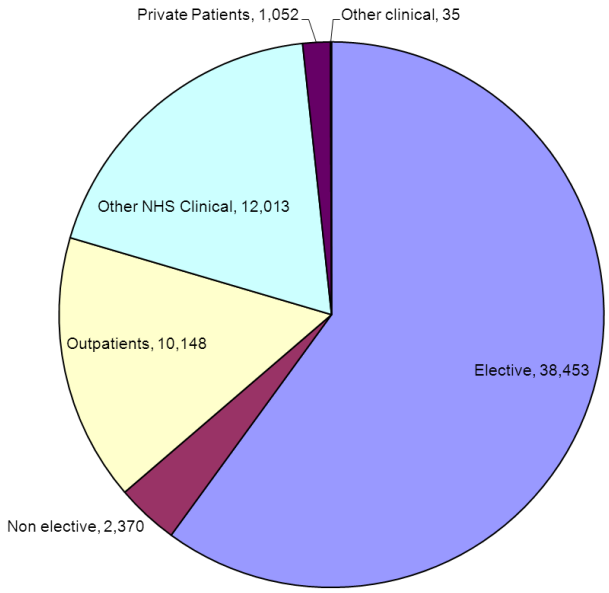
	2010/11 £'m	**2009/10 £'m**
Operating Income	69.38	67.58
Operating Expenses*	(68.22)	(64.24)
Operating Surplus	1.16	3.38
Net Finance Costs	(1.18)	(1.18)
Net Operating Surplus	**(0.25)**	**2.57**

* Operating expenses include a write off of project expenses relating to the new outpatient facility of £1.7m (site revaluation reduction 09/10 £0.7m), which is excluded from the operating surplus measured by Monitor as it is a one-off exceptional adjustment.

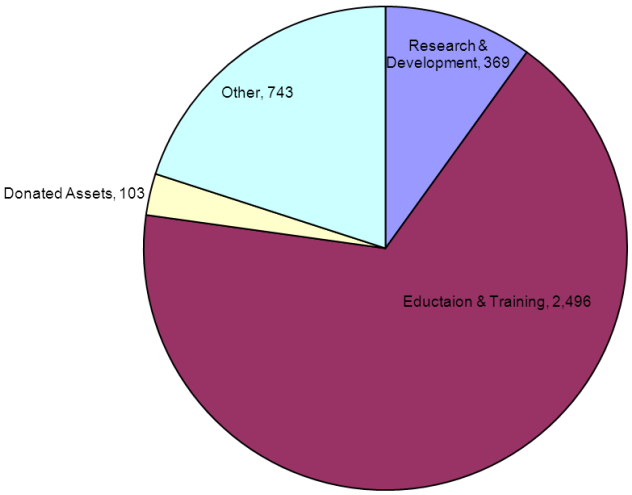
Sources of Income (following page):



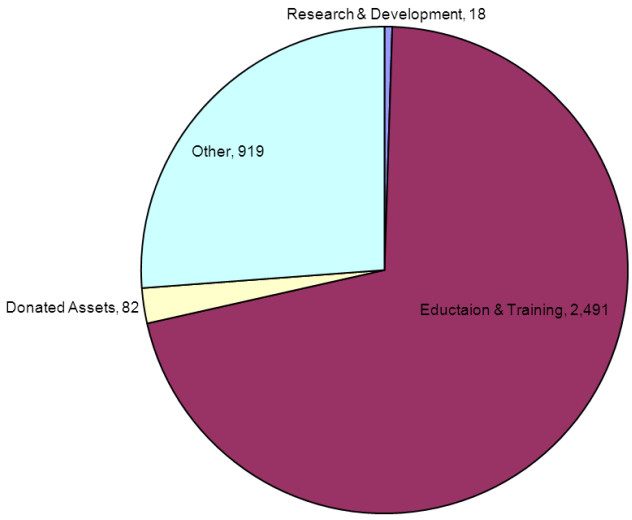
Operating Income 2009/10 (£'000)



Other Income 2010/11 (£'000)



Other Income 2009/10 (£'000)



Private Patient Cap

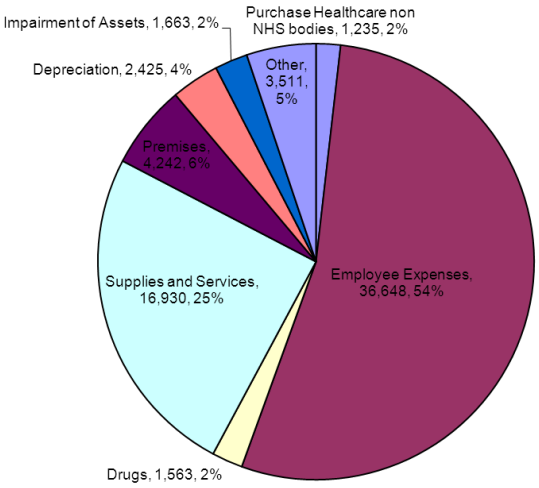
In accordance with section 44 of the Health and Social Care (Community Health and Standards Act 2003), the Trust must not exceed the proportion of income generated from treating private patients compared to total patient income as generated in 2002/3. This measure is used to show that the trust has not 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 2010/11 the Trust percentage of private patient income was 1.26% (1.6% 09/10).

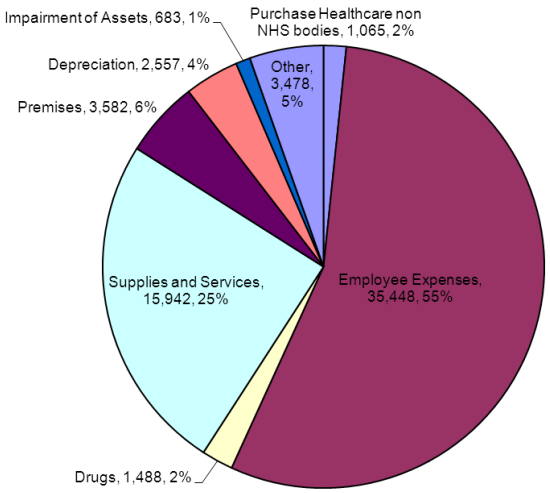
Trust Expenditure

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.

Operating Expenditure 2010/11 (£'000)



Operating Expenditure 2009/10 (£'000)



The largest element of expenditure for the Trust is staffing which accounts for 54% of expenditure. The cost of staffing decreased proportionally from 55% in 2009/10 with the asset impairment increasing to 2% from 1% of Trust expenditure in the same period.

The first quarter of the year saw particular cost pressures which drove a lower financial risk rating but continued focus and work particularly on staff costs saw the

trust recover in quarter two and by quarter four exceed the plan. This was as a result of a number of difficult initiatives and continued hard work by managers in clinical areas. This helped drive the lowering of the proportion of staff expenditure.

Improving efficiency and ensuring continued value for money

During 2010/11 the Trust introduced a Lean Academy and continued to work on its Excellent Health programme to ensure 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. During the last six months of the year the trust recognised £0.8m in cost improvement driven from the efficiencies and models created by staff in the Excellent Health programme.

In 2010/11 the Trust delivered in excess of £2.8m 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.

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. Despite pressures generated by the financial environment the trust must invest in its facilities and site to ensure that they remain fit for purpose and safe for patient care. Capital investment should also save costs by helping to improve processes and services.

Since being licensed the Trust has set aside monies to fund a new outpatient building. Key areas of spend in year were:

- Provision of a new outpatient department building (£4.2m)
- Medical equipment purchases (£0.2m)
- Information equipment (£0.2m)
- Lift improvement programme (£0.2m)
- Improving the Trust estate (£0.3m)
- Theatre improvement programme (£0.2m)

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]

2010/11	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	4	3	4	4	4
Governance risk rating	Amber	Amber	Amber	Amber	Amber-Red
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.

2009/10	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	5	5	5	5	5
Governance risk rating	Green	Green	Green	Amber	Amber-Red
Mandatory services	Green	Green	Green	Green	Green

The key risks facing the Trust in 2011/12 are split into two areas, regulatory and financial. They are shown in the tables below:

Key Regulatory Risks			
Risk	**Nature of risk**	**Actions to rectify/mitigate, and responsibilities**	**Measures 2011/12 2012/13 2013/14**
Governance processes and procedures	The Health Bill may change governance arrangements for FTs with regard to the board and governors.	Maintain active review of Bill's passage. Provide clear information to board and governors. Amend constitution. - Chair, CEO and Company Secretary	Dependent upon date of assent.
Having regard to the NHS Constitution	Failure to uphold patients' right to treatment within 18 weeks.	Retain 18 weeks route to treatment target as headline performance indicator.	Delivery of 18 weeks each quarter for duration of plan.
Hospital-acquired infection targets	Risks associated with having unrealistic reduction targets imposed that are undeliverable in an organisation with low levels of MRSA, MSSA, e-coli and C Diff.	Continue to lobby locally and nationally. Continue to negotiate realistic targets with commissioners.	HCAI targets are delivered.

Meeting information governance standards	Standards are raised and insufficient resource available to improve.	Dedicated information governance manager in-post. Agreed work plan and regular board scrutiny. Information governance group chaired by deputy CEO.	Agree necessary toolkit scores. Confirm this at Board in declaration. Include as part of quality measurement for organisation and review through Integrated Governance Committee.

Key Financial Risks		
Risk	**Amounts**	**Mitigating actions and delivery risk**
The local health economy goes bankrupt	£1m	The Trust is working with the local concordat on the future healthcare provision within the cluster.
Tariff changes to reduce specialist tariff further	£1m	By leading the work of the Strategic Orthopaedic Alliance, the Trust is working with the PbR team at the DoH to work on coding and resources for specialist orthopaedic work.
Patient choice reduces referral rates	£0.5m	The Trust is committed to patient quality and experience and has a strategy to promote its good outcomes and to demonstrate quality.
The Trust cannot achieve the challenging efficiency programme required in the current financial environment	£3m	The Trust has a programme for the next three years and has a programme management office which is overseeing the delivery of the schemes and monitoring the effect of patient experience and quality of service to ensure that we continue to improve as well as reduce cost.

The Forward Look

The Trust will continue to be under significant financial pressure from the health economy and it is clear that there will be continued pressure on reducing the availability of secondary care thus reducing the volumes of patients seen.

However the investment in lean thinking and the efficiency work undertaken over the last eighteen months puts the Trust in a strong position to both adapt and survive and the Trust Board has signed off an annual plan which continues to show the Trust achieving a financial risk rating of 4. The plan includes continued investment in the Trust and introduces a large capital improvement scheme for the theatres (£5.5m) as well as a new MRI (£1.6m) and improved information technology.

We are committed to working with the local health economy to find an affordable solution for the local health economy.

4. Quality Account and Report 2010/11

Part 1 - Our commitment to continual quality improvement

In 2010/11, the Trust continued to embed its strategy for the hospital that is built around quality and excellence in all that we do. The strategy had been widely consulted on in 2009/10 and incorporated the views of our patients and carers and Members' Council.

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

- Quality
- Integrity
- Leadership
- Innovation
- Partnership

Actively listening to others

We were proud to see our commitment to safe high quality care recognised during 2010/11 with the achievement of unconditional registration with the Care Quality Commission. During the course of the year we have focussed on quality with our Members' Council, in particular through our patient experience sub-committee of this council. That committee has been involved in driving a number of improvements in our administrative processes particularly with regard to letters sent to patients, our environmental inspections and receiving feedback from mystery shoppers to the Trust.

We also finally received handover of our new outpatients department which was opened early in May 2011. We will be implementing some of the experience based design methodology work we undertook last year with colleagues at the University of Birmingham involving patients, carers, volunteers and staff to influence the development of how this service will be offered in the new department. We will be evaluating these changes later in the year to ensure the significant improvement in our new facilities benefit our patients to the full.

Throughout the year we have continued to expand the number of locations where we deliver services in order to ensure we deliver care 'closer to home'. This is as a result of patients telling us that this is how they would like us to provide services for them.

Actively involving our staff

We have continued to pursue our service transformation programme based on lean methodology and have seen major quality improvements during the course of the year linked to this. Our Excellent Health programme and Productive Ward initiatives have demonstrated improvements for staff as well as patients and have empowered our staff to lead and implement quality improvements within their own areas of work. We were delighted when some of this work was recognised in the National Health Service Journal awards where we were finalists in this category. As a result of some of this focus we have seen a reduction in falls across the Trust and have hit our CQUIN target for this year based on that reduction. We have also seen improved efficiencies in our operating theatres with fewer over-runs and more patients being treated during the course of the day.

During the year we involved our membership staff and patients in an exercise to rate our service and to give us ideas to save money through efficiencies. All of these ideas have been included in our plans for the new financial year

Communicating with our staff

Throughout the year we have introduced a number of different ways to enable improved communication between staff and the management team.

I launched my own blog in the autumn as a more informal way of keeping staff up to date with Trust issues and encouraging them to feedback to attract staffs individual thoughts and ideas.

In the Autumn of 2010 a series of staff listening events were held where staff from across the organisation were invited to meet with me and the Director of Workforce and Organisational Development to share their views about the organisation. As a result of these sessions we have purchased new equipment, designed a staff only coffee lounge as part of the new dining area that is currently being constructed and recruited additional contact officers to support our staff in the workplace. We have also recruited an additional clinical training post and identified a number of improvements to our patients' journey through the hospital which will also help our staff reduce their workload and be more efficient.

"It was really useful to have the opportunity to share directly with Penny our views about the hospital. It is clear that staff care about our patients and the hospital very much and are committed to making sure we provide a good service.

We were able to tell her what is important to us as staff and it is good to feel that we are being listened to and to see that some of our ideas have already been implemented"
Staff member

We also held a number of staff briefing events in early January 2011. I shared with staff some of the challenges ahead and how we need we alter the way we provide our services in new pathways with the local community. We know that these challenges will only be overcome with the involvement and engagement of staff and have therefore been delighted that these sessions resulted in lots of ideas from staff on how the hospital can become more efficient and offer a better service to patients. These have been fed into our work programme for next year. Both the listening and briefing events evaluated very positively and we have therefore decided to continue these throughout the coming year.

Visibility of the senior management team
The senior management team have developed the 'patient safety walkabouts' into wider 'leadership walkabouts' where, by visiting wards and service areas, they can see for themselves the standards of care and service we offer 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's 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.

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

We have also sought external and independent assurance on a number of key quality issues such as infection prevention and control and critical care to identify areas of good practice and areas for improvement.

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 high 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, the senior management team and the Integrated Governance Committee. Discussions have also been held with the Members Council Patient Experience sub-committee and our commissioners, NHS South Birmingham.

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

Chief Executive Officer

Part 2: Priorities for improvement and statements of assurance from the Board

Quality improvement priorities for 2010/11

In our 2009/10 Quality Account/report we set a range of priorities for 2010/11 that were agreed by the Board and stakeholders as important areas to focus on. The following tables show how we have performed against those priorities with further information available in Part 3.

Table 2 – Quality improvement priorities for 2010/11 that were achieved

Achieved	
Improvement priority	**Performance**
Reduction in inpatient falls	Target – 10% Achieved – 21%
VTE risk assessment	Target - >90% Achieved – 90.4%
Reduce the number of prescribed medications not given	Target – 5% Achieved – 16%
Reduce non-MRSA bacteraemias	Target - 50% from 09/10 baseline Achieved – 59.4%
Reduce pressure ulcers	Target - 10% Achieved – 24%
To examine re-admission data identifying, implementing and monitoring actions as necessary	Target - Review of Dr Foster readmission data Achieved – Dr Foster data reviewed, further information required
Reduce the number of patients reporting they share toilet facilities with the opposite sex	Target < 8% Achieved – 7.2%

Table 3 – Quality improvement priorities for 2010/11 that were not achieved

Not achieved	
Improvement priority	**Performance**
To increase the number of questions in the National Inpatient Survey where ROH scores in the top 20% of all Trusts	Target >75% Under achieved 74%
Reduce the numbers of patients rating the quality of food as poor	Target<12% Under achieved 17.8%

With regard to the national inpatient survey, although the Trust continues to do well when compared to other organisations both locally and nationally, our patients are scoring our performance less well when compared to last year. This will be a key area of focus for the Trust to ensure improvements are made over the coming year.

The new kitchen facilities will be in place in April that will allow full implementation of new menus and training on the delivery and serving of food will be provided to all staff.

The table overleaf (Table 1) outlines the quality improvement priorities for 2011/12. 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 our commissioners.

In the summer of 2010 the Chief Nursing Officer for England launched the High Impact Actions for Nursing and Midwifery. These identified 8 key areas where nurses and midwives could really make a difference to patient care. Not all are relevant to The Royal Orthopaedic Hospital but those that are have also been used to influence our quality improvement priorities.

The table also explains why each priority was 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 1: Quality improvement priorities for 2011/12

PRIORITIES	RATIONALE	MEASURING, MONITORING AND REPORTING
1. SAFETY		
90% of patients will be assessed for risk of 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)*	National requirement - CQUIN Local audit work demonstrates that although there have been significant improvement there is still work to be done in this area.	Via monthly reports to the Board and the PCT
>90% of patient will have ongoing falls risk assessments completed and evidence of care plans in place for those at high risk. (*This is to ensure that we are doing all that we possibly can to identify patients at risk and then care for them appropriately)*	National priority – High Impact Action Local priority CQUIN	Via CQUIN monitoring reports quarterly to the Board
100% of patients whose condition deteriorates and requires transfer to the High Dependency Unit or an Intensive Care Unit will have their case notes reviewed to ensure trends are identified and actioned *(This will allow us to identify common causes and take necessary action)*	Local priority as initial audit work has demonstrated areas for improvement	Via quarterly reports to the Clinical Outcomes Committee (COEC)

2. EFFECTIVENESS		
To reduce the length of time patients are starved before surgery to < 10 hours *(Reducing starvation times before surgery is known to improve recovery)*	National priority - High Impact Action Local priority as identified through audit work and feedback from patients	Via 6 monthly audits reported to the Integrated Governance Committee
To establish readmission rates of our patients back to us and other hospitals (*this work is to look at why patients are returning to hospital and to identify ways to reduce this)*	Local and national priority The Trust now has access to better information about patients that are admitted to other hospitals after they have been admitted to our hospital	Via monthly reports to the Board
To reduce length of stay for patients on the enhanced recovery programme *(this work allows some patients who are in good health overall to stay in hospital for a shorter time)*	National priority – High Impact Action Local priority	Analysis of information presented to COEC Quarterly to the Board
3. EXPERIENCE		
To reduce the % of patients who rated hospital food as poor as reported in the national survey to <12% *(Improving the food we serve to patients continues to be important to us)*	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 number of patients cancelled on the day of surgery by the hospital from an average for the year of 1.2% to <1% *(it is upsetting and inconvenient for patients if we cancel them on the day of surgery)*	Local priority	Via monthly reports to the Board
To increase the numbers of patients reporting in the national patient survey that they had received written information before admission to >65% *(Although we have made some improvements in this area patients are telling us they would like us to do more)*	Local priority as evidenced in patient feedback	Via quarterly reports to the IGC

Statements of assurance from the Board

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

Review of services

During 20010/2011 The Royal Orthopaedic Hospital NHS Foundation Trust provided 4 NHS services (trauma and orthopaedic, neurosurgery, pain management and general medicine).

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

The income generated by the NHS services reviewed in 20010/11 represents 95% of the total income generated from the provision of NHS services by The Royal Orthopaedic Hospital NHS Foundation Trust for 2010/11.

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

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

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

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

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

- The Trust has invited a number of service based peer reviews including critical care as well as specific peer review as a result of a particular issues e.g. *clostridium difficile.* The Trust also collaborated with the Care Quality Commission in their pilot assessment of the Essential Standards of Quality.

Participation in clinical audit

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 2010/2011 4 national clinical audits and 3 national confidential enquiries covered NHS services that The Royal Orthopaedic Hospital NHS Foundation Trust provides.

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

The national clinical audits and the national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2010/11 were:

1. *National Joint Registry – hip and knee replacement*
2. *Patient Reported Outcome Measures – hip and knee replacement*
3. *Pain Database*
4. *NCEPOD Cardiac Arrest*
5. *Blood Transfusion audits*
6. *NCEPOD 'An Age Old Problem'*
7. *NCEPOD 'A Mixed Bag'*

The national clinical audits and national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust participated in during 2010/11 are as follows:

1. *National Joint Registry – hip and knee replacement*
2. *Patient Reported Outcome Measures – hip and knee replacement*
3. *Pain Database*
4. *NCEPOD Cardiac Arrest*
5. *NCEPOD 'A Mixed Bag'*

The national clinical audits and national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit	***Participation***	***% Cases submitted***
NJR	*Yes*	*101.95% (Apr-Dec 10)*
PROMS	*Yes*	*97.4% hips (Apr-Dec 10)* *97.3% knees (Apr-Dec 10)*
Pain Database	*Yes*	*Registered – complete.*
NCEPOD Cardiac Arrest	*Yes*	*There were no eligible patients during the audit period*
Blood Transfusion	*No*	*The Trust was not aware of this possibly due to incorrect contact details. This has been addressed for 2011/12.*
NCEPOD 'An Age Old Problem'	*No*	*There were no eligible patients during the audit period.*

The reports of these 5 national clinical audits were reviewed by the provider in 2010/2011 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- NCEPOD 'An Age Old Problem': the November 2010 report sent through by NCEPOD has been reviewed by the Clinical Outcomes Committee. Actions include a review of the level of support from physicians in elderly care available to patients in the trust, and the management of post-operative pain by the outreach team with anaesthetic support. Regular audits are undertaken to ensure pain assessment and nutritional assessment tools are in use and acted upon.
- The level of compliance with the NJR and PROMS has shown an excellent improvement this year. Figures and statistics are regularly taken to the Clinical Outcomes Committee to generate discussion and be reviewed as necessary.
- NCEPOD 'A Mixed Bag' – report reviewed and all recommended actions had been completed.

In addition to national clinical audits, the Trust undertakes its own clinical audits. Such audits are frequently undertaken by the clinical 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 94 local audits were reviewed by the provider in 2010/11 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Review and consider implementation of consent training booklets used by other Trusts.
- Improve the review of venous thrombo-embolism (blood clot) risk assessments carried out and the frequency in which they are done.
- Improve falls risk assessments and the care and planning of that care for patients that are at high risk and for those patients that do fall.
- Improve the layout of patients' medical notes and implement multi-disciplinary records.
- Improve the delivery of meals to patients.
- Continue to reduce the numbers of doses of prescribed medicines not given to patients.
- Reduce the time patients are kept in the recovery area before being moved back to the ward area.
- Reduce the number of changes to the order of the operating theatre lists.
- Make changes to the antibacterial products currently used for cleaning the skin before surgery.
- Make changes to the ways in which patients are kept warm during surgery.
- Reduce delays in discharging patients by improving systems for x-rays and medicines needed for patients to take home.

"We have always been proud of the quality of presentations and debate of our audits. Over the past year we have continually improved our documentation and made more robust links between discussions at audit committee and other governance committees"

Matt Revell, Clinical Director, Clinical Outcomes

Research

Participation in clinical research

The number of patients receiving NHS services provided by The Royal Orthopaedic Hospital NHS Foundation Trust in 20010/2011 that were recruited during that period to participate in research approved by a research ethics committee was 148.

Participation in clinical research demonstrates The Royal Orthopaedic Hospital NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The Royal Orthopaedic Hospital NHS Foundation Trust was involved in conducting 14 clinical research studies in orthopaedics during 2010/11. Over the same period, mortality amenable to healthcare/mortality rate from causes considered preventable in orthopaedics changed from the previous year by 20%. The improvement in patient health outcomes in The Royal Orthopaedic Hospital NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatments for patients.

There were 32 clinical staff participating in research approved by a research ethics committee at The Royal Orthopaedic Hospital NHS Foundation Trust during 2010/11. These staff participated in research covering 7 sub-specialties.

Also, in the last three years, 0 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

However there have been a range of other publications from clinical staff within the organisation as per appendix 1.

During the reporting period 2010/11, The Royal Orthopaedic Hospital NHS Foundation Trust has significantly invested in the R&D infrastructure to ensure the long term sustainability of orthopaedic related research activity.

The Royal Orthopaedic Hospital NHS Foundation Trust continues to expand its R&D portfolio and has attracted new business with industry partners both within the UK and overseas. Additional collaborations have also been developed with universities (academia) both within the UK and overseas.

Some examples of our current research studies:

BUPA Obesity Study
This study is being run in collaboration with partners from the University of Birmingham and looks at the links between obesity and osteoarthritis to determine whether inflammation contributes significantly to the disease process in obesity-associated osteoarthritis.

PRP study
The aim of this study is to improve results of rotator cuff surgery by helping to improve healing of the tendon after it has been repaired by giving a specially prepared injection of the patients own platelet rich plasma into the shoulder under ultrasound guidance

ITAP study
The purpose of this study is to investigate the benefits of a new reconstructive technique for patients who have had an above knee amputation of their leg. The use of this new technique is intended to improve the comfort, control and feel of the prosthesis.

One of the major activities of our Research and Teaching Centre is the gathering and analysis of outcome measures. This includes the largest hospital database of joint replacement outcomes in the United Kingdom. In addition, a spinal deformity service has been established with the Cadbury Assessment Unit for measuring the surface of the back (topography) of children suffering from scoliosis and other spinal deformities.

The Research and Teaching Centre hosts many conferences and symposia for external organisations. The International Erasmus MRI course for radiologists attracts around 120 delegates from throughout Europe. Online case studies derived from this course are available as an interactive computer teaching aid and contains over 1,000 radiological case histories.

National meetings during the year include:

- Elbow Study Day
- Naughton Dunn Orthopaedic Club
- 6th Birmingham Bone Tumour Study Day for Registrars
- The Birmingham FRCS Trauma and Orthopaedic revision Course

In addition the hospital hosted the 23rd Annual Meeting of the European Musculo-Skeletal Oncology Society (EMSOS) and 11th Symposium of the EMSOS Nurses and Allied Health Professionals Group. The conference was attended by 350 delegates from across Europe.

This meeting has been one of the biggest and best ever. It has set a new standard of education and involvement for EMSOS which ultimately will benefit patients with musculo-skeletal tumours all around Europe.
Stefan Bielack, President of EMSOS

Use of the CQUIN payment framework

CQUIN (Commissioning for Quality and Innovation) funding is made available to the Trust on the basis that agreed improvements are made in specific areas of quality improvement. 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 20010/2011 was conditional on achieving quality improvement and innovation goals agreed between The Royal Orthopaedic Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

The total amount of income conditional upon achieving quality improvement and innovation goals in 2010/11 was £783,032. The payment made to the Trust was £772,701, an achievement of 98.7% of the total potential value.

Further details of the agreed goals for 2010/2011 and for the following 12 month period are available on request from the Trust's Head of Commissioning, Gareth Hyland, Gareth.Hyland@nhs.net.com)

Statements from the Care Quality Commission

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

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

The Care Quality Commission has not taken any enforcement action against The Royal Orthopaedic NHS Foundation Trust during 2010/2011.

The Royal Orthopaedic Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the 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 will be taking the following actions to improve data quality.

- Annual Independent data quality audits focusing on different metrics each year
- A programme of internal ad hoc audits focussing on specific metrics e.g. 18 week targets
- Wider dissemination of quality metrics with clinicians to allow greater scrutiny and challenge
- Provision of training for operational staff to increase awareness of their role in data quality

NHS Number and General Medical Practice Code Validity

The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 20010/2011 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:
98.3% for admitted care
99.9% 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:
99.9% for admitted care
100% 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 Information Governance Assessment Report score overall score for 2010/2011 was 66 % and was graded 'not satisfactory'

However, the Royal Orthopaedic Hospital NHS Foundation Trust has met Monitor's required standard in 2010/11 to score 2 in all 22 key requirements in the Information Governance Toolkit.

Clinical Coding error rate
The Royal Orthopaedic Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

PART THREE

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

We set a range of priorities for 2010/11 that were agreed by the Board and stakeholders as important areas to focus on. The following tables show how we have performed against those priorities.

Table 2 – Quality improvement priorities for 2010/11 that were achieved

Achieved			
Improvement priority	**Performance**	**National definition**	**Data source**
Safety			
Reduction in inpatient falls	Target – 10% Achieved – 22%	Yes – NPSA However we use a local definition that includes all falls even if no harm was caused	Incident reporting system
VTE risk assessment	Target - >90% Achieved – 90.4%	Yes - national CQUIN	Unify
Reduce the number of prescribed medications not given	Target – 5% Achieved – 16%	Yes - NPSA	Incident reporting system
Effectiveness			
Reduce non-MRSA bacteraemias	Target - 50% from 09/10 baseline Achieved -	Yes - DH	IPCT and lab reports
Reduce pressure ulcers	Target - 10% Achieved – 24%	Yes – High Impact Actions	Incident reporting system and audit
To examine re-admission data identifying, implementing and monitoring actions as necessary	Target - Review of Dr Foster readmission data Achieved – Dr Foster data reviewed, further information required	Yes - DH	Dr Foster
Experience			

Reduce the number of patients reporting they share toilet facilities with the opposite sex	Target < 8% Achieved – 7.2%	National in patient survey	National in patient survey

Table 3 Quality improvement priorities for 2010/11 that were not achieved

Not achieved			
Improvement priority	**Performance**	**National definition**	**Data source**
Experience			
To increase the number of questions in the National Inpatient Survey where ROH scores in the top 20% of all Trusts	Target >75% Under achieved 74%	National Inpatient Survey	National Inpatient Survey
Reduce the numbers of patients rating the quality of food as poor	Target<12% Under achieved 17.8%	National Inpatient Survey	National Inpatient Survey

With regard to the national inpatient survey, although the Trust continues to do well when compared to other organisations both locally and nationally, our patients are scoring our performance less well when compared to last year. This will be a key area of focus for the Trust to ensure improvements are made over the coming year.

The new kitchen facilities will be in place in April, and will allow full implementation of new menus and training on the delivery and serving of food will be provided to all staff.

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

The focus for 2010/11 has been to embed our strategy alongside a culture of continual quality improvement. This has become increasingly important in the current financial climate and has made our commitment to providing a quality service even stronger

At Board level we have constantly challenged ourselves, and others, on the decisions that we make ensuring that we have come back every time to underpin our decisions with a view of what is right for the patient.

The Board receives feedback from patients in a number of different ways and is aware of where our services do not meet patient expectation. The focus of the Board is to continually champion improvements in these areas whilst ensuring that we continue to balance the books. We know that car parking, catering and administration are all areas where we need to improve.

The Board continues to welcome and recognise the contribution and benefits of Foundation Trust membership, its strong group of volunteers and wider public engagement.

All of these interests can sometimes compete, but the challenge remains 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

The Excellent Health programme combines the principles of lean thinking and eradicating waste from processes with process and workforce redesign to ensure that the Trust can save money whist improving the patient experience and quality of service.

We have a detailed plan of initiatives which have lead Executive Directors, lead managers and a savings target. Each initiative is scored for risk to ensure that it will not harm patient safety and all risks are managed. The programme has a programme board chaired by the Chief Executive and has medical representation.

> ***"As a Trust that prides itself on providing the best care, patient experience and safety has to remain at the front of mind always regardless of the financial environment we are working in. Excellent Health allows us to remain focussed on the quality of our service and reduce the cost of those services so it is vital to the continuing viability of the Royal Orthopaedic Hospital. It empowers staff at all levels and all disciplines to take control of the service they provide and remove the barriers to high quality whilst allowing the finance function to sleep at night because we are still making savings."***
>
> *Steve Bloomer - Director of Finance*

Building for the Future

"This has been an ambitious and exciting year in terms of our estate and building works with a number of large projects being completed.

The new outpatients department looks amazing and has provided a central focus for the whole hospital. The external work has also resulted in a very pleasant landscaped area for everyone to enjoy and this will continue to develop with the new dining area next year"

Colin Rea – Head of Estates

In our report last year we explained our plans to build a new outpatient department and why, as a Foundation Trust, we had been able to move forward on this scheme.

During the year, we have seen these plans become a reality with the building of our new outpatient department. This scheme was completed in March 2011 and handed over to the Trust ready for opening in April. This scheme has been built to BREEAM (BRE Environmental Assessment Method) 'excellent' standards demonstrating our commitment to the very best environmental standards and sustainable developments.

This will mean that patients will no longer have to walk significant distances between outpatients and the imaging department and will be seen in a purpose built, modern and more spacious environment than we were previously able to provide.

This scheme is a real example of how patients, the public and staff have come together to design a building that will take us forward.

"Whilst we have always been very proud of our outpatient department we have always known that we could provide an even better service for patients in a more modern building that was fit for purpose.

After all the planning and hard work over the past year or so myself and the team are really looking forward to moving into this exciting new building; it is a real achievement and will be an ideal environment for treating our patients"

Amritpal Randhawa – Sister, Outpatients

In addition to the outpatient building the new kitchen has been built this year, again with opening planned for April 2011. Following the fire in the kitchen and dining room our catering staff have been working in very difficult temporary facilities. The dining room scheme will then start early in the new financial year.

"The staff have been doing an amazing job since the fire – it has been a real team effort. We know that once we have our new facilities we will be able to continue to build on the improvements we have made during the year to the food we provide for staff and patients"

Tracey Mitchell – Head Chef

Through our partnership with the Teenage Cancer Trust (TCT) and with their generous financial support we have opened the new facility on the Children's ward for our teenage patients. This is a separate purpose built area that provides a relaxation area with refreshment facilities and a wide range of gadgetry to entertain them!

"The TCT facilities make a real difference to my stay in hospital. They are a good distraction when you are stressed and allow you to socialise more with other patients. It's amazing!"

Daniel Anderson – Patient Ward 11

Our lift replacement programme has been completed during the year in the treatment centre. Broken lifts had been an area of concern for some time and we have now replaced both.

Putting Patients First

The Board continues to be committed to putting patients first. We continued to listen to what patients and the public told us rather than making assumptions about what we thought they'd say.

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 Members Council has a well-established Patient Experience Committee that works closely with the Patient Forum to ensure that we take the patient perspective into account.

This group has been instrumental in providing a patient perspective to the outpatient building scheme, acting as mystery shoppers to provide feedback on particular issues e.g. privacy and dignity, and sharing with the trust feedback that they receive informally from patients and the public.

"The Patient Experience Committee has enabled staff and public members to work together with the management team to highlight and resolve concerns that are brought to our attention. It also enables the Trust to gather positive feedback on the areas where it is doing well"

Stella Noon –Chair, Patient Experience Committee

Unfortunately we did not achieve our aim to reduce our complaints this year and this will be a key area for improvement during 2011/12. Of the six cases referred to the Healthcare Ombudsman, one remains open, four were closed without investigation and one identified a number of recommendations all of which have been acted upon and resolved.

We collect feedback from patients in a number of different ways including a 'real time' survey, local departmental surveys, patient stories and by observing the care that patients receive. These initiatives have resulted in a number of changes including more frequent housekeeping service in the Pre-Operative Assessment Centre, a greater awareness of noise at night with actions to reduce this, the implementation of posters explaining staff uniforms, the introduction of pegs for keeping bedside curtains closed and changes to the patient menu.

High Impact Actions

In the summer of 2010 the Chief Nursing Officer for England launched the High Impact Actions for Nursing and Midwifery. This identified a number of key areas where nurses and midwives could make a real difference to patient care demonstrating improvements in quality alongside greater efficiency.
These have been considered alongside existing priorities for the Trust and have resulted in a number of real improvements.

Reducing inpatient falls

This had already been identified by the Trust as an improvement priority for the year and formed part of the quality schemes included in the contract with commissioners (CQUINs).

In addition to the aim of reducing the numbers of inpatients who fall the intention was to also improve risk assessments, care planning and the subsequent care of any patient who did fall.

Achievements:

- Reduction of inpatient falls by 22%
- Purchasing of 2 high / low beds to care for patients at high risk of falling
- Falls awareness training including on clinical skills training

Pressure ulcer prevention

The prevention of hospital acquired pressure ulcers and providing the best care for patients with pressure ulcers was another improvement priority identified during the year.

This priority was supported by the appointment of a tissue viability nurse to lead this work.

Achievements:

- Reduction of pressure ulcers from 84 to 64 (target 75)
- Increased levels of risk assessment from 73% to 92% (target 85%)

- Increase numbers of patients with appropriate care plans from 36% to 86% (target 85%)
- 100% pressure ulcers reported
- 115 staff have attended training in pressure ulcer assessment and management
- New documentation implemented including skin inspection charts, re-positioning charts, pocket guides for skin assessment and flow charts to follow to identify appropriate mattresses

Nutrition

Improving the nutrition of our patients was also important to us not least because of the links between good nutrition, effective wound healing and the prevention of infection. The nursing leads in these areas work very closely together to drive changes.

Achievements

- Increased level of risk assessment for malnutrition
- Reduction in starvation times before surgery
- Increased use of supplements
- Increased support from a dietician including the introduction of new menus

Although some improvements have been made throughout the year this is an area that we will continue to focus on next year.

Healthcare acquired infections

We know how important not getting an infection is for patients and we have continued to build on our successful infection prevention and control programme.

We have introduced new antibiotic guidelines to reduce the risk of patients getting *clostridium difficile* (c. diff) and for the first time we have not had any cases for a whole quarter. Disappointingly, we did not hit our local target for c. diff; we had 8 cases against a target of 7. The evidence suggests that whilst we believe some were unavoidable some were due, earlier in the year, to antibiotic prescribing. This is a really difficult issue for the clinicians as it is also important that we prevent patients from getting wound infections not just c. diff. We believe that the new guidelines will result in a reduction in both wound and c. diff. infections.

During the year we have introduced a new review service for any patients who have concerns over their wounds and are worried that they may have an infection. This has not only allowed us to provide a better service for patients but also track more accurately our rates of wound infection to identify further steps that we can take to reduce these.

"We have had a really good response to our helpline for patients. They are now able to ring us directly for advice, and if necessary we can either send out ROCS (our community team) to see them or see them in clinic.

This service allows us to pick up problems quickly to ensure the patient gets the right treatment"

Sarah Mimmack – Lead Nurse, Infection Prevention and Control

We have continued to lead the way in reducing catheter associated urinary tract infections. We have won awards for this work and are leading this programme across the West Midlands.

Ensuring the privacy and dignity of our patients
This has continued as an important area of work within the hospital and we are pleased to report that we were able to declare compliance with the national requirement to eliminate mixed sex accommodation during the year.

In addition to the national requirements we have undertaken an extensive programme of education in this area, utilised mystery shoppers to help give us feedback in this area and provided all staff with name badges. We have privacy and dignity champions in all areas and have implemented a programme of customer care training for our administrative and clerical staff to support this work.

> ***"As privacy and dignity champion my role is to ensure that we always look at things through the eyes of the patient and consider how we would feel in their shoes. Coming into hospital is a very anxious time for people and when staff are kind, caring and treat people as individuals this can really help to reduce their fears. We are often the first contact the patients have with the hospital so it is important we get it right"***
>
> *Helen Genders –Privacy and Dignity Champion (administrative and clerical staff)*

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

The Chaplaincy aims to be welcoming and inclusive, respecting people of all faiths or none and responding to individuals at their point of need. An important part of their role is to enable people to practice their particular faith whilst in hospital. The Chaplaincy Team regularly visit wards and can be called to visit individuals at any time.

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

Religious calendar events are held throughout the year and are displayed on the noticeboard outside the Prayer, Contemplation and Meditation Room and on the Trust intranet. In the past 12 months these have included Maundy Thursday service, Christmas Carol service to the wards and events related to the Sikh religious

calendar. Leaflets about the chaplaincy service are available via the Trusts internet site under patient information.

Our workforce

During the year we have continued to encourage staff in their work to improve quality. A programme of diversity training was put in place for all nursing staff which created opportunities for staff to reflect on how they deliver quality care to our diverse patients. We have also undertaken work with the administrative staff responsible for patient booking and correspondence, to enable them to improve their ways of working and to celebrate the vital role they play in ensuring our patients and carers receive great service.

We continue to welcome undergraduate, post-graduate and work experience students on placement, many of whom return as volunteers or as employees. As part of Apprenticeship Week, the Trust hosted a back to the floor opportunity for senior managers from Apprenticeship UK. Our visitors were able to meet three of the dozen apprentices who worked in the Trust in 2010/11.

"All three apprentices were keen to talk about the real jobs they are able to do whilst still learning at college and gaining a qualification. They are making a valued contribution to the quality of service delivered to the patients."

Sara Holyhead, Employer Services Director at the National Apprenticeship

The internationally renowned outcomes and audit activity within the Research and Teaching Centre has enabled us to attract three academic trainees for the foreseeable future. The Programme Director and Director of the research and teaching Centre are responsible for the supervision of these junior trainees. These posts are externally funded and in addition to the academic input provide additional clinical support to the hospital.

All staff have the opportunity to be appraised annually and in 2011/12 we will re-launch a revitalised approach to enable a discussion on both performance, personal development and how each member of staff lives the Trust's values in their day to day work. This is supplement by a whole trust review of training needs the results of which will be used to inform our learning and development programme.

As part of preparing for the revalidation of medical staff, the Trust has assessed progress against the General Medical Council's standards. Whilst there is considerable work to be done over the coming year, this important work will be led by the Clinical Director for Medical Workforce and Regulation, Mr Andre Jackowski.

Public engagement

During the year the trust has continued to develop its relationship with the public and its patients through increased use of feedback surveys. Almost 700 members responded to a survey asking their views on the quality, efficiency and effectiveness of the trust's activities and their suggestions were built into the mid-year review of plans and will roll forward to next year's annual plan. Reducing delays in outpatients and x-ray, reducing unnecessary paperwork, food and car parking are all areas that are being addressed.

Patient involvement in the design of the outpatient building coupled with the development of a greeters and escorts volunteering group, will mean the building and its services are more closely tailored to the needs of users.

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 continue to find that our achievements are better than most.

National target	08/9	09/10	10/11	Target
Fully meet all core standards	Achieved	Achieved	n/a	
MRSA	Achieved 2 cases	Achieved – 0 cases	Achieved – 0 cases	
C diff	Achieved 7 cases	National target - achieved Local target – not achieved 9 cases	National target – achieved Local target – not achieved 8 cases	Local target of 7 since 09/10
31day subsequent treatment all cancers	NA	Achieved – 100%	Achieved – 100%	94% standard
31 diagnosis to treatment all cancers	Achieved-100%	Achieved – 100%	Achieved – 99.3%	96% standard
62 day referral to treatment of all cancers	Achieved-92%	Not applicable due to low number of patients	Achieved-98.3%	85% standard
2 week cancer wait	Achieved-100%	Achieved – 99%	Achieved – 99.5%	93% standard
18 week referral to treatment admitted	Achieved-88%	Achieved – 91.6%	Achieved – 90.5%	Target since 09/10 is >90%
18week referral to treatment non admitted	Achieved-87%	Achieved – 95.2%	Achieved – 95.2%	Target since 09/10 is 95%
Screening all emergency / elective admissions for MRSA	NA	Achieved-102.9%	Achieved – 105%	100% target
Access to healthcare for people with learning disabilities	NA	Achieved	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 Board have agreed to move away from the Dr Foster system for collecting patient outcome data to a system developed by the University Hospital Birmingham NHS Foundation Trust. This system allows greater analysis and interpretation of data and will be used during the coming year as a further measure of quality.

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.

The Trust introduced and piloted a consultation toolkit that allows 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 has allowed us to involve our members in identifying what we do well and what areas we need to work on during the forthcoming year. This in turn has informed the service delivery plans for 2011/12.

"In conclusion- in a period of significant change our focus upon quality has intensified and we are very conscious of the importance of patient safety and experience at our hospital. Over the past year we have pushed the boundaries out to stretch ourselves to deliver a standard of care that is beyond our already high standards. For us this is about creating and embedding an ethos that everyone within the organisation instinctively puts into practice day in day out. Of course we don't always get it right but our culture is such that we are open about our shortcomings and we learn from them.

"My Board and team are committed to a process of continuous improvement as far as quality is concerned and this is reflected in the discussions we have and the initiatives we instigate and support. We are eager to be the best and in doing so strengthen our reputation as a specialist orthopaedic centre. In a world where patients are having greater influence over their healthcare provision we want to be the first choice for patients based upon our reputation for excellent care and superior outcomes.

"We are lucky that we have such a loyal group of staff and proud members to support us in this challenge and it is through them that we shall further our ambition. It is difficult to convey all the passion and commitment we have for quality in this report but I do hope it provides an insight into 'how we do things around here' and the importance we place upon quality in achieving our goals"

Laurence James - Chairman

Annex: Statements from Local Involvement Networks, Overview and Scrutiny Committees and primary care trusts

Statement of Birmingham LINk

Whilst the LINks have not had a direct group attached to ROH – the ROH has a good Members' Council which continually involves the patients and the public, some of which are members of Links, in the services provided. This is demonstrated with this Account.

During the course of the year the ROH has continued with its extensive rebuilding/alteration programme and they are to be congratulated in maintaining and over achieving most of their targets during these alterations. The target under achieved in relation to quality of food, hopefully will be over achieved in the next account, once the new kitchens and menus are fully implemented.

The ROH delivers a much wider service to the UK than just the local population and tends to prioritise on the greatest needs of the patient.

These accounts reflect well on the knowledge which we have about the Hospital and its services. They are well presented and make easy and understandable reading for their patients and the public.

Overview and Scrutiny Committee

The Birmingham Overview and Scrutiny Committee has received the Quality Report/Account and has decided not to make comment in 2010/11. This is due to the workload associated with commenting on all of its relevant healthcare organisations and the necessary timescales.

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

This statement from NHS South Birmingham as the lead commissioner for The Royal Orthopaedic Foundation Trust has been developed in consultation with key leads within NHS South Birmingham. The Quality Account for 2010/11, has been reviewed in line with the Department of Health guidance and we can confirm that to the best of our knowledge that this quality account is a true and an accurate reflection of the 2010/11 made against the identified quality standards.

The Quality Account offers an overview of some of the areas where the organisation is doing well; where improvements in service quality are required and actions to address them and priorities for improvement for the coming year. It is evident that 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. NHS South Birmingham however recommends that in future Quality Accounts, The Royal Orthopaedic FT need to consider how they link reducing health inequalities and quality for all.

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

CQUINs for 2010/11. We acknowledge that it must have been frustrating for the Trust to just miss the target for the patient experience in the National Patient Survey however it is important to recognise that they are still performing above national average.

NHS South Birmingham have an on-going quality assurance monitoring process with the Trust which includes monthly contract meetings, quality reviews and quarterly performance meetings. To enhance this process we have undertaken unannounced visits and in the next contractual year we intend to undertake reviews in particular around pathways of care. These monitoring mechanisms provide the PCT with a good understanding of the issues facing the Trust, its internal systems and processes that are in place to provide assurance.

NHS South Birmingham has developed effective partnership and collaborative working with The Royal Orthopaedic Foundation Trust .This is a healthy relationship which seeks to ensure the delivery of the quality agenda and development of quality assurance mechanisms.

In summary, NHS South Birmingham would like to acknowledge the progress made in the drive to deliver high quality care for all those using their services. The Quality Account provides a balanced view of the Trust's achievements throughout 2010/11 and has set clear priorities for quality improvement in 2011/12.

How to provide feedback on the account

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

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

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

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Appendix 1: Statement of directors' responsibilities in respect of the 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) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

 the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
 the content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period April 2010 to June 2011
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 20/5/2011
- Feedback from governors dated 25/5/2011
- Feedback from LINks dated 20/05/2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25/5/2011;
- The [latest] national patient survey 27/4/11
- The [latest] national staff survey 27/4/11
- The Head of Internal Audit's annual opinion over the trust's control environment dated 31/05/2011
- CQC quality and risk profiles dated Dec 2010, Feb 2011, March 2011

 the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
 the performance information reported in the Quality Report is reliable and accurate;
 there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
 the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Director of Finance

.....Date.....Chief Executive

5. Sustainability/Climate Change report 20010/11

The Royal Orthopaedic Hospital NHS Foundation Trust carries out Sustainability reporting to meet the Government's target of reducing its carbon footprint by 10% by the year 2015.

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

We have also invested in saving greenhouse gas emissions with directly identified gas consuming plant. We have commenced with the replacement of certain boilers within the Hospital. With indirect electrical usage, we have begun a programme of replacing our controls and luminaires and, where appropriate, applying meters and energy saving devices to electrical usage.

The Trust endeavours to reduce waste wherever possible and has met its water consumption target. The Trust continued to develop its travel strategy in reducing the carbon footprint in business travel and where contracts with non-emergency ambulance services are held.

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

The Good Corporate Citizen Group reports quarterly to the Executive Management Team and they in turn annually to the Trust Board.

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

The target for 2010/11 was 1306 tonnes. The ROH failed to achieve this target having used 1368 tonnes. This total included the new outpatients department which has been commissioned, and therefore using its boilers, since August 2010 although the building itself was not handed over to the Trust until March 2011. The Trust anticipated allocation of an allowance in carbon terms for this new building when it set the target for carbon reduction in April 2010. The Government however declined to make such an allowance. If gas consumed for the new outpatients department is taken from the base figure, consumption is reduced to 1340 tonnes compared with our target of 1306 tonnes.

The target for 2015 is to reach 1278 tonnes and the ROH must revise its strategy for meeting this target to incorporate the new outpatients department. The Trust still expects to be at least 2% more efficient than it was with previously existing estate due to the specification for the new building which included solar panels and sophisticated controls for mechanical and engineering, all designed to save energy.

Area:	Greenhouse Gas Emissions			
Type:	**Direct Gas Boilers**			
2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**
Tonnes				
1,420	1,546	1,406	1,366	1,368
Financial (£)				
165,000	172,000	243,000	181,000	192,000

Greenhouse Gas Emissions – indirect Electricity

The target for 2010/11 was 1519 tonnes which the ROH failed to achieve as it used 1570 tonnes. The total for 2010/11 also included the outpatients department as the electricity had also been used for commissioning this building since August 2010 additional electricity was consumed. Adjusted, the data, gave a revised target of 1493 tonnes compared with the original target of 1510 tonnes.

The target for 2015 is 1385 tonnes which will be achieved through investment the ROH has already commissioned in respect of:

- Replacing controls and luminaires with energy efficient units in the therapy department, children's ward, corridors and treatment centre and this we will continue.
- Installing voltage controlled devices and metres to our plant rooms wherever appropriate to save voltage usage.
- Installing inverters to our electric motors to also save on energy usage.

The ROH will continue to invest in energy efficient devices for the remaining years up to 2015.

Area:	Greenhouse Gas Emissions			
Type:	**Indirect Electricity**			
2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**
Tonnes				
1,539	1,629	1,714	1,585	1,570
Financial (£)				
266,000	256,000	422,000	358,000	314,000

Official Business Travel Emissions

The ROH has not to date retained any non-financial information in respect of business travel emissions but we will start this process from April 2011. In financial terms, we only have figures

for two years but we will endeavour to reduce staff business travel wherever possible. They are (next page):

Area:	Travel			
Type:	Staff Business Travel			
2006/7	2007/8	2008/9	2009/10	2010/11
Financial (£)				
-	-	-	55,000	65,617

Staff Travel to Work

The ROH only has data for one year for this which will be built upon in subsequent years, and we have consumed 1180 tonnes of carbon.

Non-emergency Ambulance Service

The ROH has negotiated its patient transport contracts with planned reductions in carbon as follows:

Area:	Travel			
Type:	Non-Emergency Ambulance			
2006/7	2007/8	2008/9	2009/10	2010/11
Tonnes				
-	-	92.8	64.8	76.1
Financial (£)				
-	-	587,000	607,300	630,680

Waste

The Trust continues to endeavour to reduce its waste and, wherever possible, recycle waste itself. The Trust does recycle aluminium cans, cardboard, printer cartridges and batteries and will begin collection of data on this from 1 April 2011.

The target for 2010/11 was 140 tonnes. The ROH exceeded this by 8 tonnes but remains confident that it can reduce this further when it segregates and compiles the data for aluminium cans, cardboard, printer cartridges and batteries. The target for 2015 is 125 tonnes.

Area:	Waste				
	2006/7	2007/8	2008/9	2009/10	2010/11
Tonnes					
Total Waste	-	-	139	152	148
Waste Sent to	-	-	139	152	148

Landfill					
Waste recycled	-	-	0	0	0
Waste incinerated (food)	-	-	0	0	0

Area:	**Waste**				
	2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**
Financial (£)					
Total Waste	-	-	12,764	15,830	18,381
Waste Sent to Landfill	-	-	12,764	15,830	18,381
Waste recycled	-	-	0	0	0
Waste incinerated (food)	-	-	0	0	0

Finite Resources – water consumption

The Trust has already taken action in reducing its water consumption through maintenance and refurbishment programmes by introducing energy efficient devices. The target for 2015 is 26,392 cubic metres of water used and consumed within the Hospital. The Trust has already achieved this target. In 2010/11, 22967 cubic metres of water were consumed but the ROH set a stretch target of 22600 cubic metres of water which we failed to reach, but was nonetheless well within its 2015 target.

Area:	**Finite Resources**			
Type:	**Water Consumption**			
2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**
Tonnes				
29,374	24,737	26,950	23,039	22,967
Financial (£)				
43,484	41,310	46,861	44,348	45,210

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.

Staff have continued to be engaged in the development of the trust's plans throughout 2010/11. Clinical Director meetings have evolved to include robust discussions on service development, re-design and performance. All staff have been involved in face-to-face meetings with the CEO and together with the Director of Workforce and Organisational development , confidential listening events have taken place with groups of staff throughout the year. This has enabled the Trust to take on board ideas and reflect back changes as a result. In addition staff have been able to contribute to changes that affect their work through improvement work embracing lean methodologies. Each of our wards is 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 54% which is average for acute specialist trusts in England. Overall, the individual findings have not changed significantly, however improvements have been seen in diversity training, career progression and reduced discrimination at work.

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

Key Factor	This Year's Score	National Average	Improvement Since
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	1%	3%	Comparisons not possible due to format change
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	98%	96%	No significant change
Quality of job design	3.52	3.48	No significant change
Percentage of staff suffering work-related stress in the last 12 months	21%	26%	No significant change

Our bottom four ranking scores were:

Key Factor	This Year's Score	National Average	Deterioration Since
Staff intention to leave jobs	**2.61**	**2.46**	**-09%**
Percentage of staff receiving relevant training, learning or development in the last 12 months	**74%**	**79%**	No significant change
Staff motivation at work	**3.76**	**3.85**	**-09%**
Percentage of staff witnessing potentially harmful error, near misses or incidents in the last 12 months	**36%**	**33%**	No significant change

In light of these results, the priorities for action in 2011/12 will be to engage with staff about process improvement in their work to reduce work pressure and to highlight the learning opportunities available to staff.

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 led by the Director of Workforce and OD and this agenda is monitored by the Workforce and OD Committee. The Trust has a Single Equality Scheme and a range of policies which support this to ensure all staff are treated fairly and equitably regardless of gender, colour, ethnic status, sexual orientation or religion.

There is a multi-faith room available to staff and patients and the Trust is supported by representatives of several faiths and by local chaplains.

During the year an external training provider was commissioned by the Trust to deliver diversity awareness training for nurses. Many reported the positive impact of this training on their attitudes, beliefs and approaches to colleagues, patients and carers. The Trust is extending the number of trained contact officers available for staff to discuss any concerns.
The Trust has not yet published its equality objectives for the next four years.

Workforce Statistics

	Staff 2009/10	%	Staff 2010/11	%	Membership 2009/10	%	Membership 2010/11	%
Age								
0-16	1	0.12	0	0.00	1	0.12	0	0.00
17-21	19	2.30	18	2.02	19	2.30	18	2.02
22+	806	97.57	872	97.98	806	97.57	872	97.98
Ethnicity								
White	641	77.60	684	76.85	641	77.60	684	76.85
Mixed	24	2.90	27	3.03	24	2.90	27	3.03
Asian or Asian British	108	13.07	109	12.25	108	13.07	109	12.25
Black or Black British	30	3.63	33	3.71	30	3.63	33	3.71
Other	23	2.78	37	4.16	23	2.78	37	4.16
Gender								
Not Stated	0	0.00	0	0.00	0	0.00	0	0.00
Male	247	29.90	261	29.33	247	29.90	261	29.33
Female	579	70.90	629	70.67	579	70.90	629	70.67
Recorded Disability								
Not Declared	98	11.86	89	10.00	98	11.86	89	10.00
Undefined	0	0.00	1	0.11	0	0.00	1	0.11
Yes	727	88.01	799	89.78	727	88.01	799	89.78
	1	0.12	1	0.11	1	0.12	1	0.11

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

- Develop the network of contact officers
- Embed equality impact assessment of services across the organisation to ensure all services have been assessed.
- 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, which, following a re-tendering exercise, is Heart of England NHS Foundation Trust.

7. The Board of Directors' Report on Activity and Obligations 2010/11

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. The Trust operates no branches outside the UK.

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

The Board of Directors' activity 2010/11

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. Following a robust recruitment process supported by external headhunters, the trust appointed an additional NED (Mrs. Frances Kirkham) and a replacement for Professor Andrew Stevens (Professor Taunton Southwood). Both took up office as independent NEDs in February 2011.

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, at the end of March 2011 there were six Executive Directors and six Non-Executive Directors. The Directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business, with The Royal Orthopaedic Hospital NHS Foundation Trust.

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

Following consultation in February 2006, Monitor issued a final version of the NHS Foundation Trust Code of Governance in October 2006 for implementation. The Code applies with effect from 1st April 2006. The Code is issued as best practice advice and is not mandatory; however, the Code imposes disclosure requirements on NHS Foundation Trusts. The Board of Directors considers that throughout the year 20010/11 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 had a Senior Independent Director (SID), Professor Andrew Stevens until his retirement from office at the end of January 2011. The role remained vacant until the end of the financial year pending the appointment by the Members' Council of a Vice Chairman (the same NED having hitherto held both roles). The SID has held no meetings with Non-Executive Directors without the Chairman during the period covered by this report. Non-Executive Directors have met with the Chairman prior to all but one board meeting 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.

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

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

A register of Director's Interests is available for inspection from the trust's Company Secretary, ROH NHSFT, Bristol Road South, B31 2AP.

Directors holding office during 2010/11 The following Directors held office throughout the period of this report unless otherwise indicated:
Mr Laurence James - Chair (1st term of office expires 31/10/11)
Professor Andrew Stevens - Senior Independent Director and Deputy Chair (3rd term of office expired 31/01/11)
Professor Taunton Southwood – Non-Executive Director (Appointed February 1st 2011, 1st term of office expires 31/01/2014)
Dr Elizabeth Hensel - Non-Executive Director (2nd term of office expires 31/12/12)
Mr Robert Millinship - Non-Executive Director (term of office expires 4/10/11)
Mr Chris Monk - Non-Executive Director (2nd term of office expires 31/12/12)
Mr Roger Otto - Non-Executive Director (2nd term of office expires 31/12/12)
Mrs Frances Kirkham – Non-Executive Director (Appointed February 11th 2011, 1st term of office expires 10/02/2014)
Ms Penny Venables - Chief Executive Officer
Mr Graham Bragg - Deputy Chief Executive and Director of Finance (part year) then Director of Strategy and Business Development
Mr Stephen Bloomer – Director of Finance (1st May 2010)
Mrs Valerie Doyle - Director of Operations
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 continued to revise its Assurance Framework and Corporate Risk Register and Board members take an active role in the assessment of evidence of compliance with standards.

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

Mr S Bloomer as Finance Director attends

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 until 31st January 2011); then
Professor Taunton Southwood (Chair from 1st February 2011)
Mr L James
Dr E Hensel
Mrs F Kirkham (from 11th February 2011)
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:
(Chair) Professor A Stevens (until 31st January 2011)
Mr L James (Chair from February to March)
Mr R Otto
(Any NED may attend this committee as a full member)
Professional advice is provided from time to time by the Trust's Director of Workforce and Organisation Development, Mrs Anne Gynane.

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 were 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.
- 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** **3 meetings**	**Charitable Funds Committee** **3 meetings**	**Investment committee** (from October 2009) **5 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 recommendations 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 was also Chairman of Stroud and Swindon Building Society for part of this year	**Chairman**12/12	8/9	**Chairman** 3/3	**Chairman** 3/3	4/5

Professor Andrew Stevens Deputy Chairman and Senior Independent Director (to January 31st 2011)	**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) 6/10 Undertaking chair appraisal and feedback to Members' Council	**Chairman** 6/8 Chairman Focus on clinical guidance and outcomes	1/2 Acts as interface with Members' Council	2/3

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	11/12 Leading on capital development and estates	5/6 Particular focus on best practice HR & OD	2/3	**Chairman** 5/5

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 Tilly. He has also served as a non-executive director on a PCT	11/12 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.	2/3	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	6/6 Acts as link person with integrated governance	(Deputy Chairman) 6/9 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	10/12 Leading on 18 weeks project delivery	5/6 Key focus on performance criteria	1/3	5/5

Professor Taunton Southwood (from 1st February 2011)	**Trust Board**	**Integrated Governance Committee**	**Charitable Funds Committee**	**Remuneration Committee**
Professor Southwood is a consultant paediatric rheumatologist at Birmingham Children's Hospital.	1/2	Chair from 1 February 2011 2/2 Key focus on clinical outcomes		

Mrs Frances Kirkham (from 11th February 2011)	**Trust Board**	**Integrated Governance committee**	**Charitable Funds Committee**	**Investment committee**
Mrs Kirkham is a retired judge.	2/2 Leading on legal issues and complaints/PALs	2/2 Key focus on reputational awareness of performance		

Executive Director attendance at Board and Committee meetings.

	Trust Board	Audit Committee	Integrated Governance Committee	Investment Committee	Remuneration Committee	Charitable Funds Committee
	12 meetings	6 meetings	9 meetings	5 meetings	3 meetings	4 meetings
Penny Venables	12		8	4		4
Graham Bragg	12			5		4
Steve Bloomer	11	6		3		3
Andrew Thomas	11		7			3
Lindsey Webb	12		9			4
Valerie Doyle	9		4			3

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.

Trust Contractual Arrangements

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

Audit arrangements

The Trust's external auditor is

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

The external auditors' remuneration for 2010/11 was £41,000.

The directors confirm that, so far as they are aware, having taken all steps to review information available to them, there is no relevant audit information of which the auditors are unaware and

that each director has taken all reasonable steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Valuation of fixed assets

During 2009/10 the Trust completed a new outpatients department and upon completion it was valued in line with International Financial Reporting Standards which created a write off of £1.8m this is recognised as an exceptional loss on the revaluation in the Statement of Comprehensive Income with a total write down of assets of £2m.

Political and Charitable Donations

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

Post Balance Sheet Events

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

Consultation with staff

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

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

Health and Safety at Work
The Trust takes its responsibilities for the health and safety of its staff and patients very seriously. During 2010/11, responsibility for this area of worked was assumed by the Director of Operations. Throughout the year work has taken place to raise awareness of security issues and improve lockdown procedures. Robust procedures for staff in dealing with violent and aggressive individuals and lone working have been maintained 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 one visit from the HSE during this period which was in line with the European Directive (sharps, staff injuries). Following this visit an action plan was devised and delivered.

Risk Assessment Training
There were four Health and Safety/Risk Assessment training course run by the Trust's Health and Safety Advisor and a further four are scheduled in 2011/12. All clinical areas now have ward mangers/Head of Department or a nominated member of staff trained in carrying out risk assessments.

Audits of wards' risk assessment status continued to be monitored over 2011/12 Audits will be carried out at least twice yearly and reported to the H&S committee

Policies

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

- NSI/Sharps Policy
- COSHH Policy
- Health & Safety Policy
- Risk Assessment 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 new local exhaust ventilation (LEV) equipment following the recommendations of the report. The department is now up and running with new LEV system in place

COSHH (control of substances hazard to health)

Following the HSE visit in October 2009, the ROH continues to roll out a review of all its COSHH assessments and updates these as necessary. The Trust may seek a new service/provider to further develop the assessments process.

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 the departments Health & Safety Rep. Three more staff within the theatre department have also been trained in delivering the mandatory manual handling sessions. This has proved very popular as the training is set in theatres around theatre movements.

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 a fire. The Trust has decided to upgrade the fire evacuation equipment and is in the process of purchasing new fire e-vac chairs, which are much easier to use than present chairs, also the Trust is complementing the e-vac chairs with fire e-vac ski pads which will give the Trust more options/flexibility when evacuating in an emergency.

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 servery 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/departments. The status of all CAS alerts are reported at Quality Committee meetings and escalated to the Board. A new process is in place for CAS alerts which places responsibility on managers to respond to all CAS alerts in timely manner

West Midlands Health & Safety Advisors Association (WMHSAA)
The Trust's Health &Safety Advisor has continued to attend this meeting, representing the hospital. This facilitates the discussion of health and safety issues with similar organisations 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. The ROH takes part in local resilience forums for the economy and the Chief Executive takes part in the regional ERMA rotas to fulfil responsibilities of partnership working under the Civil Contingencies Act.

Environment

The Trust recognises its responsibilities with respect to the environment and focuses on reducing its environmental impact by using less, recycling more and disposing of waste sensitively and remains committed to reducing its carbon footprint. The Trust is installing new, efficiently fuelled boilers in the nurses' home and administration building and is pursuing sustainability by joining the NHS Forests 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 paid 99% 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.

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 2010/11 the Trust has focused on the development of clinical systems and the strengthening of the IT infrastructure as well as introducing NHSmail to improve efficiency and security of information.

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

The Trust has commissioned a refresh of its IT strategy to ensure that it facilitates the delivery of the Trust's strategic direction.

The Trust achieved level 2 in all of the 22 key requirements of the Information Governance Toolkit for 2010/11.

Serious untoward incidents relating to data loss and breaches of confidentiality

During 2010/11 the Trust had one serious untoward incident relating to Information Governance. This incident related to the loss of a ward handover sheet listing several patients which was found in the dining room by a member of staff. An investigation took place, new procedures put in place and staff reminded of their responsibilities to dispose of records carefully in line with Trust policy.

Policies and procedures relating to counter-fraud

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

Remuneration and Pensions Disclosures

Salary and Pension Entitlements of Senior Managers

A) Salaries*						
Name and Title	**2010-11 (12 months to 31st March 2011)**			**2009-10 (12 months to 31st March 2010)**		
	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 James – Chairman (from 1st November 2008)	40-45	**0**	0	35-40	**0**	0
Mrs. P Venables – Chief Executive	120-125	**0**	0	120-125	**0**	0
Mr. G Bragg-Director of Strategic and Business Development	100-105	**0**	0	100-105	**0**	0
Mr. A Thomas-Medical Director	20-25	**110-115**	0	20-25	**110-115**	0
Mrs. L Webb – Director of Nursing & Governance	80-85	**0**	0	80-85	**0**	0
Mrs. V Doyle – Director of Operations	85-90	**0**	0	95-100	**0**	0
Mr. S Bloomer – Director of Finance and IM&T (from 1st May 2010)	85-90	**0**	0	75-80	**0**	0
Professor A Stevens-Non Executive Director	5-10	**0**	0	10-15	**0**	0
Dr. E. Hensel-Non Executive Director	10-15	**0**	0	10-15	**0**	0
Mr. R. Otto–Non Executive Director	10-15	**0**	0	10-15	**0**	0
Mr. R. Millinship -Non Executive Director	10-15	**0**	0	10-15	**0**	0
Mr. C. Monk -Non Executive Director	10-15	**0**	0	10-15	**0**	0

Mrs. F. Kirkham – Non Executive Director (from 1st February 2011)	0-5	**0**	0	0	**0**	0
Mr. T. Southwood – Non Executive Director (from 1st February 2011)	0-5	**0**	0	0	**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. 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.Mr S Bloomer served as a non-executive in an unremunerated capacity for part-year on the Board of Heanton Housing Group.Mrs P Venables served as a trustee of Walsall Art Gallery in an unremunerated capacity for part of the year.

No compensation for loss of office has been paid or is payable in respect of this financial period neither to any voting Director nor senior manager listed above.

Salary and Pension Entitlements of Senior Managers

B) Pension Benefits*

Name and title	Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2011 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase/ (decrease) in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mrs. P Venables - Chief Executive	2.5 – 5	165 - 170	705	771	(66)	0
Mr. G Bragg – Director of Business and Strategic Development	12.5 – 15	170 - 175	969	954	15	0
Mr. A Thomas – Medical Director	12.5 - 15	205 - 210	1,090	1,096	(5)	0
Mrs. V Doyle – Director of Operations (1st July 2009)	12.5 – 15	120 - 125	612	541	71	0
Mrs. L Webb - Director Of Nursing and Governance	2.5 – 5	80 - 85	277	306	(29)	0
Mr. S Bloomer - Director Of Finance and IM&T	15 – 17.5	75 - 80	235	223	12	0

*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 2007-08 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.The Real Increases in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee and uses common market valuation factors for the start and end of the period.

Signed: Date:

Chief Executive

Details of senior employees' remuneration can be found in the Remuneration Report on pages 79 and accounting policies for pensions can be found on pages 110.

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

The work of the Members' Council 2010/11

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. The Council has 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.

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.

The Members' Council appointed Mr Neil Hart as their Lead Governor. He has had no cause to exercise this role during the year in regard to dialogue with Monitor. He may be contacted through the Trust's Company Secretary, ROH NHSFT, Bristol Road South, B31 2AP.

Doing its job – as a whole Council

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

Members' Council involvement in strategy

The Council approves the Annual Plan prior to submission each year at one of its public meetings. This is underpinned by a mixture of workshops and formal meetings. Council members attend two Board meetings each year and these focus on performance and future direction.
In this way the Council can be seen to be actively engaged in the work of the Trust, directly able to assess the work of the Board and observe the work of the Chairman in a context other than as Chairman of the Members' Council.

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

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

The Nominations and Remuneration Committee is supported by the Director of Workforce and Organisation Development and Company Secretary and reviews NED remuneration based on available benchmark data and also considers the appointment of additional NEDs on behalf of the full council prior to making recommendations for appointment. The Committee has appointed two NEDs during the year using the services of an external headhunter appointed following competitive tender. The company appointed had no other connection with the Royal Orthopaedic Hospital NHS FT than for these purposes.

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 2010/11 have been overseen by the Electoral Reform Society.

Election to the vacant seat in Heart of Birmingham failed to secure candidates for election during the year. Interest was expressed but then candidates withdrew from standing.
Only one nomination was received in East and North Birmingham, leaving a further election to be held at a future date.

Public: Rest of West Midlands January 2011

Number of eligible voters:	**1705**
Total number of votes cast:	**455**
Turnout:	**26.7%**
Number of votes found to be invalid:	**4**
Blank or Spoilt Declaration form received	
Total number of valid votes to be counted:	**451**

Result (one to elect):

The following candidate was elected:
LAST, Alan

Public: East and North Birmingham January 2011

Result (one vacant seat):

The following candidate was elected:

COULTHARD, Elaine Mary (uncontested)

Public: South Birmingham January 2011

Result (one vacant seat):
The following candidate was elected:

BLACKLEDGE, Joseph (uncontested)

Election nominations were also sought for an additional East & North Birmingham seat and a single Heart of Birmingham seat. No eligible nominations were received by the due date and so a further election is to be held in 2011/12. The Membership Engagement group is discussing strategies to encourage more people from both of these constituencies to stand as governors.

Elected Members serving during the year 2010/11
(Names in bold held office at March 2011)

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 5 Council meetings (of 5) and serves on the Membership Engagement Committee (**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 5) and serves on the Remuneration Committee (Chair)
4. MULLINEX, David, appointed for 3 years until end January 2013
Attended 1 Council meeting (of 5) and serves on the Membership Engagement Committee
5. RICHMOND, **Isobel Ingrid** – re-elected for 3 years to 15th April 2012. Attended 5 Council meetings (of 5) and serves on the Environment Committee
6. LAST Alan, appointed for 3 years to end 15th April 2012 and serves on the Membership Engagement Committee. Attended 4 Council meetings (of 5) and serves on the Membership Engagement Committee (resigned due to moving and was elected in his new constituency)
7. BLACKLEDGE, Joseph – appointed for 3 years to end January 2014 **(no meeting held in-year following his appointment)**

Heart of Birmingham (1 seat)
Vacant

Rest of the West Midlands (4 seats)

2. NOON, Stella - appointed for 3 years until end January 2010, re-elected for 3 years until end January 2013
Attended 5 Council meetings (of 5) and serves on the Patient Experience Committee
3. GILL, Judy – appointed on re-election, for 3 years until 15th April 2012. Attended 2 Council meetings (of 5) and serves on the Patient Experience Committee. Resigned January 2011
4. SCOTT, Yvonne - appointed on re-election, for 3 years until 15th April 2012
Attended 3 Council meetings (of 5) and serves on the Patient Experience Committee
5.DOHERTY, John appointed for 3 years until end January 2013, resigned having not attended any meetings, April 2010
6. **LAST Alan**, appointed for 3 years to end January 2014**(no meeting held in-year following his appointment)**

East and North Birmingham (2 seats)

1. COUTHARD, Elaine – appointed January 2011 (no meeting held in-year following her appointment)

.
2. Vacant

Rest of England (1 seat)

1. TALBOYS, Robert – appointed for 3 years to end January 2013, Attended 2 meetings (of 5)

Clinical Staff Representatives

1. CHURCHMAN, John re-elected for 3 years until end March 2012
Attended 5 Council meetings (of 5) and serves on the Member Engagement Committee
2. GRIMER Robert – appointed for 3 years until end March 2012
Attended 0 Council meetings (of 5) and serves on the Patient Experience Committee

Non-Clinical Staff Representatives

1. **WALSHAW, Janet,** elected for 3 years until end of May 2013. Attended 3 meetings of 3 and serves on the Member Engagement Committee

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 5) Council meetings and served on the Remuneration committee

Heart of Birmingham PCT
Jacqui Francis Attended 3 Council meetings (of 5)

Birmingham City Council
Cllr. Keith Barton Attended 3 Council meetings (of 5) and served on the Governance Committee

University of Birmingham
Professor Catherine Sackley (from end February 2010). Attended 2 Council meetings (of 5)

Birmingham City University
Marion Thompson Attended 3 Council meetings (of 5) and serves on the Remuneration Committee
Bournville Village Trust
No nomination made for 2010/11 due to work pressures

Patient Support Groups
Sue Arnott Attended 2 Council meetings (of 5) and serves on the Patient Experience Committee

Member of Parliament
Richard Burden MP Attended 0 Council meetings (of 5)

Birmingham Council of Faiths
Parwez Hussain
Attended no Council meetings (of 5).

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

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

Engaging Our Membership

Public Membership has continued to grow during 2010/11 and now stands at 6,000. The profile of our membership remains representative of our community and we recognise the ongoing need to maintain a real relationship with our members.

The focus for the year has therefore concentrated on identifying ways for members to become involved and offering opportunities for members to input in a cost effective, realistic manner. In particular, the opportunities for involvement on site have diversified.

During 2010/11

- Efficiency questionnaire
- Simulated Patients
- Mystery shopping (real feedback from three people, so far)
- Board listening exercise to patient members
- Assisting with outcomes data collection

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

Membership size and movements

Public constituency	**2010 - 11**	**2011 - 12 (estimated)**
At year start (April 1)	5773	6010
New members	477	250
Members leaving	240	200
At year end (March 31)	6010	6070
Staff constituency		
At year start (April 1)	826	872
New members	80	20
Members leaving	34	70
At year end (March 31)	872	822

Analysis of current membership

At the end of 2010/11 the Trust had grown its membership to over 6000 and maintained it as representative to the population as a whole. The trust will continue to develop its membership base in 2011/12 but will not seek significant growth, focusing on more varied opportunities for engagement with existing members. Staff numbers may reduce slightly over this period due to natural wastage and service reconfiguration.

Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	10	
17-21	179	5,690, 271
22+	5452	
Not stated	369	
Ethnicity		
White	4251	1,138,054
Mixed	107	16,501
Asian or Asian British	376	83,078
Black or Black British	292	44,384

Other	103	4,408,254
Not Stated/Do not wish to state	881	

Public constituency	**Number of members**	**% of membership**
Socio-economic Category		
ABC1	3167	52.7
C2	1121	18.7
D	1276	21.2
E	412	6.9
Data not available	36	0.5
Gender		
Male	2347	39
Female	3628	60
Unspecified	35	1

The Royal Orthopaedic Hospital NHS Foundation Trust

Accounts for the Year Ended 31st March 2011

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

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

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

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

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

Statement on Internal Control

Scope of responsibility

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

The purpose of the system of internal control

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

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives of The Royal Orthopaedic Hospital NHS Foundation Trust; and

- to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31st March 2011 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 Audit Committee is a sub-committee of the Trust Board and is chaired by a Non-Executive Director of the Trust. The Committee meets six times a year and reviews the Board Assurance Framework where it robustly challenges mitigation and action plans to deal with key corporate risks.

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 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.

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 a computerised system which has been updated as of March 2011 to incorporate a more refined management review functionality. All managers have been provided with the opportunity to access training on the new system. A small amount of targeted training will continue in the early months of 2011/12 to ensure all relevant staff have received training regarding the system.

Serious events analysis continues to develop; both the quality and timescales for completion of investigations and subsequent reports have improved and the Trust is working closely with the host commissioning PCT on this.

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

A review of the risk management strategy commenced in March 2011, and it is anticipated that this will complete the approval process in May 2011.

The Trust recognises the importance of collecting meaningful and relevant data in a statistical format so that it can be analysed and trends can be monitored and appropriate action taken. Quarterly reports 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 and non-clinical incidents is collated on a quarterly basis and incorporated in the quarterly quality reports. The new computerised system now provides the opportunity for feedback from an incident to be provided directly, and electronically to the member of staff who reported the incident.

Information on serious incidents is shared with key staff. Once completed serious incident investigation reports are anonymised and circulated to key stakeholders for comments and feedback. Meetings are arranged where necessary to discuss the findings of serious incident investigation reports.

Actions and learning are detailed within the Clinical Governance quarterly report to the Integrated Governance Committee. Quarterly Clinical Governance reports are now produced and reported to the Quality Committee, containing data directly submitted and agreed by service managers, ensuring full local engagement. Monthly ward reports commenced in 2009/10, which detail complaints and incidents relating to the ward have continued in 2010/11 allowing the staff to challenge and learn from the issues raised.

The Board Assurance Framework provides a framework for reporting key information to the Board. It identifies which of the Trust's objectives are at risk because of inadequacies in the operation of controls and at the same time it provides structured assurances about where risks are being managed effectively and objectives are being delivered. The Board Assurance Framework draws together the key corporate risks from the Corporate Risk Register and is considered by the Integrated Governance and Audit Committees during the year to ensure a bottom up and top down approach to capturing key corporate risk. 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 undertaken 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 Compliance with Complaints Processes. The key control weaknesses highlighted were:

- Key documentation not held on file and therefore a lack of a robust management trail to confirm all stages of the complaints process had been applied.
- Not all complaints tested were resolved within 25 workings days as outlined in the Trust's Policy.
- Detailed action plans were not consistently in place along with robust monitoring arrangements not being in place.

Internal Audit recognised that at the time of their review, the Trust were aware of a number of these issues and were already considering the required system improvements. In particular, the transfer of responsibility for both Patient Advice and Liaison Services and Complaints to the Public Engagement Manager was actioned in January 2011 to oversee the process, check and monitor compliance with the Trust's policy and procedures and develop both additional cover and escalation processes.

A focused piece of internal audit work was undertaken in 2010/11 to review progress made against issues highlighted in the 2009/10 data security audit. This review identified that the Trust had taken action to address all of the recommendations made in the previous audit and that there was a plan in place to deliver mandatory training by the Connecting for Health extended deadline of 30th June 2011. During 2010/11, the Trust has migrated all email accounts to nhs.net, further increasing controls on data security.

Data Security is monitored via the Information Governance Group, which 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 one serious untoward incident (SUI) in

2010/11 relating to the loss of a ward handover sheet which listed several patients. New procedures have been implemented following an investigation and staff have been made aware of responsibilities to dispose of records carefully.

The Board monitors compliance with the IG Toolkit Statement of Compliance criteria each quarter and confirms that it 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.
- A Corporate Records management procedure has been implemented introducing good practice for managing and securing corporate information.
- 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.

The Trust has implemented a range of training methods for Information Governance including e-learning. Since December 2010 all staff being trained on Information Governance complete a test to evidence their understanding of the key requirements. The Trust is making a concerted effort to train 95% of all staff by 30th June 2011 in line with the IG toolkit requirements.

In 2010/11, an incident of fraud was identified relating to an overcharge of Theatre agency staffing by a particular company. The Trust's internal controls highlighted that invoiced hourly rates were greater than those within an agreed SLA, and the Trust is in the process of negotiating for the return of any overpayments from the company in question.

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 Foundation Trust is fully compliant with the requirements of registration with the Care Quality Commission.

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 Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that 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.

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 areas of potential inefficiency and compares its use of resources with other specialist orthopaedic centres. As a member of the Specialist Orthopaedic Alliance both formal and informal reviews of services and their cost effectiveness are carried out.

The Trust benefits from the data produced by the Patient Level Information and Costing System, which has enabled the Trust to increase the understanding of where efficiencies can be targeted and has focused discussions with the Department of Health around issues with the national Payment by Results tariff system. Information from the Patient Level Information and Costing System has been used to develop Service Line Reporting, which has been circulated to management and clinicians from Quarter 2 2010/11. This has further developed the understanding of the link between income and costs and has provided clinical management with a greater depth of information to support their decision making.

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 External Audit. They receive and consider the Internal Auditors opinion and the Annual Management Letter by the External Auditors which comments on the economy,

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

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

The financial risk rating of 4 awarded by Monitor, the independent regulator represents a sound and robust financial performance in 2010/11.

The governance rating of Amber-Red awarded by the independent regulator represents the breach of our C. Diff target, with 8 cases recorded in 10/11 against a maximum target of 7. The independent regulator and our host commissioner have undertaken reviews of our internal protocols and have satisfied themselves that robust protocols are in the place. An action plan was developed to implement the recommendations of this review, and this has been monitored by the Trust Board. All other indicators within the calculation of the governance rating are assessed as Green.

The Trust Board held regular meetings to discuss areas for improvement in the provision of services that the Trust provides with its Patient Forum and other specialist patient care groups to ensure it takes account of any concerns or recommendations for service improvement. Patients were also invited to address the full membership of the Trust Board to outline their views on our service, and to suggest areas for review and improvement.

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*.

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

The metrics included within the Annual Quality Report and Account are regularly reported to the Trust Board within the monthly and quarterly Corporate Performance Reports, where they are subject to review and challenge. The Annual Quality Report and Account, and the metrics included within in it, have been audited by both Internal and External Audit during 2010/11 and have been given positive audit opinions.

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

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Integrated Governance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- The Board regularly reviewing progress against a number of action plans including the red risks on the Board Assurance Framework to ensure that identified actions are implemented in the timely manner.
- The Audit Committee receiving regular reports on reviews undertaken by the Internal and External Auditors and monitors the system of financial control.
- The Audit Committee receiving update reports on audit recommendation tracking to ensure that the management team are implementing the agreed improvements to internal control processes within the agreed timeframe or that there are reasonable explanations for variances.
- The Audit Committee receiving updates on prior year audit recommendations from the Trust's Internal Auditors.
- The Integrated Governance Committee monitoring progress and suggesting action to be taken as appropriate in relation to regular reports regarding complaints, incidents, legal claims and other risks identified.
- The Executive Management Team ensuring actions on lapses in the core standards are implemented.
- The Audit Committee reviewing its objectives annually and revising them in the knowledge of the Trust's objectives and the major risks identified on the Assurance Framework. The Audit Committee objectives are designed to monitor the major organisational risks throughout the year as well as the systems of internal control.
- The Integrated Governance Committee having a programme for reviewing clinical audit and outcomes including the use of comparative benchmark data and the National Joint registry.
- Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems.
- Executive and Non-Executive Directors having been allocated specific areas within the Trust to visit and gain feedback on safety and experience issues.
- Staff listening events being hosted by the Chief Executive and the Director of Workforce and Occupational Development to gain direct feedback from staff on a wide variety of issues.

Conclusion

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 Care Quality Commission inspection, resulting in an unconditional registration
- the local Counter Fraud Reports
- the National Patient Satisfaction Survey
- Healthcare Evaluation Data (HED) outcome data
- the National Staff Opinion Survey and Patient Survey
- the Clinical Pathology Accreditation (CPA) for the Histopathology Lab
- the Human Tissue Authority (HTA) inspection and licence
- Data Quality Audits
- the Independent Regulator's assessment of the Trust as part of the Compliance Framework
- the Members' Council meetings
- Connecting for Health - Payment by Results Assurance Framework Clinical Coding Report
- Health & Safety Executive reviews
- the review meetings held with the Trust's host commissioner and quarterly meetings with associate Primary Care Trusts
- NHSLA Assessment
- The Fire Group and Improvement Action Plan
- Process reviews as part of the Excellent Health programme

Signed

Penny Venables
Chief Executive Date:

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

We have audited the financial statements of The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2011 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Cash Flow Statement and the related notes 1 to 27. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

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

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and

- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the National Health Service Act 2006 requires us to report to you if, in our opinion:

- proper practices have not been observed in the compilation of the financial statements; or

- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

Certificate

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

Guis Miah (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
6 June 2011

Foreword to the Accounts

These accounts for the year ended 31 March 2011 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

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

	Notes	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
Operating Income	3	69,375	67,581
Operating Expenses	4	(68,467)	(64,243)
Operating Surplus		**908**	3,338
Finance Costs			
Finance income		131	151
Finance expense - financial liabilities		(30)	(30)
Finance expense - unwinding of discount on provisions		(9)	(18)
PDC Dividends payable		(1,275)	(1,284)
Net Finance Costs		**(1,183)**	(1,181)
(DEFICIT) / SURPLUS FOR THE YEAR		**(275)**	2,157
Other comprehensive income			
Impairments on property, plant and equipment		(405)	(1,496)
Increase in the donated asset reserve due to receipt of donated assets		279	93
Reduction in the donated asset reserve in respect of depreciation, impairment and/or disposal		(103)	(82)
TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE YEAR		**(504)**	672

There is no deficit for the period attributable to minority interests.

The notes on pages 108 to 141 form part of these accounts.

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	Notes	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Intangible assets	8	137	92
Property, Plant and Equipment	9	39,647	37,679
Trade and other receivables	11	36	36
Total non-current assets		**39,820**	37,807
Current assets			
Inventories	10	3,155	2,583
Trade and other receivables	11	5,408	4,757
Other current assets	11	1,119	709
Cash and cash equivalents	13	14,803	18,704
Total current assets		**24,485**	26,753
Current liabilities			
Trade and other payables	14	(6,501)	(7,474)
Borrowings	14.2	(235)	(80)
Provisions	16	(116)	(100)
Tax payable	14	(809)	(767)
Other liabilities	14.1	(682)	(468)
Total current liabilities		**(8,343)**	(8,889)
Total assets less current liabilities		**55,962**	55,671
Non-current liabilities			
Borrowings	14.2	(960)	(101)
Provisions	16	(239)	(242)
Other liabilities	14.1	(154)	(215)
Total non-current liabilities		**(1,353)**	(558)
Total assets employed		**54,609**	55,113
Financed by taxpayers' equity			
Public Dividend Capital		38,905	38,905
Revaluation reserve		2,821	3,156
Donated asset reserve		2,522	2,416
Income and expenditure reserve		10,361	10,636
Total taxpayers' equity		**54,609**	55,113

The financial statements were approved by the Audit Committee on behalf of the Board of Directors on 6 June 2011 and are signed on its behalf by:

Penny Venables – Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2011

	Total	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	**55,113**	38,905	3,156	2,416	10,636
Surplus/(deficit) for the year	(275)	0	0	0	(275)
Impairment gains/(losses) on property, plant and equipment	(405)	0	(405)	0	0
Increase in respect of receipt of donated assets	279	0	0	279	0
Reduction in respect of donated assets depreciation, impairment or disposal	(103)	0	0	(103)	0
Other transfers between reserves	0	0	70	(70)	0
Taxpayers' Equity at 31 March 2011	**54,609**	38,905	2,821	2,522	10,361

	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
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
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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
Cash flows from operating activities		
Operating surplus	908	3,338
Non-cash income and expense		
Depreciation and amortisation	2,443	2,573
Impairments	1,913	683
Reversal of impairments	(284)	(283)
Transfer from the donated asset reserve	(103)	(82)
Amortisation of government grants	61	30
Increase in Trade and Other Receivables	(1,060)	(447)
Increase in Inventories	(572)	(494)
(Decrease)/Increase in Trade and Other Payables	(416)	2,480
Increase/(Decrease) in Other Liabilities	1,014	(80)
Increase in Provisions	13	67
Other movements in operating cash flows	1	1
NET CASH GENERATED FROM OPERATING ACTIVITIES	**3,918**	7,786
Cash flows from investing activities		
Interest received	130	151
Purchase of intangible assets	(124)	(56)
Purchase of Property, Plant and Equipment	(6,429)	(4,142)
Sale of Property, Plant and Equipment	0	54
NET CASH USED IN INVESTING ACTIVITIES	**(6,423)**	(3,993)
Cash flows from financing activities		
Interest element of finance lease	(30)	(30)
Capital element of finance lease rental payments	(80)	(80)
PDC Dividend paid	(1,286)	(1,284)
NET CASH USED IN FINANCING ACTIVITIES	**(1,396)**	(1,394)
(Decrease)/Increase in cash and cash equivalents	**(3,901)**	2,399
Cash and Cash equivalents at 1 April	**18,704**	16,305
Cash and Cash equivalents at 31 March	**14,803**	18,704

Notes to the accounts

1.1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual (FT ARM)* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2010/11* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual (FREM)* to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Significant accounting policies, judgments and sources of estimation uncertainty

Accounting policies that have been selected during the process of applying International Reporting Standards have been considered by management, 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 to which the revision relates.
The accounting policies that have a significant effect on the amounts recognised in the financial statements are detailed below:

Leases

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

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

Determination of useful lives for Property, Plant and Equipment

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

Partially completed spells

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

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.

Annual Leave provision

The total number of annual leave days that each of the Trust's employees has not taken at year end is accounted for within the financial statements. The number of unused days is multiplied by the employees' average salary per day, to give the total cost on individual cost centres.

1.2 Consolidation

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

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

HM Treasury has granted dispensation to the application if IAS 27 by NHS Foundation Trusts in relation to the consolidation of NHS charitable funds for 2009/10 and 2010/11.

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'.

1.3 Income

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

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

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

1.4 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. 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 income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.5 Expenditure on other goods and services

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

1.6 Property, Plant and equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably and:
    - individually have a cost of at least £5,000; or
    - form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
    - form part of the initial setting-up cost of a new building of a refurbishment of a ward or unit, irrespective of their individual or collective cost.

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 2011 by GVA Grimley international property advisers. The revaluation undertaken at that date has been accounted for in these accounts on 31 March 2011 as follows:

- Land £3,135,060
- Buildings and Dwellings £32,506,845

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

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying value amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Trust and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

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

Property, Plant and Equipment which has been reclassified as ‘Held for Sale’ ceases to be depreciated upon reclassification. Assets in the course of construction 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 Professional Valuer’s estimate

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

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

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

De-recognition

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

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

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7 Donated assets

Donated property, plant and equipment 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 the Income and Expenditure Reserve.

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. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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

Amortisation

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

1.9 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.10 Inventories

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

1.11 Cash and cash equivalents

Cash and cash equivalents comprise of cash in hand and demand deposits, together with short-term highly liquid investments with maturities of 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.

1.12 Finance income and costs

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

1.13 Financial instruments and financial liabilities

Recognition

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

The Trust holds a financial liability in respect of assets acquired or disposed of through a finance lease at 31 March 2011. The Trust has not entered into any regular way purchases or sales in the year to 31 March 2011.

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

De-recognition

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

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

Classification and Measurement

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

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

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

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

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

The Trust does not hold any assets in this category.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.
The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

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

The Trust does not hold any assets in this category.

Other financial liabilities

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

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

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

Determination of fair value

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

Impairment of financial assets

At the statement of financial position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

1.14 Leases

Finance leases

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.15 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to its technical feasibility and its resulting in a product or services that will eventually be brought into use; and
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It is 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 Statement of Comprehensive Income separately.

However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.16 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% 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 16 on page 137 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises. The Trust has also taken out additional insurance to cover claims in excess of £1 million.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 19 on page 138 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 19 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

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

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 Corporation Tax

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

1.21 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

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

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

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

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

1.22 Third party assets

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

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure in an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks with insurance premiums then being included as normal revenue expenditure.

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.24 Application of International Financial Reporting Standards

The following standards and interpretations 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:

2011/12

- IAS 24 related party disclosures
- IAS 32 financial instruments: presentation
- IAS 23 Borrowing costs

1.25 Charitable funds

The Trust is not required to apply IAS 27 in 2010/11 following dispensation obtained by Monitor. However, this only applies to the consolidation of NHS Charitable Funds. The Trust has therefore not consolidated 'The Royal Orthopaedic Hospital Charitable Fund' into the financial statements for the Trust for the year ending 31 March 2011.

1.26 Accounting standards adopted early

There are no accounting standards that the Trust has chosen to adopt early.

2 Segmental Reporting

The Trust Board as 'Chief Operating Decision Maker' considers that all of its activities fall within one material segment, which is the provision of healthcare services. The segmental reporting format applied to these accounts reflects the Trust's management and internal reporting structure.

The Trust has identified five operating segments based on expenditure, being identified by the corporate performance report presented monthly to the board. All five operating segments have similar characteristics, the nature of services is similar, the production processes are similar, and also the type or class of customer and nature of the regulatory environment are the same. The five operating segments are all active in the same business being the provision of healthcare, thus reporting a single segment of Healthcare is consistent with IFRS 8.

The provision of healthcare is within one main geographical segment being the United Kingdom, and materially from Departments of HM Government in England. Income from within the whole of HM Government is disclosed below:

	Year Ended 31 March 2011		Year Ended 31 March 2010	
	£000	%	£000	%
Income from whole HM Government	67,438	97.21%	66,012	97.68%
Income from non HM Government	1,937	2.79%	1,569	2.32%
	69,375	100.00%	67,581	100.00%

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

3 Income from Activities

3.1 Income by type

	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
Elective income	41,578	38,453
Non elective income	2,784	2,370
Outpatient income	7,470	10,148
Other NHS clinical income	12,959	12,013
Private patient income	825	1,052
Other non-protected clinical income	48	35
Total income from activities	**65,664**	64,071
Other operating income		
Research and development	369	18
Education and training	2,496	2,491
Transfer from donated asset reserve in respect of depreciation on donated assets	103	82
Profit on disposal of other tangible fixed assets	0	45
Reversal of impairments of property, plant and equipment	284	283
Other	459	591
Total other operating income	**3,711**	3,510
TOTAL OPERATING INCOME	**69,375**	67,581

Other income includes £156,453 from onsite catering services (2009/10 - £157,203); staff accommodation rentals of £64,751 (2009/10 - £69,156); private guests accommodation rentals of £22,677 (2009/10 - £25,772); and staff recharges of £9,145 (2009/10 - £8,153).

Other NHS clinical income includes £6,190,947 (2009/10 - £6,556,781) for oncology block contract income from the Department of Health and £6,402,746 (2009/10 - £6,652,539) for non-payment by results patient services, including £1,761,170 (2009/10 - £1,433,513) for critical care bed days and £1,272,185 (2009/10 - £1,260,489) for physiotherapy services.

The Terms of Authorisation set out the mandatory goods and services that the Trust is required to provide (protected services). All of the income from activities before private patient income shown above is derived from the provision of protected services.

3.2 Income by Source

	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
NHS Foundation Trusts	174	1,013
NHS Trusts	138	23
Strategic Health Authorities	6,191	6,557
Primary Care Trusts	57,253	54,450
Department of Health - other	0	8
NHS Other	0	0
Non NHS Private Patients	720	960
Non NHS Overseas patients	105	92
NHS Injury scheme (RTA)	48	35
Non NHS Other	1,035	933
TOTAL INCOME FROM ACTIVITIES	**65,664**	64,071

3.3 Private Patient Income

	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000	Base Year £'000
Private patient income	825	1,052	1,446
Total patient related Income	65,664	64,071	33,956
Proportion (as percentage)	**1.26%**	1.64%	4.26%

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.

4 Operating Expenditure

	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
Services from other NHS bodies	5	0
Purchase of healthcare from non NHS bodies	1,235	1,065
Employee Expenses - Executive directors	623	512
Employee Expenses - Non-executive directors	96	94
Employee Expenses - Staff	35,929	34,842
Drug costs	1,563	1,488
Supplies and services – clinical (excluding drug costs)	16,028	15,149
Supplies and services - general	902	793
Establishment	717	738
Transport	178	200
Premises	4,242	3,582
Increase in bad debt provision	211	13
Depreciation on property, plant and equipment	2,425	2,557
Amortisation on intangible assets	79	46
Impairments of property, plant and equipment	1,913	683
Audit services - statutory audit	40	65
Other auditor's remuneration - further assurance services	10	7
Clinical negligence	760	721
Loss on disposal of other property, plant and equipment	3	0
Legal fees	111	69
Consultancy costs	405	563
Training, courses and conferences	216	169
Patient travel	13	10
Hospitality	2	8
Insurance	86	112
Other services e.g. external payroll	242	266
Losses, ex gratia & special payments	69	94
Other	364	397
TOTAL OPERATING EXPENDITURE	**68,467**	64,243

Impairment of property, plant and equipment includes an amount of £1,765,623 which relates to an impairment (due to market revaluation) of the New Outpatients building situated on the existing premises.

Included within staff costs is a provision for an exit package for an employee of the Trust for £30,672 (31 March 2010 - £0). This was not a compulsory redundancy, it was a mutual agreement between the employee and the Trust.

Reversals of impairments of property, plant and equipment are now shown within total operating income in line with the Annual Reporting Manual. The comparatives for this figure have also been changed for 2009/10.

5 Operating leases

5.1 Payments recognised as an expense

	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
Minimum lease payments	2,234	1,979
TOTAL PAYMENTS	**2,234**	1,979

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 2011 £000	Year Ended 31 March 2010 £000
- not later than one year;	2,259	2,180
- later than one year and not later than five years;	4,464	6,451
- later than five years.	0	0
TOTAL FUTURE PAYMENTS	**6,723**	8,631

6 Finance income and costs

	31 March 2011 £000	31 March 2010 £000
Interest from deposit account investments	131	151
TOTAL FINANCE INCOME	**131**	151

	31 March 2011 £000	31 March 2010 £000
Finance lease interest	30	30
TOTAL FINANCE COSTS	**30**	30

7 Employee costs and numbers

	2010/11			2009/10		
	Total	Permanently Employed	Agency	Total	Permanently Employed	Agency
	£000	£000	£000	£000	£000	£000
Salaries and wages	28,581	28,581	0	27,559	27,559	0
Social security Costs	2,452	2,452	0	2,369	2,369	0
Employers contributions to NHS Pensions	3,070	3,070	0	2,892	2,892	0
Agency and contract staff	2,449	0	2,449	2,534	0	2,534
TOTAL EMPLOYEE COSTS	**36,552**	34,103	2,449	35,354	32,820	2,534

7.1 Employee costs

The total Employer Pension contribution payable for the period is £3,069,687 (31 March 2010: £2,892,411).

7.2 Average number of persons employed

	2010/11			2009/10		
	Total Number	Permanently Employed Number	Agency Number	Total Number	Permanently Employed Number	Agency Number
Medical and dental	105	97	8	104	96	8
Administration and estates	229	228	1	228	226	2
Healthcare assistants and other support staff	78	78	0	82	82	0
Nursing, midwifery and health visiting staff	315	308	7	304	303	1
Nursing, midwifery and health visiting learners	3	3	0	2	2	0
Scientific, therapeutic and technical staff	127	118	9	120	111	9
Bank and agency staff	6	6	0	5	5	0
TOTAL PERSONS EMPLOYED	**863**	838	25	845	825	20

7.3 Retirements due to ill health

During the year to 31 March 2011 there was no early retirements from the Trust agreed on the grounds of ill-health (31 March 2010 – 1 early retirement at a cost of £149,018).

8 Intangible assets

	Software licences (purchased) £000	Total £000
Gross cost at 1 April 2010	152	152
Additions - purchased	124	124
Gross cost at 31 March 2011	**276**	276
Amortisation at 1 April 2010	60	60
Provided during the year	79	79
Amortisation at 31 March 2011	**139**	139
Net book value		
NBV - Purchased at 31 March 2011	137	137
NBV - Donated at 31 March 2011	0	0
NBV total at 31 March 2011	**137**	137

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

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

9 Property, plant and equipment for year ended 31 March 2011

	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 2010	48,485	3,133	28,107	1,034	3,929	9,322	19	2,804	137
Additions - purchased	6,151	0	4,368	23	278	1,394	0	88	0
Additions - donated	279	0	225	0	0	54	0	0	0
Impairments charged to revaluation reserve	(405)	2	(407)	0	0	0	0	0	0
Reclassifications	0	0	3,929	0	(3,929)	0	0	0	0
Disposals	(269)	0	0	0	0	(269)	0	0	0
Cost or Valuation at 31 March 2011	**54,241**	3,135	36,222	1,057	278	10,501	19	2,892	137
Accumulated depreciation at 1 April 2010	10,806	0	1,643	0	0	6,864	6	2,156	137
Provided during the year	2,425	0	1,187	39	0	635	2	562	0
Impairments charged to income and expenditure	1,629	0	1,641	(12)	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Disposals	(266)	0	0	0	0	(266)	0	0	0
Accumulated depreciation at 31 March 2011	**14,594**	0	4,471	27	0	7,233	8	2,718	137
Net book value									
NBV - Purchased at 31 March 2011	35,930	3,135	29,229	1,030	278	2,073	11	174	0
NBV - Finance lease at 31 March 2011	1,195	0	0	0	0	1,195	0	0	0
NBV - Donated at 31 March 2011	2,522	0	2,522	0	0	0	0	0	0
NBV total at 31 March 2011	**39,647**	3,135	31,751	1,030	278	3,268	11	174	0
Analysis of Property, plant and equipment									
NBV - Protected assets at 31 March 2011	35,916	3,135	31,751	1,030	0	0	0	0	0
NBV - Unprotected assets at 31 March 2011	3,731	0	0	0	278	3,268	11	174	0
Total at 31 March 2011	**39,647**	3,135	31,751	1,030	278	3,268	11	174	0

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

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
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

9.2 Impairments

	31 March 2011	Operating income	Operating expenses	Revaluation reserve
	£000	£000	£000	£000
Changes in market place	2,318	0	1,913	405
Reversal of impairments	(284)	(284)	0	0
TOTAL IMPAIRMENTS AT 31 MARCH 2011	**2,034**	**(284)**	**1,913**	**405**

	31 March 2010	Operating income	Operating expenses	Revaluation reserve
	£000	£000	£000	£000
Changes in market place	2,179	0	683	1,496
Reversal of impairments	(283)	(283)	0	0
TOTAL IMPAIRMENTS AT 31 MARCH 2010	**1,896**	**(283)**	**683**	**1,496**

10 Inventories

	31 March 2011 £000	31 March 2010 £000
Materials	3,155	2,583
TOTAL INVENTORIES	**3,155**	2,583

	31 March 2011 £000	31 March 2010 £000
Inventories recognised in expenses	9,852	10,689
Write-down of inventories recognised as an expense	13	8
TOTAL	**9,865**	10,697

11 Trade receivables and other receivables

	Financial Assets		Non-Financial Assets	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Current financial assets				
NHS Receivables	5,229	4,075	0	0
Other receivables with related parties	144	106	0	0
Provision for impaired receivables	(251)	(40)	0	0
	5,122	4,141	**0**	0
Prepayments	0	0	212	519
Accrued income	51	2	0	0
PDC receivable	11	0	0	0
Other receivables	1,057	707	74	97
	1,119	709	**286**	616
Total Current Financial Assets	**6,241**	4,850	**286**	616
Non-Current financial Assets				
Trade and other receivables	36	36	0	0
TOTAL TRADE AND OTHER RECEIVABLES	**6,277**	4,886	**286**	616

11.1 Impairment of receivables

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	40	27
Increase in provision	211	13
Balance at 31 March	**251**	40

A provision has been made as at 31 March 2011 for impairment of receivables in the amount of £251,000 (31 March 2010: £40,000). The provision relates to NHS and Non NHS debts.

The ageing analysis of NHS and Non NHS impaired debts is as follows:

	31 March 2011 £000	31 March 2010 £000
Up to three months	130	40
In three to six months	121	0
Over six months	0	0
TOTAL AGEING OF IMPAIRED RECEIVABLES	**251**	40

The ageing analysis of NHS and Non NHS non-impaired debts is as follows:

	31 March 2011 £000	31 March 2010 £000
Up to three months	1,207	451
In three to six months	1,079	614
Over six months	0	0
TOTAL AGEING OF NON IMPAIRED RECEIVABLES	**2,286**	1,065

12 Other current assets

12.1 Current and Non-Current asset investments

The Trust did not hold any current asset investments or non-current asset investments in the period to 31 March 2011 (£nil – 31 March 2010).

13 Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
Cash and cash equivalents at 1 April	18,704	16,305
Net change in year	(3,901)	2,399
Cash and cash equivalents at 31 March	14,803	18,704
Broken down into:		
Cash at commercial banks and in hand	(24)	90
Cash with the Government Banking Service	14,827	18,614
Other current investments	0	0
Cash and cash equivalents as in Statement of financial position and Statement of Cash Flows	**14,803**	18,704

14 Trade and other payables

	Financial Liabilities		Non-Financial Liabilities	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
NHS Payables	1,637	2,805	0	0
Amounts due to other parties	15	0	0	0
Trade payables - capital	636	918	0	0
Taxes payable	0	0	809	767
Other trade payables	3,568	3,110	0	0
Accruals	645	641	0	0
TOTAL TRADE AND OTHER PAYABLES	**6,501**	7,474	**809**	767

Other Trade Payables include £398,649 outstanding pension contributions at 31st March 2011 (31 March 2010: £373,213). There are no payments due in future years under arrangements to buy out the liability for early retirements over five years.

14.1 Other liabilities

	Current		Non-Current	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Deferred income	621	407	0	0
Deferred government grant	61	61	154	215
TOTAL OTHER LIABILITIES	**682**	468	**154**	215

Other liabilities include a deferred government grant for single sex wards in the amount of £215,214 (31 March 2010: £276,704). This will be written off over a 5 year period with 12 months written off in the year to 31 March 2011. Fixed assets relating to this Grant will also be written off over 5 years and are included within buildings excluding dwellings.

14.2 Borrowings

	Current		Non-Current	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Obligations under finance leases	235	80	960	101
TOTAL BORROWINGS	**235**	80	**960**	101

14.3 Finance lease obligations

	Net lease liabilities		Gross lease liabilities	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Within one year	235	80	287	111
Between one and five years	811	101	729	138
After five years	149	0	351	0
	1,195	181	**1,367**	249
Included in :				
Current borrowings	235	80	0	0
Non-Current borrowings	960	101	0	0
	1,195	181	**0**	0

15 Prudential Borrowing Limit

NHS foundation trusts are required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and

- the amount of any working capital facility approved by Monitor.

As per Section 46 of the Act, the Trust has a Prudential Borrowing Limit of £17,200,000 in 2010/11 (£17,400,000 in 2009/10). The Trust borrowed/repaid a net £0 in 2010/11 (£0 in 2009/10) and at 31 March 2011 had £0 of outstanding borrowing (£0 at 31 March 2010).
The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £13.2m (£13.4m – 31 March 2010), and
(ii) Approved working capital facility of: not to exceed £4.0m

Financial Ratio	Actual 2010/11	Plan 2010/11	Actual 2009/10	Plan 2009/10
Minimum Dividend Cover	2x	2x	2x	2x
Minimum Interest Cover	0%	0%	0%	0%
Minimum Debt Service Cover	0%	0%	0%	0%
Maximum Debt Service to Revenue	0%	0%	0%	0%

The Trust has an approved working capital facility of £4.0m (£4.0m in 2009/10). The Trust had not utilised any of its working capital facility at 31 March 2011 (£0 at 31 March 2010).

Until the Trust draws down a loan only the Minimum Dividend Cover is relevant. The Trust was within the appropriate limit.

Further information on the NHS foundation trusts Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

16 Provisions for liabilities and charges

	Current		Non-Current	
	31 March 2011 £000	31 March 2010 £000	31 March 2011 £000	31 March 2010 £000
Legal claims	96	81	0	0
Other	20	19	239	242
TOTAL PROVISIONS	**116**	100	**239**	242

	Legal claims	Other	Total
	£'000	£'000	£'000
At 1 April 2010	80	262	342
Change in discount rate	0	0	0
Arising during the year	40	0	40
Utilised during the year	(24)	(12)	(36)
Reversed unused	0	0	0
Unwinding of discount	0	9	9
At 31 March 2011	96	259	**355**
Expected timing of cash flows:			
not later than one year	96	20	116
later than one year and not later than five years	0	44	44
later than five years	0	195	195
Total expected timing of cash flows	96	259	**355**

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 2011 has £4,029,561 (£1,233,687 – 31 March 2010) in respect of clinical negligence liabilities of the Trust included in its accounts.

17 Contractual Capital Commitments

	31 March 2011	31 March 2010
	£000	£000
Property, plant and equipment	1,508	5,446
TOTAL CONTRACTUAL CAPITAL COMMITMENTS	**1,508**	5,446

Capital commitments include £208,687 for car park resurfacing, £541,112 for MRI scanner building work, £270,038 for kitchen building work and £102,737 for canteen equipment.

18 Revaluation Reserve

	Total Revaluation Reserve	Revaluation Reserve - property, plant and equipment
	£'000	£'000
Revaluation reserve at 1 April 2010	3,156	3,156
Impairments	(405)	(405)
Other reserve movements	70	70
Revaluation reserve at 31 March 2011	**2,821**	2,821
	£'000	£'000
Revaluation reserve at 1 April 2009	4,761	4,761
Impairments	(1,496)	(1,496)
Other reserve movements	(109)	(109)
Revaluation reserve at 31 March 2010	**3,156**	3,156

19 Contingencies

	31 March 2011	31 March 2010
	£000	£000
Gross value of contingent liabilities	8	20
Amounts recoverable against liabilities	0	0
NET VALUE OF CONTINGENT LIABILITIES	**8**	**20**

The above contingent liabilities relate to two employee liability claims.

There are no contingent assets for the year ending 31 March 2011 or the previous financial year.

The Trust is involved in an ongoing legal dispute in relation to a capital project, which may provide a future benefit or charge to the statement of comprehensive income.

20 Post Balance Sheet Events

The Trust does not have any disclosable post balance sheet events.

21 Related party Transactions

The Royal Orthopaedic Hospital NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by the independent regulator for Foundation Trusts Monitor on February 1 2007.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with The Royal Orthopaedic Hospital NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year The Royal Orthopaedic Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Receivables £000	Payables £000	Revenue £000	Expenditure £000
London Strategic Health Authority	0	0	6,191	0
Birmingham East and North PCT	317	5	6,005	0
Dudley PCT	423	4	4,400	0
South Birmingham PCT	0	140	18,877	0
Sandwell PCT	307	3	4,305	0
Solihull Care PCT	14	184	1,808	0
Sandwell and West B'ham Hospitals NHS Trust	15	115	26	232
South Staffordshire PCT	421	2	2,768	0
Walsall PCT	264	2	2,095	0
Worcestershire PCT	569	6	6,626	0
Birmingham Children's Hospital NHS Foundation Trust	86	209	0	795
University Hospital Birmingham NHS Foundation Trust	909	573	238	2,035

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
NHS Litigation Authority	0	0	0	766
National Health Service Logistics Authority	0	0	0	951
NHS Purchasing and Supply Agency	0	84	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 £13,402 during the year (£13,107 – 31 March 2010).

22 Private Finance Initiatives

The Trust did not have any Private Finance Initiative schemes as at 31 March 2011.

23 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

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2011 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 2011. Fair value approximates to the book value because of the short maturity of these instruments.

23.1 Financial Assets

	Carrying value 31 March 2011 £000	Fair value 31 March 2011 £000	Carrying value 31 March 2010 £000	Fair value 31 March 2010 £000
Current financial assets				
Trade and other receivables	5,122	5,122	4,141	4,141
Other current assets	1,119	1,119	709	709
Cash and cash equivalents	14,803	14,803	18,704	18,704
	21,044	21,044	23,554	23,554
Non-current financial assets				
Trade and other receivables	36	36	36	36
TOTAL FINANCIAL ASSETS	**21,080**	**21,080**	23,590	23,590

23.2 Financial Liabilities

	Carrying value 31 March 2011	Fair value 31 March 2011	Carrying value 31 March 2010	Fair value 31 March 2010
Current financial liabilities	£000	£000	£000	£000
Measured at amortised cost:				
Finance leases	1,195	1,195	181	181
Trade and other payables	6,501	6,501	7,474	7,474
Provisions under contract	116	116	100	100
	7,812	7,812	7,755	7,755
Non-current financial liabilities				
Provisions under contract	239	239	242	242
TOTAL FINANCIAL LIABILITIES	**8,051**	**8,051**	7,997	7,997

24 Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. In the year 2010/11 the Trust had 23 (31 March 2010: 41) separate losses and special payments, totaling £46,484 (31 March 2010: £68,440). These were in relation to cash losses and ex-gratia payments to patients.

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

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

25 Third Party Assets

The Trust did not hold assets in the bank which relate to monies held by the Foundation Trust on behalf of patients.

26 Going Concern

After making enquiries, the directors have a reasonable expectation that The Royal Orthopaedic Hospital NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

27 Auditors Liability

The auditors have a limitation of their liability in accordance with their engagement letter signed on the 29 October 2010 for the amount of £1 million.