The Royal Orthopaedic Hospital NHS Foundation Trust

Annual Report and Accounts 2013/14

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

Contents 2013/14

Chairman's Message

I became Interim Chairman in February 2014 following the resignation of Dr Bryan Jackson, CBE who had successfully chaired the Trust since April 2013 and under whom I had worked as a non-executive director and Vice Chairman throughout that period.

As an independent NED (Non Executive Director), coming new to the NHS in 2013, I am genuinely proud to have had the opportunity to lead a Trust which is so focused on patient care and on achieving the very best outcomes. The wealth of fantastic compliments we receive from patients, our great 'net promoter score' and the feedback as I visit clinical areas is testament to the caring, family feel of our hospital. The sense of pride rubs off from clinician to volunteer and cook to cleaner – and it is far from hollow as we have evidence to show how high our standards are and how consistent we are in our care.

Nonetheless, this is not an easy time for the public sector, and despite the financial protection afforded to the NHS, the pressure to drive efficiency as well as make investment in the essential underpinning elements of modernisation has never been greater. As a Board, we have closely scrutinised risk, grappled with the difficult balancing act of delivering treatment targets across all our sub-specialities and been keen to ensure that staff engagement remained the touchpoint of our success.

I am pleased to say that I have witnessed teams of staff working together to solve problems and to tackle the thinking challenge of developing a robust forward plan. I was particularly proud to attend a Bollywood event in January 2014 which was our themed staff awards evening. The mix of colourful saris and the pleasure on people's faces as they congratulated colleagues for their awards was genuinely uplifting. I had been told the Trust was a family and that evening I saw that first hand. It has to be a good sign, that from a headcount of less than 1,000 staff, almost 200 nominations for awards were received. It is these people who make our organization special.

I would like to commend the Trust for its endeavours to pull back performance after a sluggish summer in 2013. The task was daunting with an ambitious plan to bring everything right back to plan. Doctors, theatre staff, nurses and managers all worked tirelessly for nearly five months to secure the good outturn position we achieved. Extra hours, extra effort and no dip in quality, once more indicates how much of a team the Trust is.

I have very much enjoyed my time as Chair and it has given a great opportunity to lead the Trust's approach to strategic planning. Whilst the nuts and bolts of regulator requirements may be daunting, the principles of evidence based planning, good external environmental assessment and an honest look at strengths and weaknesses form the essential grounding to any ambitious plan. The Trust is highly self-aware and has prioritised those things that will give it indigenous strength – investment in IT, imaging and service development. It has taken the brave but business-like decision to invest now

rather than save still more for the future. The time has come to deliver a modernised organisation capable of even greater efficiencies that can lead orthopaedic care in the region.

I would like to take this opportunity to thank all the incredibly dedicated people at the Royal Orthopaedic Hospital who work with a smile and live the NHS dream in all that they do. They are a credit to us all.

Tim Pile

Interim Chairman

Chief Executive's Statement

I am delighted to have joined the Trust in late 2013 having been aware of its great reputation, financial stability and not insignificant ambition for the future. Like all NHS organisations we are looking to the future and making plans for our services. This has given me a great opportunity to find out what people care most about at the Royal Orthopaedic Hospital. We face all the challenges of a small organisation – never enough staff to split the thinking roles from the doing roles, always behind the curve with major investments in infrastructure and often punching below our weight. My challenge is to capitalise on the good aspects of being small – a real family spirit and pride; an ability to move direction quickly if necessary and the courage brought by years of independence.

The executive team changed considerably over the year, refreshing its composition but also meaning experience and organisational knowledge had been lost. This too gives an opportunity to see things differently and do things differently as new perspectives on old problems challenge the paradigms of previous solutions.

Our team has pulled together brilliantly to deliver a great performance in a year that has probably been the Trust's most challenging yet. We have never taken our eyes off quality and have taken no short cuts in order to move toward planned financial outturn.

I should also like to thank the Board as they have supported us through a few tough months and have taken time to really understand the complex dynamics at play in an elective hospital such as the Royal Orthopaedic Hospital.

We are now several months into planning for the next five years and this gives me an opportunity to lead thinking and offer a blank sheet on which all colleagues can sketch ideas. The Trust has taken stock and considers it time to invest rather than save and will access the funds so prudently built up over previous years to enable a step change in its core capability.

I would like to thank all of our staff for their skill and commitment to the delivery of high quality care for our patients. In the short time I have been at the Royal Orthopaedic Hospital, I have had the opportunity to meet some extraordinary people and have been made to feel very welcome. As well as leading the development of our strategy for the future, I am also keen to ensure that the Trust engages more in the wider health and social care system for the benefit of our patients. As a specialist Trust, we hold a special place, providing high quality services and collaborating with others and I will actively engage with partners to mutual benefit.

I hope this Annual Report gives a flavour of our achievements and good governance and look forward to developing the work of the organisation over the coming years.

Jo Chambers, Chief Executive

Strategic Report 2013/14

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

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

Review of 2013/14

2013/14 represents a successful year for the Royal Orthopaedic Hospital, albeit one in which the ongoing challenges facing the NHS as a whole continued to be felt.

The Trust continues to be rated highly by our regulators, with Monitor issuing the Trust with a Green governance rating and a Continuity of Services rating of 4, both of which represent the lowest rating of risk that can be awarded.

2013/14	Annual Plan	Q1	Q2	Q3	Q4
Continuity of Services risk rating	4	4	4	4	4
Governance risk rating	Amber-Green	Green	Green	Green	Green

(Note – On 1st October 2013, Monitor replaced the Financial risk rating with a Continuity of Services risk ratings. Prior to this date, Continuity of Services risk ratings were issued in shadow form. The Trust was scored as a 4 under the Financial risk rating system for Q1 and Q2)

Patient Care

The Royal Orthopaedic Hospital NHSFT continues to strive to deliver exceptional patient experience and world class outcomes in all that we do.

The Care Quality Commission undertook two routine inspections in 2013/14, reviewing the Management of Medicine, the Care and welfare of people who use services,

Safeguarding people who use services, Supporting workers and Assessing and monitoring the quality of service provision. We were found compliant in all areas and are committed to maintaining this standard in 2014/15.

The Trust is extremely valued by our patients, as evidenced by our excellent results for the Friends and Family test introduced in 2013. In our latest data collection, based on March 2014, 85% of our inpatients stated they were “extremely likely” to recommend our services to their friends and family, whilst no patients stated that they were unlikely to recommend our services. This places the Trust in the Top 15 of NHS providers in England.

We have also made great progress in a number of our key quality priorities for 2013/14:

- Over 95% of patient s are assessed for the risk of VTE (venous thrombo-embolism) upon admission to hospital.
- The incidence of avoidable pressure ulcers reduced from 34 in 2012/13 to 22 in 2013/14.
- Surgical site infection rates reduced in both primary hip replacements (1.9% in 2012/13 to 1.3% in 2013/14) and primary knee replacements (4.9% in 2012/13 to 3.1% in 2013/14).
- The number of inpatient falls reduced by over 20%, with no falls resulting in harm as reported by the Safety Thermometer.

The Trust has worked hard to improve the experience of our patients, with key successes including:

- A massive increase in the quality of food provided to our patients. At the start of 2012/13, only 59% of patients reported that the food provided was of a good standard. For 2013/14, this increased to an average of 90% across the full year, peaking at 98.2% in March 2014.
- The number of complaints received by the Trust reduced from 183 in 2012/13 to 150 in 2013/14. The management of complaints was reviewed by the CQC during the unannounced inspection in January 2014, no concerns were noted and good practice of personally making contact with and agreeing timescales with complainants was noted. Complaints staff are reported as helpful and professional and many complainants reported that they would feel confident in complaining again if they felt the need to do so.
- The Trust has put a lot of focus on improving our appointments process in order to offer a reliable and effective service to all of our patients. There is still work to be done to continually improve this, however the positive progress is demonstrated by a reduction in PALS (Patient Advice and Liaison Service) contacts relating to appointments from 104 in March 2013 to 46 in March 2014.

Operational performance

The Trust treated 14,379 admitted patients and 68,586 outpatients in 2013/14, an increase of 7.3% and 6.8% respectively as compared to the previous financial year.

	Performance against Plan			Performance against 2012/13 Actual	
	Actual Treated 2013/14	**Plan to Treat 2013/14**	**Variance**	**Actual Treated 2012/13**	**Variance**
Elective	6,695	7,134	(439)	6,815	(120)
Non-Elective	383	453	(70)	429	(46)
Day Cases	7,301	6,418	883	6,161	1,140
Total Admitted Patient Care	**14,379**	**14,005**	**374**	**13,405**	**974**
First Appointment	18,766	16,707	2,059	16,669	2,097
Follow Up Appointment	42,373	41,449	924	39,769	2,604
Outpatient Procedures	7,447	7,734	(287)	7,800	(353)
Total Outpatients	**68,586**	**65,890**	**2,696**	**64,238**	**4,348**

The most significant areas of growth in 2013/14 relate to our small joints and MSK (Musculo-skeletal) services. Small joints, comprising of our hand and foot and ankle services, has built on the appointment of 2 new surgeons in 2012 to address a clear demand for surgical services in the Birmingham Area. The team are also leading the way in reviewing innovative ways of treating patients through non-surgical methods, with the success of our pilot providing collagenase injections for Dupuytren's contracture allowing this condition to be treated without the need for surgical intervention.

The Trust's MSK service continues to grow, offering an integrated medical and therapeutic care model for musculoskeletal conditions. New services, such as our Functional Restoration Programme and Heel Pain service, have been successful in providing non-surgical for patients with orthopaedic conditions.

The growth in these 2 areas contributed to a noticeable change in case-mix in our inpatient services in 2013/14, with a significant increase in day case surgery alongside a reduction in inpatient services. The combination of these changes resulted in a shortfall against our income targets, as outlined in more detail in the section on financial performance below.

Compliance with our national performance targets in 2013/14 was strong, however the Trust has failed to achieve one of our three 18 week referral to treatment time targets since November 2013. The Trust is required to treat 90% of patients admitted to the hospital within 18 weeks of receiving a referral. This target was achieved in the first 7

months of the year, but dropped to 88.1% in November with a low point of 83.3% in December.

There are numerous factors that have influenced this performance, most notably the consistent increase in referrals into the service as highlighted in the outpatient figures shown in the table above. This, combined with a significant drop in inpatient activity over the summer months of 2013, resulted in a greater number of patients breaching the 18 week threshold. The Trust has undertaken a thorough review of all aspects of the management process to support 18 week delivery, enlisting the support of our Internal Auditors, and have highlighted a number of actions that can be taken to strengthen our processes. These actions have already begun to be implemented and, along with a concerted effort to increase activity levels in Quarter 4 of 2013/14, have resulted in the backlog of patients waiting over 18 weeks reducing from 537 in December 2013 to 353 in March 2014. This should ensure that the Trust is on track to achieve compliance with all 18 week targets from April 2014 onwards.

All other annual Monitor performance targets were achieved in 2013/14, as shown in the table below, although the 62 day cancer target was narrowly breached in Quarter 2. Performance against this target is volatile due to the extremely low numbers of applicable patients, however the overall annual target has still been achieved.

Target	**Target performance**	**Actual performance**			
		Q1	**Q2**	**Q3**	**Q4**
18 weeks RTT – Admitted	90%				
18 weeks RTT – Non Admitted	95%				
18 weeks RTT – Incompletes	92%				
Cancer – 2 week wait to be first seen following urgent GP referral	93%				
Cancer – 31 day wait from diagnosis to first treatment	96%				
Cancer – 31 day wait for second or subsequent treatment - surgery	94%				
Cancer – 62 day wait for first treatment (from urgent GP referral)	85%				
C. Diff Cases	<=2 per year				

Financial Performance

2013/14 was another challenging year for NHS finances, with continued pressure on providers and health economies to meet the growing demand for NHS services. In addition to this, providers are ensuring that learning from several national reports, including Francis and Keogh, are embedded into their services, whilst starting out on the pathway towards meeting the national ambition of 7 day services within the NHS.

In order to meet these pressures and to deliver a £2.4m financial surplus (before impairments) that would allow continued investment in the Trust's infrastructure, the Trust set itself a cost improvement target of £3.0m (4%). It was expected that achievement of these challenging targets would support the Trust to record a Monitor Continuity of Services Rating of 4, representing the lowest rating of risk to financial sustainability.

Based on these targets, as agreed by the Board of Directors and the Council of Governors, the financial performance of the Trust during 2013/14 can be measured as follows:

Financial Objective	**Outcome**	
Deliver a minimum surplus of £2.4m before impairments and the consolidation of the Charitable Fund	Surplus achieved £2.2m	
Achieve a Monitor Continuity of Services Rating of 4	Achieved a rating of 4	
Deliver £3.0m in cost reduction and growth	Achieved £2.5m	
Deliver a capital programme of £7.5m	£4.6m capital spend	

Whilst the Trust did not achieve a number of its initial financial targets, 2013/14 can still be judged as reasonably successful from a financial viewpoint. The target surplus of £2.4m was not achieved, however the final year end surplus of £2.2m (before impairments and the consolidation of the Charitable Fund) still represents a surplus margin of 3%, which places the Trust amongst the higher performing Foundation Trusts in an increasing financially challenged health service.

Significant investment, both in time and financial resources, was incurred in 2013/14 in the development of a strategic direction for Information Management and Technology. Work within the early months of the financial year highlighted the need for focused investment in the IT infrastructure required to underpin future developments in clinical systems. As such, the original capital programme, which included assumptions around clinical system investment towards the end of the year, was revised to take account of the changing priorities. £1.7m of planned spend was rephased into the 2014/15 capital

plan, revising the in-year plan down to £5.8m. The Trust ended the year with capital spend of £4.6m, which was £1.2m behind our revised plan. This was due to estates development plans slipping into 2014/15.

In setting our financial plan for 2013/14, the Trust recognised that as a small, specialist Trust, there needed to be a balance between the continued drive for increased efficiencies and reduced cost and wastage, and the need to continue to grow to provide the Trust with greater financial resilience. As such, the Trust's £3.0m Cost Improvement Target was split down to £1.9m of expenditure savings and £1.1m of contribution from activity and income growth. The delivery of these savings has proved a major challenge for the Trust, resulting in a shortfall of £0.5m for the full year.

£1.8m of expenditure schemes were delivered in 2013/14, slightly below targeted levels. This saving was achieved through a large number of smaller schemes, largely transactional rather than transformational in nature. There was a significant focus on non-pay schemes, with noticeable savings in orthotic appliances, pathology testing, specimen transportation and various theatre equipment and consumables.

Income schemes failed to deliver planned savings, and made up the majority of the overall shortfall on Cost Improvements. Whilst some schemes were successful, particularly linked to growth in services and demand in therapies, there was less success around planned inpatient growth.

Along with the adjustment in case-mix driven by a greater proportion of surgical patients being treated as day cases, the overall underperformance against efficiency savings schemes resulted in a small shortfall on the Trust's planned surplus position.

The Health and Social Care Act 2012 removed the requirement for Foundation Trusts to limit income from private patients to below their original private patient cap. The new act still requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. In 2013/14, the Royal Orthopaedic Hospital's income from the provision of goods and services for other purposes, derived from private patients, was 1.0% (£752,000), therefore the Trust has complied with the Act in this regard. Any financial profit from the treatment of private patients is reinvested into improving care for NHS patients.

Capital Investment

The Trust invested £4.6m in capital schemes in 2013/14, utilising the cash surpluses generated in previous years. Capital investment is vital to the on-going success of the hospital, ensuring that patients are treated in modern, clinically appropriate facilities with the advanced equipment required to maintain our status as an internationally renowned specialist centre for orthopaedic surgery.

The main schemes delivered in 2013/14 included:

- The development of our new Admissions and Day Case Unit, which opened in August 2013, has provided a modern health care facility enabling day case patients to be looked after in an environment specifically designed for their needs. The unit supports the introduction of staggered admissions, meaning patients will only need to arrive at hospital shortly before their planned surgery time, and provides an efficient flow for patients into the adjacent theatre block.
- The purchase of a new, state of the art CT Scanner, enabling improved diagnostic accuracy and using significantly reduced radiation doses.
- A £1.5m investment in IT infrastructure, providing the server, desktop and business continuity framework required to support the Trust's plans for major clinical system development over the next 5 years.
- New medical equipment, including new operating tables and new cardiac and spinal cord monitoring units in theatres.

Going Concern

The financial statements, as provided in detail in later sections of the Annual Report have been prepared under the direction of Monitor as the sector regulator for health services in England, and have been prepared on a going concern basis. The assumptions within the financial statements have been fully challenged through Audit Committee and Trust Board, and the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

In reaching this conclusion, the directors have taken account the Trust's two year operational plan, information relating to which is provided in the Forward Look section of this Strategic Report, and the work that is ongoing to develop the Trust's five year strategic plan. Despite the difficult financial environment in which all public services exist within, the Directors are confident that the Trust has robust plans in place to ensure its sustainability. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Charitable Funds

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

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

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

The impact of our business on the environment

The Trust takes its role in supporting environmental sustainability seriously, and endeavours to reduce its carbon footprint in all the areas considered appropriate, such as energy, gas, electricity, water usage, waste and travel. Staff are encouraged to participate in all aspects of good housekeeping which we consider will make a major contribution in the drive to reducing our carbon footprint. Engagement and encouragement will hopefully also enable staff to be more carbon efficient in their own personal lives.

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

In 2013/14 the Trust installed an insulation system to the roof of the building which accommodates our Paediatric and Therapy Services, thereby significantly reducing the demand for additional heating.

The Trust endeavours to reduce waste wherever possible and for 2014/15 it is focussing on further developing its recyclable waste streams. The Trust continues to develop its travel strategy and encourages reductions in staff travel.

The Trust is also the proud owner of a Green Apple Award as a result of our efforts to maintain and develop the semi-wooded environment on our Woodlands site. This continues the tradition maintained by the Cadbury family of keeping tree planting a vibrant part of the environment.

Human Rights

We have adopted the FREDA principles – this stands for Fairness, Respect, Equality, Dignity, and Autonomy - as they are considered to underpin all international human rights treaties. We meet these aspirations by putting patients first, demonstrating compassion, showing respect for patients, families and colleagues. As we evolve patient pathways we actively engage patients in helping us design them as well as ensuring they understand each element of their treatment. The avoidance of degrading treatment, ill-judged correspondence and unnecessary discrimination help deliver our aims. By empowering our staff to work with patients in these terms we are increasingly able to work to rigorous standards but with the flexibility needed to match individualised care needs.

Valuing and Engaging our Workforce

Feedback from staff during late 2013 indicated improvement is needed in the engagement of staff on issues that matter to them. As a result a significant piece of work was undertaken during the year to understand what had caused this. The findings from this work have provided some important insights into the priorities for action. Immediate

changes have been made to internal communication, visibility of Executive Directors and Senior Managers, increased investment in areas such as radiology and nursing, as well as improved external marketing of the Trust.

Some improvements in engagement were noted in the 2013/14 staff survey, although overall levels of staff engagement remain worse than average, compared to other acute specialist Trusts. Significant steps have been taken during 2013/14 to improve the involvement of employees in the Trust's performance, more details of which are found in Chapter 6 of the Annual Report.

The Trust gives active consideration to how both employment and patient care practices and policies impact on people with Protected Characteristics under the Equality Act 2010, including people with a disability. The Trust provides equal access to learning and career development for all staff and has policies to support this. We assess all policies and changes to services to identify any aspects which could have a positive or negative impact on people with a protected characteristic. We also monitor how we are progressing with regards to our public sector equality duty and the results of this are made publicly available in the annual Diversity Report which can be found on the Trust's website.

Workforce Summary

As at 31/03/2014	Male	Female	Total
Directors	5	6	11
Other employees	266	676	942

Sickness Absence Figures

The following table shows the Royal Orthopaedic Hospital reported sickness absence figures. These have been a key focus of attention for the board and the Trust continues to find ways to support staff returning to work early.

Statistics Produced by HSCIC from ESR Data Warehouse		**Figures Converted by DH to Best Estimates of Required Data Items**		
Quarterly Sickness Absence Publications	**Monthly Workforce Publication**			
Average of 12 Months (2013 Calendar Year)	**Average FTE 2013**	**FTE Days Available**	**FTE – Days Lost to Sickness**	**Average Sick Days per FTE**

			Absence	
4.6%	781	175,613	8,060	10.3

The number of FTE-days available has been estimated by multiplying the average FTE for 2013 (from March 2014 Workforce publication) by 225.

The number of FTE-days lost to sickness absence has been estimated by multiplying the estimated FTE-days available by the average sickness absence rate.

The average number of sick days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE.

Sickness absence rate is calculated by dividing the sum total sickness absence days (including non-working days) by the sum total days available per month for each member of staff).

The Forward Look – Strategic Context

As a recognised specialist provider operating in close proximity to a very large acute facility, we recognise the need to identify ourselves as the leading provider of orthopaedic services within the changing NHS landscape. We see ourselves as a provider achieving better outcomes than others and as having the capacity and capability to undertake complex and specialist work not done elsewhere. We intend to concentrate on basic modernisation in support of an enhanced patient journey – rectifying the previously under-resourced investment in technology and building robust partnerships that underpin service development rather than trying to achieve everything independently ourselves. In the longer term this will allow the Trust to establish itself as a self-evident leader in orthopaedic care, looking beyond surgical intervention towards health promotion and preventative activity and also ensuring that the Trust is both innovative and an early adopter of best practice innovations in its field.

The Trust will maintain a balance between elective routine and specialist work but will consider re-balancing the organisation's activity so as to embrace opportunities for more holistic patient care both before and after surgery. This area of musculo-skeletal activity will offer commissioners and patients excellent orthopaedic care right across the pathway. The Trust will also work with Birmingham Children's Hospital to consider the future of a paediatric orthopaedic service that is sustainable and sufficiently robust and comprehensive to meet the needs of the population.

The Forward Look – Financial Implications

The Royal Orthopaedic Hospital has a long tradition of financial success, and the surpluses generated over this time have enabled major estates developments such as the new Outpatients building and Admissions and Day Care Unit to be internally funded over the last 5 years. Even with these investments, the Trust has continued to limit capital investment to levels in line with surpluses generated, maintaining a strong cash position for the Trust.

From 2014/15, the Trust Board have made a significant decision to utilise this cash to enable the fundamental and systematic transformation needed to deliver the organisations strategic aims. £1m has been set aside in 2014/15, £0.5m of which can be invested recurrently, to ensure that we are able to make major, sustainable change to key areas such as our IM&T (Information Management and Technology) capabilities and leadership development. The £0.5m non recurrent enabling budget will also remain in 2015/16, as it is recognised that a longer term approach will be needed to fully release the benefits from these key enablers. The Trust have therefore reduced our target surpluses in these 2 years to £0.5m.

In addition to this investment in revenue funds, our 5 year capital plan has also been reviewed to ensure that capital resources are invested appropriately to support our key operational and strategic aims with significant investments in years 1 and 2 on IM&T and radiology equipment. Over the next 2 years, the Trust anticipates spending £8m on IT and Informatics systems and enablers to revolutionise the working environment for our staff and provide a safer and more streamlined service to our patients. This will include the roll-out of a new IT infrastructure across the Trust, provision of an electronic prescribing and pharmacy system, and improved informatics support in the shape of a data warehouse and Trust-wide outcomes system.

In addition to this, £6m is being set aside to address radiology capacity and replace aging imaging equipment to tackle a key bottleneck in our existing services. A new MRI scanner will be added on site to address the cost of outsourcing scans currently being incurred and to provide the long term resilience to support growth over the five year period of our strategic plan. In addition to this and following on from the replacement of our CT scanner in 2013/14, a range of imaging equipment will be updated to provide a modern and efficient radiology service to our patients.

Despite these unprecedented levels of investment, the Trust's annual plan still demonstrates a Monitor Continuity of Services risk rating of 4 over the next two years, with cash balances of £7.5m remaining at March 2016.

The Forward Look – Risks and Uncertainties

The Trust manages its internal risks through the Board Assurance Framework, which highlights 8 major risk categories:

- Failure to deliver high standards of care.
- Failure to comply with the Monitor license.
- Failure to comply with CQC registration.
- Interruption to business continuity.
- Failure to deliver contract to commissioners.
- Staff Engagement.
- Organisational Leadership.
- Long-term viability.

Included within these categories are a number of principal risks that are currently mitigated through internal action. As previously highlighted, reviews into the 18 week process highlighted control weaknesses in internal administrative processes. This is also evident through complaints received by the Trust, where administrative difficulties appear as one of the more common themes. The Trust is committed to offering a smooth and efficient experience to our patients, not just during the time they are in the hospital, but also within the pre-admission and post-discharge stages of their care. A number of process and system improvements are underway, backed by planned IT investment in 2014/15, to address this risk and ensure that our administrative processes match the high standards we achieve with our clinical care.

As highlighted through our investment priorities for the forthcoming two years, the Trust recognises that without significant transformation of our IT capabilities, we will not be in a position to maintain our status as a high performing NHS provider. We also recognise that additional investment is required to address the imaging capacity needed to meet the growing needs of our services. Our two year financial plan has been designed to mitigate and address these key challenges.

The Trust has also highlighted the management of change process as a key internal risk. Additional assurances that are being introduced to mitigate this include:

- Development of a safety culture to enable staff to feel comfortable to raise concerns internally.
- Development of a culture where staff feel able to make change in their day to day work to improve service.
- Develop leadership capability to lead change and engage staff.
- Embed values into the core people management approaches of recruitment, leadership and management development and appraisal.
- Development of the strong strategic narrative for staff to see a clear future for the organisation delivered by visible leaders.
- Enhance internal communication approaches to develop effective two-way communication.

In addition to our internal risks, there are a number of external factors that create uncertainty in the medium to long term. Many of these, such as the impact of the 2015 general election of NHS policy, the continued challenge of growing NHS demand driven

by demographic growth, patient expectations and technological advances and the economic environment of static or shrinking financial resources, are relevant to NHS providers as a whole. There are however several external risks that have a particular relevance to the Royal Orthopaedic Hospital. These include:

- Proposed changes to specialist service commissioning, which could include the consolidation of specialist services to a smaller number of specialist centres and/or the creation of hub and spoke arrangements for specialist care. The Trust continues to work closely with NHS England and the Specialist Orthopaedic Alliance to ensure that the issues facing single specialty services are fully understand and accounted for in any commissioning policies.
- Local commissioning priorities aimed at developing and expanding primary care services and addressing the key pressures around urgent and integrated care. The Trust recognises that a number of the current NHS pressures and priorities lie away from day to day elective care, and we are working with commissioners and other stakeholders as part of the development of our 5 year strategy to ensure that the benefits that we can offer to supporting the full pathway of musculoskeletal and orthopaedic care, and in releasing capacity in secondary providers facing urgent care pressures, is fully understood.

Jo Chambers
Chief Executive

23rd May 2014

The Royal Orthopaedic Hospital NHS

NHS Foundation Trust

Quality

Integrity

Leadership

Innovation

Partnership

Quality Account and Report 2013/14

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1.0 Our Commitment

TO CONTINUAL QUALITY IMPROVEMENT

1.1 Our Vision

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

In 2013/14, the Trust continued to embed and further develop its strategy for the organisation that is built around quality and excellence in all that we do.

In 2014/15 we will strive to be an organisation with:

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

We will…

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

"I'm very, very pleased with the service I've received on this and other visits."
Patient Feedback noted during CQC Inspection January 2014

Our Values

QUALITY | INTEGRITY | LEADERSHIP | INNOVATION | PARTNERSHIP

As an organisation we are committed to improving the quality and safety of our services for all of our patients and staff and we shall develop the values previously set to help us meet the needs of the future. These values are:

- Quality
- Integrity
- Leadership
- Innovation
- Partnership

During the last quarter of the year we have undertaken work to refresh the Trust's strategy and staff from all areas of the workforce have contributed to this.

1.2 Putting systems in place to give assurances

PATIENT SAFETY IS AT THE CENTRE OF EVERYTHING WE DO

The Trust renewed its commitment to quality patient care through evaluating and further developing its governance structure. The Clinical Governance Committee (CGC) looks in detail at a range of quality issues and key indicators are reviewed by the Board at each meeting with quarterly declarations on quality being supported by a statement from the CGC. Executive committees with responsibility for quality matters report to CGC 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. The Board will hear patient stories from April 2014.

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

1.3 Visibility of the Executive Team

The interim and new Chief Executive continued monthly drop in sessions as an opportunity for staff to meet with him/her on a one to one basis. These are confidential and staff are able to bring any issues they wish to those meetings.

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

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

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

The Project Management Office (PMO) has developed through the year into The Clinical Programme Board (CPB) which oversees the delivery of a wide range of quality and efficiency programmes and is another forum where the senior team meet with frontline staff; both within the CPB meeting structure and also as part of the walkabouts to track the progress of projects that are underway.

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

1.4 Chief Executive's Statement of Quality

I joined the trust in late 2013 and am pleased to support the strong focus on quality set by my predecessors. Quality is something that has to be seen through the eyes of our patients. As individuals, each only sees what happens to themselves. So, while it is hugely encouraging to see a high quality of standards being met across a range of indicators, I recognise that every time we fail to achieve the highest standard, we have adversely affected the quality of a patient's experience and lost an advocate for our service.

In many NHS organisations, we are diligently discussing the recommendations for good practice following the unacceptable failures at Mid-Staffordshire Hospital, but here at ROH we like to think that we take these recommendations to heart by really challenging ourselves on the things we seem to repeatedly get wrong. Attention to pressure ulcers and falls is essential in an orthopaedic hospital and I was delighted to hear these things discussed case by case at Board level with real challenge if similar issues arose more than once. The discussions of incidents and risk management always focus on patient impact and I will strive to maintain high quality patient care as our core raison d'etre.

As a new member of staff I have been pleased to see the focus on patient care at induction and my visits to wards and theatres serve to demonstrate the culture in action. It is also fair to say that staff are proud to get great feedback from external visits and feel crestfallen at any lapses unearthed. Rather than consider any remedial work a burden, they take every chance to share new and better ways of doing things.

Over the next year I look forward to supporting staff with the introduction of better IT systems and e-prescribing as we know these mitigate risk. Leadership development and more outward –looking activities will help strengthen our loyal workforce and expose them to even better practice developed elsewhere.

I feel sure that, from Board to Ward, as we evolve our strategy around the needs of the patient, our quality will rise and serve to differentiate still further from other trusts. Already the vast majority of our patients would recommend us and many draw comparisons with other trusts that help us define the characteristics in us that they value. We will do our best to retain those identifying factors, to listen to their views and respond and to improve the ways we communicate with them to explain our service.

Our research and innovation will bring better treatment for them, our focus on outcomes will help ensure we bring added value to their care and our well-trained staff will bring them compassion and lead to great satisfaction.

To the best of my knowledge the information in this document is accurate

Jo Chambers

2.0 Priorities for improvement and statements of assurance form the board

2.1 Priorities for improvement

The following tables show how we have performed against the quality improvement priorities for 2013/14 with further information available in Part 3. Unless otherwise stated information in sections two has been taken from internal trust sources.

Table 2 – Progress against quality improvement priorities for 2013 / 14

Achieved	
Improvement priority	**Performance**
SAFETY	
95% of patients will be assessed for risk of venous thrombo-embolism	Target > 95% Achieved at year end, some inconsistency experienced earlier in the year as a result of administrative processes, corrected from Autumn 2013.
% prevalence of falls with harm is less than 2.5% as reported via Safety Thermometer	Falls with harm less than 2.5% Achieved, 0% Falls with Harm as reported by Safety Thermometer
To ensure all actions from all SIRI's are completed within agreed timescale	Target 100% actions completed Achieved
EFFECTIVENESS	
To reduce the number of avoidable pressure ulcers from 34 to 23 with no avoidable grade 3 or 4 pressure ulcers	Target avoidable 23 and no avoidable grade ¾ Achieved, 22 avoidable pressure ulcers Unachieved, avoidable grade 3 ulcers One grade 4 ulcer avoidable

To reduce the length of time patients are starved before surgery to less than 10 hours	Target less than 10 hours starvation, and clinically appropriate Partially achieved, Fluid fasting 7hours and 17 minutes and Diet fasting 13 hours and 36 minutes
To reduce 30 day surgical site infection rate from 1.9% to 1.5% for primary hips and 4.9% to 4.5% for primary knees	Target 30 day SSI rate - Primary Hips 1.5% 30 day & Primary Knees 4.5% Achieved Primary Hips 1.3% and Primary Knees 3.1%
EXPERIENCE	
A reduction in PALS contacts relating to appointments from 104 in Q4 2012/13 to less than 50 in Q4 of 2013/14	Target Q4 2013/14 less than 50 Achieved 46
To improve waiting times in OPD, setting a baseline in Q1 with an improvement target to deliver in Q4	Target improved waiting times in Q4 Quarter 1 baseline 47, Quarter 4 result 86 Achieved Based on Friends and Family methodology
To reduce the numbers of patients reporting in the national patient survey that the quality of food was poor to less than 12%	Target less than 12% of patients reporting poor food quality Achieved 10.10%

2.2 Quality Improvement Priorities for 2014 / 15

The table below identifies the improvement priorities for 2014/15, the rationale for selection and how we propose measuring, monitoring and reporting. The priorities have been considered by staff, patients and stakeholders. We believe the priorities are based on providing an excellent quality of Orthopaedic care.

PRIORITIES	RATIONALE	MEASURING, MONITORING AND REPORTING
1. SAFETY		
To improve medicine safety awareness through incident reporting of harm/potential harm	To build on increased reporting encouraged in 2013/14 To encourage culture of candour and openness	NPSA alert action plan Patient Quality Report Reporting to Executive Management Team, Clinical Governance Committee to Trust Board
More than 95% of patients will be assessed for risk of VTE	2013/14 achievement demonstrated since autumn 2013, evidence of robust ongoing achievement required	Enhanced data collection Reporting to Clinical Governance Committee and Executive Management Committee to Trust Board
To ensure actions from SIRI's are demonstrated in clinical practice	Developmental step following 2013/14 QIP of SIRI actions to be completed within timescales	Monthly spot check audits of completed SIRI action plans during the specific quarter. Reporting to Clinical Governance Committee
2. EFFECTIVENESS		
To be compliant with National Joint Registry standards of consent and reporting	Challenges were experienced during 2013/14 in achieving both aspects of NJR consistently	Current method with increased scrutiny and robust reporting to Executive Management Team and Clinical Governance Committee to Trust Board
To achieve consistent compliance with WHO checklist	Maintain high profile of steps to safe surgery	Current method reporting to Executive Management Team to Trust Board
To increase results for Q39 of the CQC National Patient Survey, Do you think hospital staff did everything to	The 2013 survey results are 8.1, a decrease from 9.0 in 2012. Best national performance is 9.3	Monthly pain control audit Matron Care Quality Rounds Senior Sister supervisory time Reporting to Clinical Governance

control your pain?		Committee and Executive Management Team to Trust Board
3. EXPERIENCE		
To increase the results for Q23 CQC National Patient Survey, Did you get enough help from staff to eat your meals?	The 2013 survey results are 7.9, an increase from 7.2 in 2012. Best national performance is 9.4	Matron Care Quality Rounds Nutritional monthly audits Protected mealtime audits Reporting to Executive Management Team and Clinical Governance Committee to Trust Board
To ensure the patient journey through the organisation for surgical interventions is considered with areas of best practice shared and opportunities for development addressed	Aligned to the new 2014/15 CQUIN scheme following patient journeys Trust Board patient stories	CQUIN scheme reporting to Executive Management Team and Clinical Governance Committee to Trust Board
To reduce the length of time patients are starved before surgery to less than 10 hours	The Trust has not achieved this improvement priority in the previous two years and it is important to both safety and experience to reduce starvation times Target less than 10 hours starvation, and clinically appropriate	Nutritional audits Patient satisfaction Matron Care Quality Rounds Reporting to Clinical Governance Committee

2.2 Statements of assurance from the Trust Board

2.2.1 During 2013/2014 The Royal Orthopaedic Hospital NHS Foundation Trust provided four NHS services (trauma and orthopaedic, neurosurgery, pain management and general medicine).

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

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

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

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

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

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

- The Trust has been involved in a number of external reviews undertaken by commissioner led unannounced inspection. Whilst each review provided some assurance they also identified areas for further work that are being addressed within the organisation. For example during an unannounced visit exploring medicine safety to our High Dependency Unit both adult and paediatric medicine was noted to be stored together, this was corrected on the day of the visit.

- In June 2013 the Trust was inspected by the Care Quality Commission in to relation to Management of medicine and in January 2014 for the Care and welfare of people who us services, Safeguarding people who use services, Supporting workers and Assessing and monitoring the quality of service provision within the Essential Standards of Quality framework. The two inspections identified that the Trust met the all the requirements of outcomes, which is an improvement from the minor concerns noted during the previous inspection in the financial year 2012/13. The CQC Essential standards continue to be reviewed internally and transitional work has been undertaken to align to the new CQC domains.

- The monthly Patient Quality report to Trust Board and Executive Management Team has been developed to encompass the range of patient experience, safety and outcomes standards.

- The Clinical Governance Committee reviews the quality governance framework on a quarterly basis. Internal audit also conducted advisory work.

- Patient stories are to be re-introduced at Board meetings to share directly with Board members the experiences of our patients to ensure these are at the forefront of our minds when making decisions about the organisation. Patient stories are currently reviewed at the Nurse Leaders Forum.

- The Board Assurance Framework was been re visited in summer 2013 and highlights the key risks to the organisation which are reviewed monthly at Board and supported by executive members and the devolved Board committees, for example CGC.

The income generated by the NHS services reviewed in 2013/14 represents 93% of the total income generated from the provision of NHS services by The Royal Orthopaedic Hospital NHS Foundation Trust for 2013/14.

2.2.2 Participation in Clinical Audit

During 2013/14 4 national clinical audits and no national confidential enquiries covered NHS services that The Royal Orthopaedic Hospital NHS Foundation Trust provides. During 2013/4 The Royal Orthopaedic Hospital NHS Foundation Trust participated in 3 national clinical audits (75%) and no national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and the national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2013/14 were:

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

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

Audit	Participation	% Cases submitted
NJR	Yes	92% submitted. 8% awaiting completion or submission.
PROMS	Yes	95.1% (estimated fig Apr 13-Mar 14) 93.7% (actual fig Apr-Sept 13.
Cardiac Arrest	Yes	100% eligible cases submitted.
Diabetes	No	New lead identified, and due to dates of audit, have registered to participate in calendar year 2014.)

The reports of these 4 national clinical audits were reviewed by the provider in 2013/2014 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The level of compliance with the NJR and PROMS has attained high levels this year. NJR data is now being used in performance appraisals of surgeons by clinical directors, and is now being reported monthly to EMT as part of the quality report. PROMS data has been reviewed at Clinical Governance Committee and has provided assurances regarding the quality of outcomes in hip and knee replacement. PROMS reports have shown that for 2012/13 the Trust is above the national average in all hips though not all knees. The 2013/14 trend data is not yet available due to the 6-month follow-up period.
- An escalation tool and escalation guidelines for deteriorating patients has been formally put together and is to be rolled out across the Trust.
- The NJR consent compliance has undergone an audit has been done which will be repeated in July 2014 to ensure continued improvement.

The reports of 51 local audits were reviewed by the provider in 2013/14 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- To continue the development and promotion of the audit database, also looking to include patients in audit, as well as form stronger links with quality improvement.
- To continue to improve and re-audit the review of venous thrombo-embolism (blood clot) risk assessments carried out and the frequency in which they are done.
- To ensure all staff as well as patients and relatives are aware of the importance of plaster care instructions.
- Improve compliance of dementia assessments (for emergency admissions aged 75 years and over) through communication with various staff groups, and include those over 65.
- Continue improvement in prescribing practice as per Medicines policy. Improve compliance with recording of omitted doses. Spot checks of drug charts and other areas relating to medicines safety/management.
- Continue to educate staff in plaster management, improve documentation, and compare practice at other trusts and pre-operative education especially with high risk groups.
- To look at how to reduce post-operative urinary retention, following the recent audit, for instance pre-operative counselling, and prophylactic urinary catheterisation in theatres for males under 50.
- Outpatient hand service satisfaction audit showed improvement targets needed in referral delays, appointment delay in clinic, therapy capacity, x-ray delays.
- To continue to monitor and review quality control testing of blood glucose tests. There have been big improvements and areas which had poor compliance at the last audit have greatly improved. No areas below 50% for quality control checking. All managers advised to note results and issues from previous audits, and ensure all staff using Performa blood glucose meters have completed the mandatory 2 yearly training.
- Continue to feedback results of re-audits of switchboard response times to the head of the switchboard service, as the recent re-audit showed little change in response times to the last audit in 2010.
- To highlight the audit done into medication incidents in HDU and various actions highlighted to staff, including knowing the medicines policy, double and triple checking drugs, checking with the doctors and teams, the importance of documentation, incident reporting any errors.
- In terms of management of peri-operative temperature, the following needs to be re-audited: documentation of pre-operative temperature, documentation of warming of IV fluid, warming of irrigation fluid, temperature monitoring during the intra-operative process, regular monitoring of temperature in the recovery unit.
- An audit of need for revision of pedicle screws following posterior instrumented fusion, has brought out the following recommendations: review CT imaging of patients who had post-operative CT imaging of the spine following posterior instrumented fusion to gain a better insight into the incidence of pedicle screw malposition, although this must be tempered by selection bias of the need for a scan post-operatively.
- Following an audit on epidural steroid injections for lower back pain, it was suggested this be re-audited with a larger sample size to see if type of delivery method makes a

significant difference, and also to look at patients with Lower Back Pain +/- radiculopathy – this needs re-audit to see the efficacy in the two groups.

- An audit into outcome following revision of metal-on-metal hip replacements for adverse reactions to metal debris has demonstrated a lower short-term complication and re-revision rate in patients undergoing revision arthroplasty for suspected adverse reaction to metal debris than previously reported in the literature. Longer-term follow-up studies for this group of patients are planned.
- Implement changes to letters to patients having local anaesthetic to ensure knowledge of starvation rules. To be re-audited with a new letter in place.
- A physiotherapy audit into hips will be analysed alongside PROMS and re-audited in 12 months. Recommendations include flagging external OPD physiotherapy requirement during Pre-Operative Assessment Clinic, creation of a protocol, minimum sessions and a standard regime.
- Audit of "Anaesthetic emergencies – Drugs and Equipment preparedness" showed a need for a Critical incident lead to co-ordinate all relevant staff and areas, safe drills/Simulation practice for all relevant staff, to improve awareness & knowledge. To be re-audited in 6 months' time.
- Following an audit on paediatric lists, recommendations were made for an increase in dedicated paediatric lists.
- Foot and ankle team audit showed that clinic resources should be planned appropriately or patient numbers reduced to allow clinics to be completed within the allotted 4 hour session.
- An audit assessing the new prescription chart to ensure it is filled out accurately and also that the prescriptions follow the guidelines, especially thrombosis and antibiotics prophylaxis, led to changes on the chart as a result. The audit tool used colour coding to highlight the areas of concern, and this was disseminated among the medical staff. The drug chart will be re-audited following these changes.
- WHO: review of the audit process highlighted a need for improvements and the method of audit changed to reflect the compliance with WHO checklists within the operating environment. Full compliance of 100% completed checklists has been achieved in February. There have been additional actions following the January Report which include a staff awareness raising session at TBALD focusing on patient safety, regular review meetings with Team Leaders to share data and to reinforce the process, and spot checks being performed whilst the patient is in theatre.
- Audits continue and are continually assessed in key areas of infection control, falls, VTE, medicines adherence, nutrition and pressure ulcers to ensure a robust knowledge of processes and those patients are being monitored appropriately. These areas are regularly reported to EMT.
- The Trust has reached agreement from the Commissioners to commence the use of The Infection Prevention Society (IPS) Quality Improvement Tools (QIT) which are specific and evidence based which will elicit clearer and more beneficial information regarding environmental and practical standards throughout the Trust. The new tools will be used from April 2014.

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

2.2.3 Participation in clinical research

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

The number of patients receiving NHS services provided by The Royal Orthopaedic Hospital NHS Foundation Trust in 2013/2014 that were recruited during that period to participate in research approved by a research ethics committee was 1057.

The Royal Orthopaedic Hospital NHS Foundation Trust was involved in conducting 65 clinical research studies in orthopaedics during 2013/14. 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 51 clinical staff participating in research approved by a Research Ethics Committee at The Royal Orthopaedic Hospital NHS Foundation Trust during 2013/14. These staff participated in research covering 7 sub -specialties.

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

There have been 35 publications generated from other research activity during this period (appendix 1).

2.2.4 Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of The Royal Orthopaedic Hospital NHS Foundation Trust's income in 2013/2014 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 2013/14 was £1.580 million. The payment made to the Trust was £1.560 million, an achievement of 98.7% of the total potential value. Highlighted font to be confirmed based on predictive outcome at time of writing.

Further details of the agreed goals for 2014/2015 are available on request from the Trust's Head of Commissioning, Gareth Hyland, Gareth.Hyland@nhs.net.com)

2.2.5 Statements from the Care Quality Commission

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

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

The Care Quality Commission has not taken any enforcement action against The Royal Orthopaedic NHS Foundation Trust during 2013/2014.

2.2.7 Care Quality Commission Reviews

The Royal Orthopaedic Hospital NHS Foundation Trust has participated in two routine inspections by the Care Quality Commission relating to the following areas:-

June 2013 for the Management of Medicine, and

January 2014 for the Care and welfare of people who us services, Safeguarding people who use services, Supporting workers, Assessing and monitoring the quality of service provision.

The Royal Orthopaedic Hospital NHS Foundation Trust was found compliant in all areas and is committed to maintaining this standard in 2014/15.

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

2.2.8 NHS Number and General Medical Practice Code Validity

The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 2013/2014 Secondary Uses Service for inclusion in Hospital Episode Statistics which are published in the Data Quality Dashboard from HSCIC. The percentage of records in the published data:-

- which included the patients' valid NHS Number was:

- 99.5% for admitted patient care
- 99.8% for outpatient care

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

- 100% for admitted patient care
- 99.6% for outpatient care

The percentage of records in the published data:

In Patients April 2013 to March 2014

Total with NHS_Number	Total patients	Percentage
14345	14407	99.56965

Out Patients April 2013 to March 2014

Total with NHS_Number	Total patients	Percentage
92577	92678	99.89102

IP

all populated

693	default codes
14407	total records
13714	number of valid codes
95.18984	percentage

OP

all but one populated

122	default codes
1	not populated
92678	total records
99.86728	Percentage

The Royal Orthopaedic Hospital NHS Foundation Trust takes the following actions to monitor and improve data quality:-

To continue with regular data quality review undertaken by the Director of Operations with support from the finance, informatics and clinical teams. To address concerns identified through review, sharing learning through the Executive Management Team monthly meeting. Since the changes implemented in the previous financial year there has been a development of knowledge within local departments with the aim of getting data quality right first time.

2.2.9 Information Governance Assessment Report

The Trust's Information Governance Assessment Report overall score for 2013/14 was 74% and was graded satisfactory.

2.2.10 Payment by results clinical coding audits

The Trust was subjected to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatments coding (clinical coding) were:

Area	% error rate
Co morbidities and complications – sub chapter HB - Orthopaedic Non-Trauma Procedures	7.0
Local focus – TFC108 Spinal Surgery Service	4.0
Overall error rate	**5.5**

This performance would place the Trust better than average, but not in the top 25 per cent of trusts compared to last year's national performance.

These results should not be extrapolated further than the actual sample audited.

2.3 Reporting against core standards

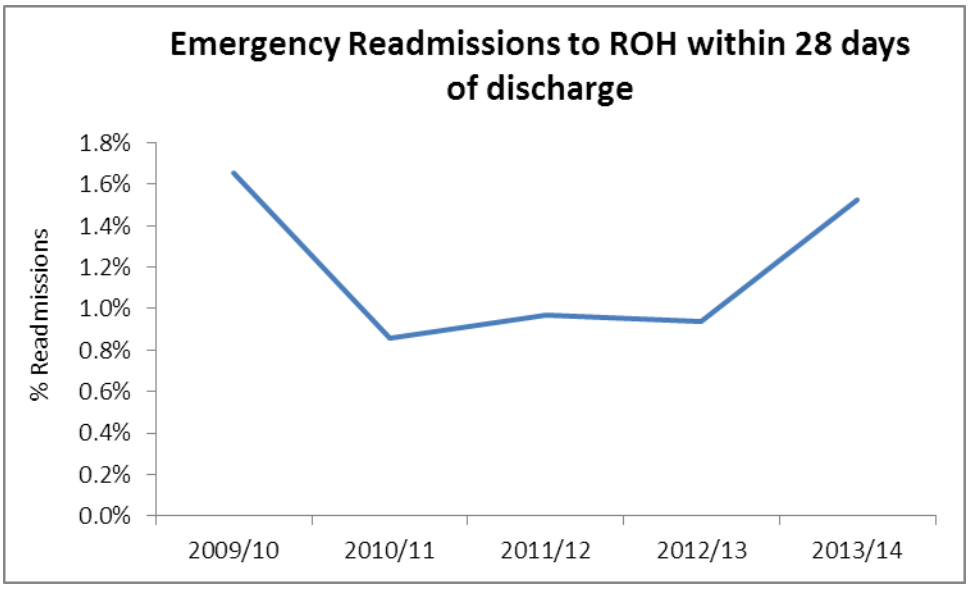
Summary Hospital-level Mortality Indictor

Specialist trusts, mental health trusts, community trusts and independent sector providers are excluded from the SHMI because there are important differences in the case-mix of patients and the SHMI has not been designed for these types of trusts. Health & Social Care Information Centre.

Patients readmitted to a hospital within 28 days of being discharged

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

Results



Emergency Readmissions to ROH within 28 days of discharge				
2009/10	2010/11	2011/12	2012/13	2013/14
1.66%	**0.86%**	**0.97%**	**0.94%**	**1.52**

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

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

Results Table

	Q1 2013-14	Q2 2013-14	Q3 2013-14	Q4 2013-14
ROH	**% : 94.74**	**% : 92.93**	**% : 96.53**	**%: 98.54**

In April 2013 the minimum requirement for assessment increased from 90 to 95% compliance monthly. This was initially a significant challenge as the Trust continues to rely on a paper based data collection system at a local department level. Including the VTE risk assessment form within the new Trust prescription chart helped us to improve completion compliance and made the collection of data simpler. In July and August 2013 the required 95% compliance target was not met, on analysis this was found to be due to certain new and temporary staff not being fully aware of the importance of the requirement and of accurate data collection. This was resolved by training and support. Whilst we await final data for quarter 4 as of middle of March 2014 compliance has been >98%.

Patient Reported Outcome Measures (PROMs)

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

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

Percentage of cases submitted is 95.1% (estimated fig Apr 13-Mar 14) and 93.7% (actual fig Apr-Sept 13).

This data is the latest available for the period April 2012 – March 2013.

Adjusted average Health Gain		
Primary Hip Replacements		
	Oxford Hip Score	Hip EQ5d
England	21.317	0.438
Royal Orthopaedic Hospital	21.719	0.452
Primary Knee Replacements		
	Oxford Knee Score	Knee EQ5d
England	16.01	0.319
Royal Orthopaedic Hospital	15.658	0.299

The Royal Orthopaedic Hospital NHS Foundation Trust intends to maintain a high focus on submitted cases and to monitor submitted case totals and EQ5d data through the Clinical Governance Committee.

Rate of Clostridium difficile Infection

The rate per 100,000 bed days of cases of Clostridium difficile infection that have occurred within the trust amongst patients aged 2 or over during the reporting period is tabled below:-

	April 2010 - March 2011	April 2011 - March 2012	April 2012 - March 2013	April 2013 - March 2014
The Royal Orthopaedic Hospital	**24.5**	**16.3**	**3.2**	**5.7**
All England Rate	**29.6**	**21.8**	**17.3**	**Not published at present**
Lowest England Rate	0	0	0	
Highest England Rate	71.8	51.7	30.8	

The Royal Orthopaedic Hospital NHS Foundation Trust considers these details as described for the following reason, the control of infection is of paramount importance for our patients and the Trust has continued to meet its targets with only 2 reportable case of Clostridium difficile during 2013-14 against a target of 2 cases. Both cases have been reviewed and deemed to be unavoidable.

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

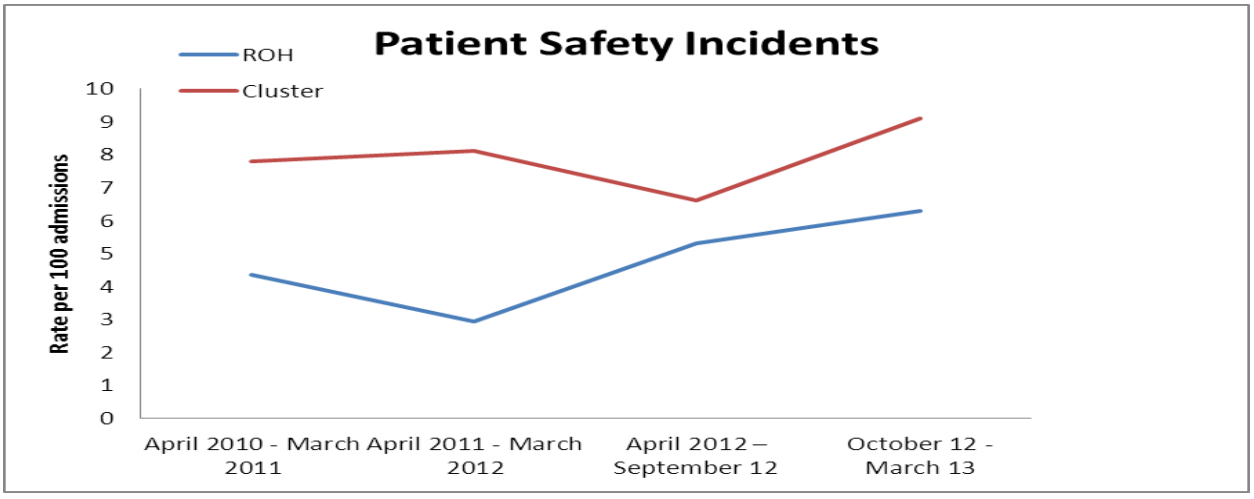
The Royal Orthopaedic Hospital NHS Foundation Trust intends to continue with its approach thereby sustaining this high standard of care.

Patient Safety incidents with severe harm/death

The National Reporting and Learning Service (NRLS) was established in 2003 and enables patient safety incident reports to be submitted to a national database on a voluntary basis designed to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all

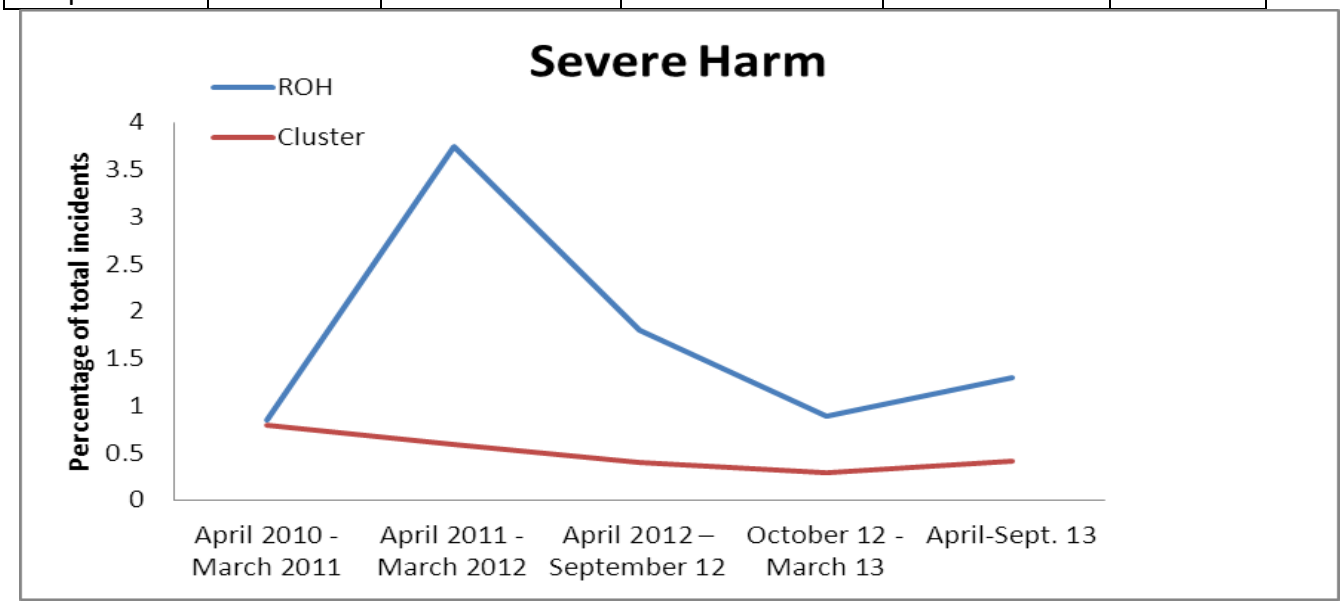
incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to report patient safety incidents under the NRLS's voluntary arrangements.

As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those 'resulting in severe harm or death', will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the Trusts as this may not be comparable. The next NRLS report will cover April-September 2013 but has been delayed until the end of the month. The October 13-March 14 data will not be released till later this year.



All Patient Safety Incidents	April 2010 - March 2011	April 2011 - March 2012	April 2012 – September 12	October 12 - March 13	April-Sept. 13
The Royal Orthopaedic Hospital rate (per 100	4.35	2.92	5.3	6.3	7.1

admissions) *					
Average Cluster Rate (per 100 admissions)	7.8	8.1	6.6	9.1	8.9
Lowest Cluster Rate (per 100 admissions)	1.67	2.7	1.37	3.8	3.69
Highest Cluster Rate (per 100 admissions)	24.5	20.48	24.88	31	27.88
Number of Patient Safety Incidents	**April 2010 - March 2011**	**April 2011 - March 2012**	**April 2012 – September 12**	**October 12 - March 13**	**April- Sept. 13**
The Royal Orthopaedic Hospital	678	452	381	456	474



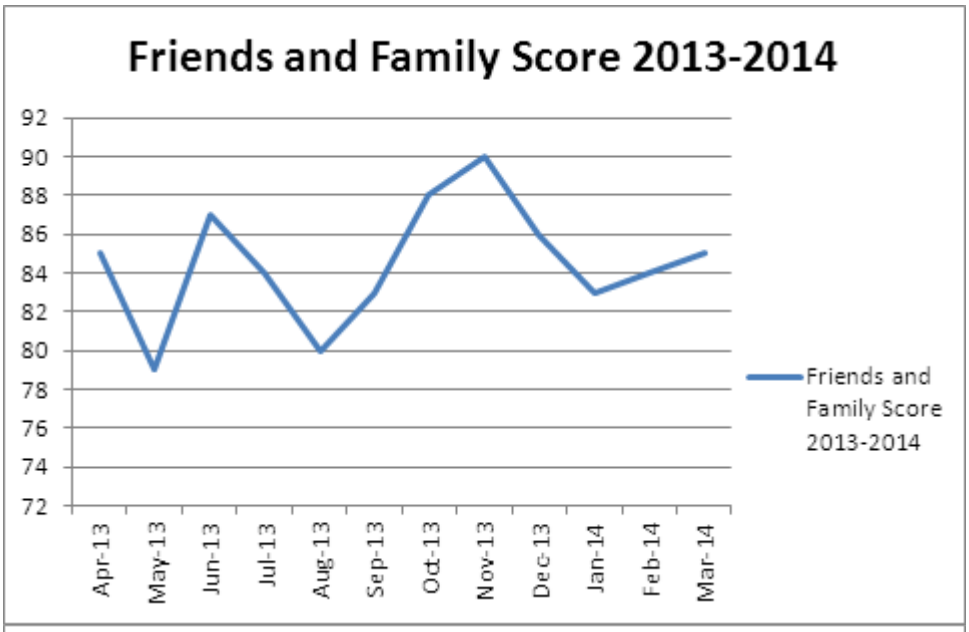
Severe Harm Incidents	April 2010 - March 2011	April 2011 - March 2012	April 2012 – September 12	October 12 - March 13
The Royal Orthopaedic Hospital rate (percentage of all PSI)	0.85	3.75	1.8	0.9
Average Cluster Rate (percentage of all PSI)	0.8	0.6	0.4	0.3
Lowest Cluster Rate (percentage of all PSI)	0	0	0	0
Highest Cluster Rate (percentage of all PSI)	3.1	2.9	1.8	1.8

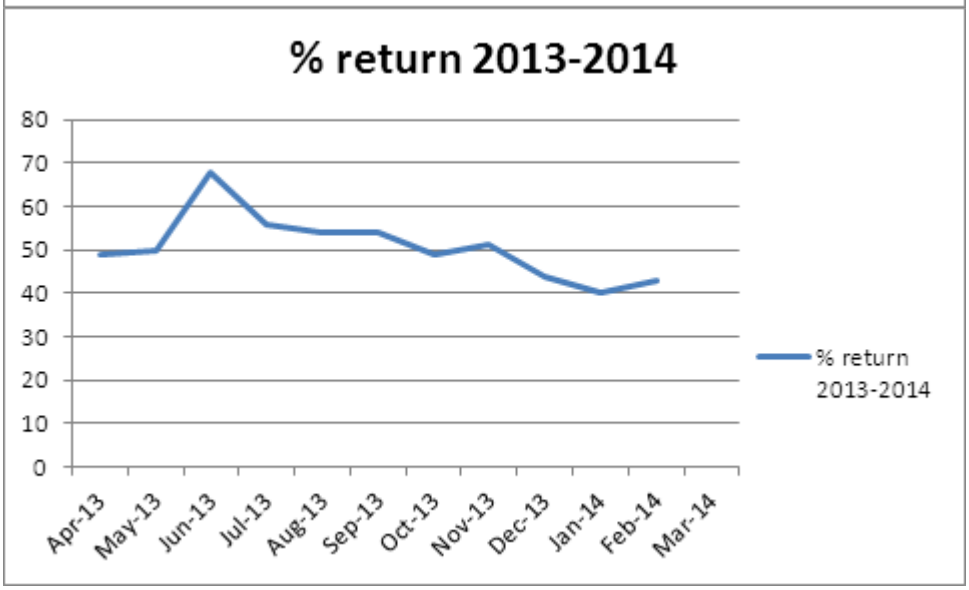
The Royal Orthopaedic Hospital NHS Foundation Trust intends to continue with its approach thereby sustaining this high standard of care through taking the following actions:

1) Regular reviews of serious harm incidents undertaken by the Governance Team and the Clinical Governance Committee.
2) The figures submitted to the NRLS are regularly reviewed to ensure all patient safety data has been submitted. There has also been extra care taken this year to ensure these are all sent off by the deadlines set by the NRLS which has led to an encouraging rise in incidents reported, more representative of the cluster group.
3) Staff training to ensure accurate grading of incidents continues and Governance is featured on staff mandatory training and inductions.
4) Random check audit of submitted incidents is undertaken to check if the actual degree of harm is being recorded accurately (instead of potential level of harm) and is a direct result of the patient safety incident, as an initial review indicates areas where accuracy can be improved.

Net Promoter Score (Friends and Family Test)

The Trust has remained one of the highest performing hospitals for FFT. Return rates have consistently remained above 40% and the additional information collected as free text has been fed back to wards and departments each month.





The Royal Orthopaedic Hospital NHS Foundation Trust considers this data is as described for the following reasons;
Generally patients felt that they had a very good experience at the hospital and would have been more than happy to recommend our services.

The Royal Orthopaedic Hospital NHS Foundation Trust intends continuing our focus on listening to our patients by ensuring high levels of customer and patient focused care are delivered in all departments of the organisation.

3 - Other information

Other information on how the Royal Orthopaedic Hospital NHS Foundation Trust focuses on the delivery of quality services to patients. Unless otherwise stated information in sections three has been taken from internal trust sources.

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 Board have recently discussed the principles of quality targets versus quality standards and whilst this may seem semantics of language, the consensus opinion is that the term 'standards' has greater value to our patient and service users. This theme of standards will be explored through stakeholder events through Spring 2014 leading the development of the organisation's five year strategy.

The focus for 2013/14 has been to continue to embed our culture of continual quality improvement within the new Clinical Directorates ensuring that the triumvirate teams at the head of each – Clinical Director, Matron and Directorate Manager – take ownership of the quality agenda and drive service culture and change. This team approach has been strengthened with the appointment of two new clinical leads within Theatres and Admissions and Day Case Unit and a matron post within the Clinical Support Services Directorate.

At Board level there have been changes, with a new Chief Executive, Director of Finance and Director of Nursing and Governance and the substantive appointment of the the Medical Director and after a successful period of time as interim Medical Director. The resignation of the Chairman in January 2014 has given one of our Non-Executive Directors the opportunity to undertake an interim role. Considering these changes to the Board we have continued to challenge ourselves, and others, on the decisions that we make, ensuring that we have come back every time to underpin our decisions with a view of what is right for the patient. The Board has received a Patient Quality Report each month which has been further developed in the last six months of the year to provide a comprehensive review of the experiences of our patients, both good and bad. In April 2014 the Board will re-commence hearing Patient Stories to hear first -hand how the service we provide impacts on our patients and their families.

Despite the financial and activity challenges faced in 2013/14 the quality of the service we provide to our patients has remained our key priority. The Executive team have led staff workshops to explore the meaning of the Francis Inquiry report recommendations for our organisation and a gap analysis has led to the development and implementation of the recommendations. This will continue into 2014/15. The Board has received papers and participated in the first of a new series of workshops to reflect the

recommendations from the Francis Inquiry report and 'Hard Truths', the government's response. The Board agree that we should not respond to the recommendations per se, rather we strive to embed the learning into what we do every day for the benefit of our patients, carers and staff.

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

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

We set a range of priorities for 2013/14 that were agreed by the Board and staff, patient and public stakeholders as important areas to focus on. The following tables show how we have performed against those priorities.

3.1 Progress against Quality improvement priorities for 2013/134

Achieved		
Improvement priority	**Performance**	
SAFETY		
95% of patients will be assessed for risk of venous thrombo-embolism	Target > 95% Achieved	2012/13 Achieved 92% against target of 90%
% prevalence of falls with harm is less than 2.5% as reported via Safety Thermometer	Falls with harm less than 2.5% Achieved	2012/13 Not assessed
To ensure all actions from all SIRI's are completed within agreed timescale	Target 100% actions completed Achieved	2012/13 Not achieved-monitoring via Ulysses (computerised system) started in March 2013
EFFECTIVENESS		
To reduce the number of avoidable pressure ulcers from 34 to 23 with no avoidable grade 3 or 4 pressure ulcers	Achieved Target avoidable 23 Unachieved no avoidable grade ¾	2012/13 To reduce the number of grade3/4 pressure ulcers by 30% Achieved
To reduce the length of time patients are starved before surgery to less than	Target less than 10 hours starvation, and clinically	2012/13 Not achieved (13.5

10 hours	appropriate Partially achieved, Fluid fasting 7hours and 17 minutes and Diet fasting 13 hours and 36 minutes	hours), a small improvement on 2011/12
To reduce 30 day surgical site infection rate from 1.9% to 1.5% for primary hips and 4.9% to 4.5% for primary knees	Target 30 day SSI rate - Primary Hips 1.5% 30 day & Primary Knees 4.5% Achieved Primary Hips 1.3% and Primary Knees 3.1%	2012/13 Not assessed
EXPERIENCE		
A reduction in PALS contacts relating to appointments from 104 in Q4 2012/13 to less than 50 in Q4 of 2013/14	Target Q4 2013/14 less than 50 Achieved	2012/13 Not assessed
To improve waiting times in OPD, setting a baseline in Q1 with an improvement target to deliver in Q4	Target improved waiting times in Q4 Achieved	2012/13 Not assessed
To reduce the numbers of patients reporting in the national patient survey that the quality of food was poor to less than 12%	Target less than 12% of patients reporting poor food quality Achieved 10.10%	2012/13 Not achieved (12.8%) although this represents and improvement from 2011/12

Data sourced from Corporate Performance Report or Patient Quality Report

3.3 Clinical Programme Board

The Clinical Programme Board (CPB) has evolved from the Programme Management Office (PMO) during 2013/14 and continues to involve staff in change projects, helping staff from all levels and disciplines to work together to create innovative solutions to improving quality whilst reducing cost.

Innovation within each of the projects has largely been driven by ideas from frontline staff. Through listening to the knowledge and experience of front line staff, critical aspects of each project have been modified to incorporate efficiency or service improvements. The benefits therefore come from the staff that see real change the most. Often efficiency savings regularly go hand in hand with improved patient care, through delivering the best experience first time.

Quality has always remained the key aspect of every project, with quality impact assessments undertaken for each scheme. ROH has built on the success of the PMO/CPB for another full financial year and it is apparent that good results have been achieved directly as a result of operating such an approach. This has been supported by the continuing high level of hospital wide patient satisfaction seen within the real time patient surveys, and the improved satisfaction levels seen within project areas.

With strong backing from the Board, the CPB has evolved, incorporating more specific projects and creating time for our team to be focused on the delivery. The success of delivery, and support to overcome challenges, is monitored through the Executive Management Team and the Board on a monthly basis.

3.3 Building for the Future

The summer of 2013 saw the opening of the new Admissions and Day Case (ADCU) facility, a project that combined the old Admissions facility and Day Case Unit. ADCU accommodates 20 patients in chairs or on a trolley. The construction works included development to the original main outpatients department and the building known as the Octagon as its main entrance where all patients will be welcomed and received. The new department is co-located with our existing Theatre complex so patients requiring an operation only have to travel a short distance to Theatres.

In December 2013 Ward 11 the Paediatric Inpatient, Day Case and Outpatients unit temporarily relocated to alternative locations to enable essential upgrade works to be completed. The works will modernise the outdated facilities, provide much needed play

space for our younger patients and greater privacy and dignity for our young patients and their families during their hospital stay. The new unit is planned to reopen in June 2014. During the CQC visit in January 2014 the development plans, temporary locations and patient/families views were sought with positive feedback received by the organisation from the inspectors and a fully compliant rating applied to these services which is an improvement on the visit of 2013 when minor concerns were noted.

3.4 Putting Patients First

The Board continues to be committed to putting patients first. At every public Board meeting the Patient Quality report is presented which prompts debate about how to improve processes and process design such that earlier mistakes are learnt from and mitigated.

PALS and Complaints, Patient Experience and Patient Information are part of Public and Patient Services Department. This allows the Trust to identify areas of good practice in real time and share this quickly across all areas. In an effort to continually improve its service to patients the Trust asks complainants to comment on their experience of complaint handling and in 2013/14 this showed sustained improvement in the satisfaction with complaint responses and the quality of the service provided. The management of complaints was reviewed by the CQC during the unannounced inspection in January 2014, no concerns were noted and good practice of personally making contact with and agreeing timescales with complainants was noted. Complaints staff are reported as helpful and professional and many complainants reported that they would feel confident in complaining again if they felt the need to do so. The department is continuing to work on improving the internal processes for complaint handling to ensure that the quality improvements made are sustained and continue and during 2014/15 we aim to devolve complaints handling to the directorate teams to embed local ownership.

The Department has led the Net Promoter, Friends and Family, Test for the organisation and is proud of its achievements in this area.

The hospital continues to perform well in the National Inpatient Survey and monitors continuously via action plans and real time surveys any areas for improvement.

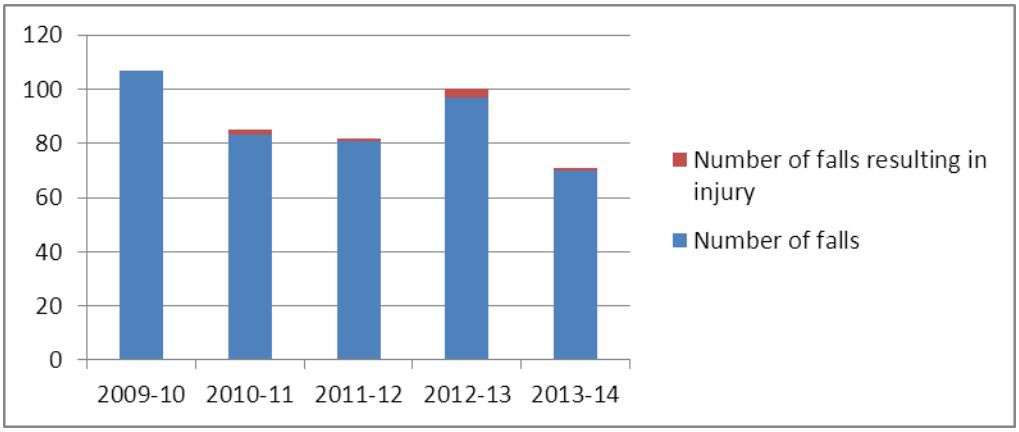
3.5 Patient falls

At the ROH we continue to develop strategies to reduce potential harm to patients who may fall during their stay in hospital.

The falls working group, including representation from all members of the multi-disciplinary team as well as a patient representative, have continued to meet through the year and have made progress against the action plan. The monthly Patient Quality report provides information on falls risk assessment, falls incidents and investigations, recognises good practice and notes areas for improvement. As a number of falls have occurred within bathroom areas of inpatient wards a new campaign has been designed to raise staff, patient and carer awareness.

This year we have had 70 patient falls which is a decrease of 28% from last year. We are mindful that within an organisation that encourages patients to regain mobility and independence as soon as possible this may result in some patients sustaining a fall. However, from the Trust Board to the frontline staff delivering care, we are all committed to ensuring that strategies are in place to reduce the risk and to ensure that all falls are reported and monitored. The falls questionnaire, which is part of our incident reporting system, continues to be of use providing accurate and more detailed data that will enable us to identify themes or patterns which need to be addressed.

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



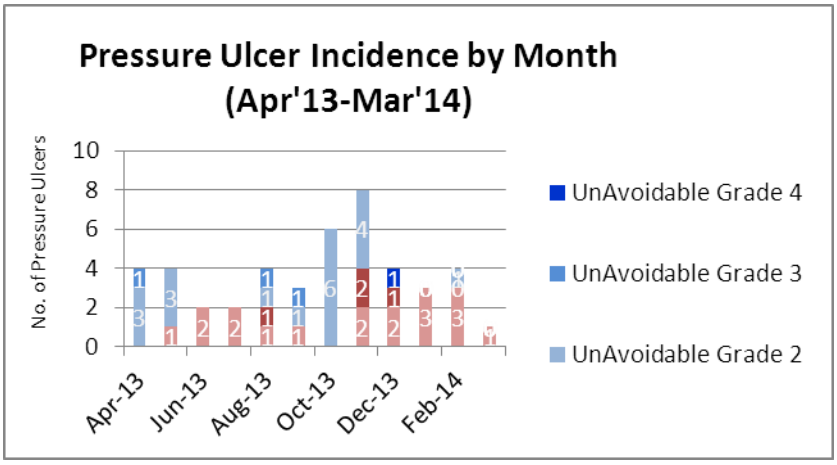
Our key quality indicators have been achieved successfully, with 93% of all falls risk assessments being completed within 6 hours of admission and 96% of all high risk patients having a care plan in place.

3.6 Pressure ulcer prevention

The Tissue Viability team have worked very hard to procure new equipment and to provide training across all areas in order to assist with prevention, early detection and appropriate interventions. Avoidable and unavoidable pressure ulceration is reported within the Patient Quality report to Board with a summary of the incidences of the

month and the cumulative incidence of the year. Much has been achieved by the Tissue Viability team and all clinical staff involved over previous years enabling us to reduce harm caused to our patients from pressure ulcers however there is more work to do.

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



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

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

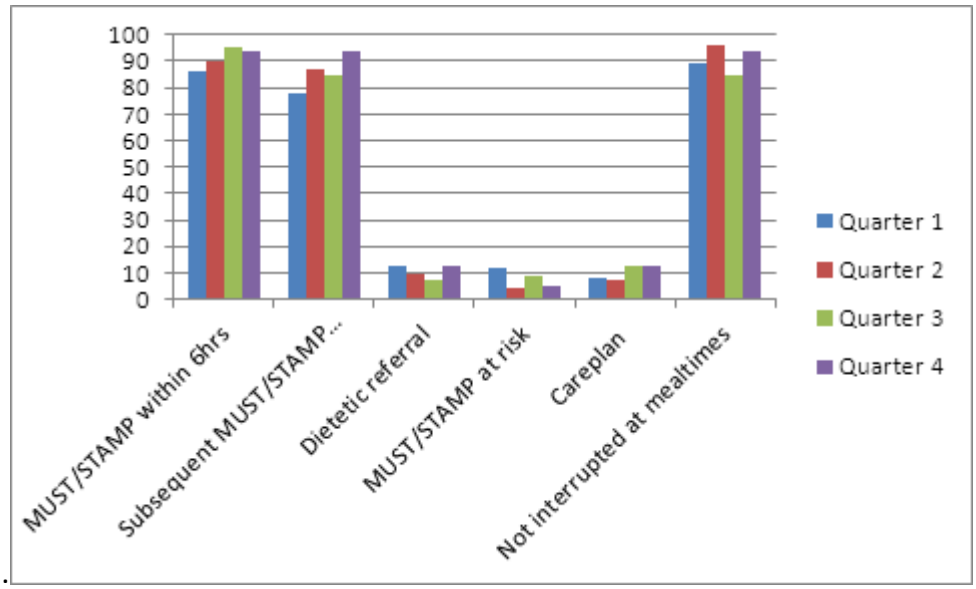
The Tissue viability link nurses audit their own ward area every quarter and from this data they can then identify areas they need to improve upon.

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

3.7 Nutrition

For our organisation ensuring the nutritional needs of our patients is met is a vital element of patient care that impacts on many outcomes for our patients; from healing

after surgery to their experience of their time with us. Quarterly audits are undertaken by our link nurses, with the following results



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

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

Mandatory training sessions once a month for both clinical staff also cover fasting guidance and recent audit results.

We have continued to review fasting times and the opening of the new Admissions and Day Case Unit has helped to support clinically appropriate fasting times. This will remain a focus of quality care in the coming year as there is still work to do to improve this whilst ensuring patients are fasted appropriately before they undergo surgery. The work undertaken, review of the menus and kitchen practice, as part of a project with the TV Chef James Martin continues and the hospital was re visited by the film production company in Autumn 2013. The kitchen staff led by the new Chef, continue to be committed to ongoing improvements to the menus and content of the meals; food delivery and ordering processes have also been reviewed and changed in order to improve the patient experience relating to food.

3.8 Healthcare acquired infections

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

We have not had any hospital acquired MRSA bloodstream infection since May 2008, and continue to see a decrease in the number of cases of *Clostridium difficile* which remain in single figures for the 6th year running. This year we have reported 2 cases against a target of 2 (2012/13 target was 6). Each case is closely scrutinised, with lessons shared and avoidable/unavoidable status confirmed. We head into 2014/15 with a target of no cases of avoidable *Clostridium difficile.*

Antimicrobial prescribing and hand hygiene standards remain under the spotlight through monthly reports to the Executive Management Team and Board with the Trusts overall hand hygiene compliance remaining above 90% throughout the year.

The wound helpline set up in 2011, continues to offer a post discharge service to all ROH patients and remains very well utilised. Rather than visit their GP we are able to give advice or review patients in person, often on the same day should they have a concern about their wound following surgery.

3.8.1 Bone Infection Unit

The Bone Infection Unit (BIU), permanently founded in March 2012, continues to provide an excellent platform for close monitoring and supervision of a group of patients with complex needs. Such patients have often already undergone several or even many) years of treatment in other hospitals before referral to the ROH. In the past these patients would have required an inpatient stay of many weeks but are now able to go home much earlier and receive care on an outpatient basis.

Our multi-disciplinary team includes tissue viability, consultant microbiologist, consultant orthopaedic surgeon, infection control specialist nurses and pharmacists. The patients have open access to the team and we also utilise the Royal Orthopaedic Community Scheme (ROCS) to undertake nursing and physiotherapy in the patient's own home. The BIU has seen an average of 11 new patients per month in 2013/14.

Antimicrobial prescribing is closely monitored through the Infection Control and Drugs and Therapeutics Committees, with all complex requirements managed through the BIU

to ensure patients receive close supervision and support throughout their course of therapy.

3.8.2 Surgical site Infection

Surgical Site Infection (SSI) surveillance is an intrinsic part of our everyday work and we collect and analyse vast quantities of data regarding our patient's outcome constantly. All joint replacements are monitored for 30 days as a minimum. The Infection Prevention and Control service was joined in quarter 4 2013/14 by an Epidemiological Data and Information Analyst, this is an important role for such a service and will provide the organisation with valuable data to develop and enhance our quality of patient care.

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

SSI Rate	2009	2010	2011	2012	2013	% Change from 09-13
Primary Hips	3.5%	4.4%	2.9%	2.4%	1.3%	-64.9%
Primary Knees	7.9%	6.4%	7.0%	5.2%	3.1%	-64.6%
No. of SSI	**2009**	**2010**	**2011**	**2012**	**2013**	
Primary Hips	37	44	33	26	13	-
Primary Knees	65	52	61	41	23	-
No. of Procedures	**2009**	**2010**	**2011**	**2012**	**2013**	
Primary Hips	1068	1004	1123	1074	1017	-
Primary Knees	821	808	873	793	751	-

SSI Rate	Year	SSI Rate per 100 procedures	LCL	UCL		
Primary Hips	2009	3.5	*2.5*	*4.7*		
	2013	1.3	*0.7*	*2.2*		
Primary Knees	2009	7.9	*6.3*	*10.0*		
	2013	3.1	*2.0*	*4.6*		

In the 2012/13 Quality Account reference was made to the 'bundle' approach, i.e. changing several things at the same time all of which are shown to be effective

individually but together seem to offer even greater benefits. A standardised approach to some of the critical parts of the surgical pathway for our patients has been introduced this year and we have been monitoring the impact of this throughout the year. Educational activities continue to raise awareness of best practice across all our staff groups and an expert panel event was held in March 2014 to debate consensus approaches. We aim to continue to build on the success to date in the coming year.

3.9 Ensuring the privacy and dignity of our patients

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

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

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

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

3.10 Safeguarding

Building on the additional resources allocated to Safeguarding (adult), in 2012/13, to strengthen training, provide better links with external agencies and to deliver the recommendations from the peer review we achieved a fully compliant rating by the CQC during the January 2014 inspection. The Combined Paediatrics and Adult Safeguarding committees have continued to meet regularly throughout the year.

Documentation packs for supplementary records, formulated for roll out in the Trust following staff education and training, continues. Our staff have attended financial abuse and Mental Capacity Act training.

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

The Trust works in partnership with Birmingham Safeguarding Board and representation and feedback given for the organisation at regional Prevent Forum, in relation to training and delivery of new formats.

We have worked in partnership with Health Facilitation Team to raise staff awareness and offer signposting for care of those who are learning disabled.

A Trust representative attends the Learning and Disabilities forum to ensure best practice is applied in our care and learning. The Trust action plan has been reviewed and a consent booklet developed in easy read format.

A service level agreement with Birmingham and Solihull Mental Health Trust was introduced to ensure that the hospital has access to staff with experience of patients with mental health needs and can access this service for our patients. We have developed a 'Creation of Mind Matters' site on the Trust intranet for staff to access which contains information and signposting.

3.11Chaplaincy services

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

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

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

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

3.12 Our workforce

We have continued to focus on the requirements of both the Care Quality Commission and GP Commissioners in relation to staff, with particular focus this year on improving attendance at mandatory training and completion of appraisal, particularly for medical staff. The Trust met the Commission's requirements with respect to staffing during their unannounced inspection. Inspectors observed our staff working in a friendly and professional way with patients and they reported no concerns about staffing levels in the areas they visited.

The Revalidation of doctors by the General Medical Council started in December 2012 and all substantive doctors have now been appraised and all doctors in the Trust scheduled to be revalidated in 2013/14 have done so. Focus in 2014/15 will be on making the appraisal process simple for doctors and ensuring Trust values and standards are consistently applied to all.

Levels of sickness absence have improved during the year with the underlying trend reducing by 0.5% across the year. The focus during 2014/15 will be on reducing absence further, particularly in relation to stress related absence and absences of less than one month duration.

In January 2014 those staff members who made a unique contribution to quality were congratulated at our annual Staff Awards Ceremony. In particular a Chef was commended for the improvements he achieved with colleagues following the review and recommendations from James Martin in a BBC programme about hospital food.

In the second half of the year staff worked extremely hard to ensure an increased number of patients received their planned clinical care which necessitated high levels of dedication and additional working. It is a tribute to our staff that the high levels of patient satisfaction continued during this period.

During the year progress was made on the Trust's Public Sector Equality Duty. Significant improvement has been seen in the information recorded on protected characteristics which will be crucial to future monitoring of the effect of policies and approaches on staff.

We have continued to participate in the new national approaches to workforce education and learning, through Health Education West Midlands. As a result of some additional income from national funding streams, we have invested in a new role to lead the development of our staff in pay bands 1 to 4, who are understood to have around 60% of the total number of contacts with patients. Historically the learning needs of this

staff group have not been prioritised and arrangements are now being started to address this during 2014/15. To support this, funding has been released by the trustees of Trust Charities for which we are very grateful.

3.12 Staff Survey

This year our response rate in the national staff survey was 53%, an increase from 51% on last year.

Our top five ranking scores were:

Key Factor	This Year's Score	National Average (Acute Specialist Trusts)
Percentage of staff having equality and diversity training in the last 12 months	71%	66%
Percentage of staff appraised in the last 12 months	88%	86%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	20%	22%
Percentage of staff receiving health and safety training in the last 12 months	84%	77%
Percentage of staff having well-structured appraisals in the last 12 months	46%	42%

Our bottom five ranking scores were:

Key Factor	This Year's Score	National Average
Fairness and effectiveness of incident reporting procedures	3.47	3.62
Percentage of staff feeling pressure in last 3 months to attend work when	29%	24%

feeling unwell		
Support from immediate managers	3.66	3.74
Effective team working	3.73	3.81
Percentage of staff believing the trust provides equal opportunities for career progression and promotion	86%	91%

Disappointingly the number of staff who would be happy with the standard of care provided by the Trust was only 82%. Although this represents an improvement on last year's survey this result is 6% below the average for other acute specialist trusts.

During 2013 the Trust engaged an external consultancy to undertake a piece of work to understand the causes of below average levels of staff engagement. The finding from this work provides some important insights into staff opinion and the priorities for action. As a result immediate actions were taken to improve internal communication, visibility of senior managers, increasing resourcing in key areas such as IT, Radiology and Nursing and making improvement in marketing the Trust's services. During 2014/15 a strategic plan for staff engagement will be developed to support and enable further improvements in how staff feels about working in the Trust.

3.13 Public engagement

Public Engagement in 2013/14 continued to be key to the Trust's work with the number of patients, members and the general public being given the opportunity to provide feedback positively encouraged in various ways.

The Public and Patient Services team continue to play a lead role across the organisation with our Volunteers ably supporting the delivery of the Friends and Family Net Promoter tool. In addition the real time survey continues and has proven of great benefit to the patients and Trust alike.

The Trust has ongoing marketing material in use and has undertaken a review of how we can promote the work of the organisation. A marketing and media specialist has been commissioned to work with the organisation during this year and she is focusing our efforts to share good practice.

The Trust membership panel has been maintained and the Trust has liaised with the new Health Watch bodies, mindful of their developing roles through 2013/14.

The Trust has worked consistently with its Governors to ensure that they are aware of all the key patient focused activities in the organisation. The Patient Experience Group provided valuable support across a range of clinical issues and were integral colleagues supporting the opening and initial first months of the Admission and Day Case Unit opened in summer 2013. These colleagues provided assurance to full Council on issues such as infection control, falls, and pressure ulceration prevention and have reviewed the experience of individual patients as case studies.

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

The table below shows the key indicators used to assess the overall quality of our performance.

Infection rates are a viewed as an 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 disease or to receive appropriate palliative care in the best location for them and their families. Achieving these standards 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, and so the patient may come to us quite late in the process.

Many members of the public are familiar with the 18 week target which 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 to the 18 week target, sometimes for clinical reasons and sometimes because of the sheer level of demand on the surgeons and the absence of colleagues elsewhere in the region with the skills to offer specialist treatment. In 2013/14 this has been particularly true in spinal deformity surgery and in general orthopaedic paediatric surgery, both of which have seen challenges to deliver this standard in 2013/14. We have well developed plans to allow us to continue to monitor and address this in the coming year. We continue to treat more patients in spinal

deformity, therefore the pool of patients requiring ongoing care increases as patients are required to have frequent repeat surgery as they grow. To support this growth in the spinal deformity work we appointed 2 spinal deformity surgeons, one in May 2013 and one in August 2013. This will help put the service into a more sustainable position and enable us to treat patients in a timely manner going into 2014/15.

During the year, and in conjunction with colleagues in the Specialist Commissioning Group, we offered patients the choice of being treated at other centres in Sheffield, London and Manchester that offer also this complex surgery. We anticipate that we shall not need to follow this route in 2014/15 with the plans we have put in place, we believe this is important for our patients, to be cared for at the ROH by our experienced multi-disciplinary team.

In general paediatric surgery the appointment of a new consultant specialising in treating young adult patients with hip problems has been a welcome addition to the organisation.

The table below shows our track record against these targets.

National target	08/9	09/10	10/11	11/12	12/13	13/14	Target
MRSA	Achieved 2 cases	Achieved – 0 cases	Achieved – 0 cases	Achieved – 0 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	Achieved 6 cases	Achieved 1 case	Achieved – 2 cases, both un- avoidable	2013/14 Target 2 cases
31 day subsequent treatment all cancers	NA	Achieved – 100%	Achieved – 100%	Achieved – 99%	Achieved- 100%	Achieved 100%	94% standard
31 diagnosis to	Achieved- 100%	Achieved – 100%	Achieved – 99.3%	Achieved – 100%	Achieved – 100%	Achieved 100%	96% standard

treatment all cancers							
62 day referral to treatment of all cancers	Achieved- 92%	Not applicable due to low number of patients	Achieved- 98.3%	Achieved – 94.7%	Achieved – 95.3%	Qtr1 90.5% Qtr2 82.6% Qtr3 89.5% Qtr4 100%	85% standard
2 week cancer wait	Achieved- 100%	Achieved – 99%	Achieved – 99.5%	Achieved – 99%	Achieved – 100%	100%	93% standard
18 week referral to treatment admitted	Achieved- 88%	Achieved – 91.6%	Achieved – 90.5%	Achieved 90.2%	Achieved >90%	Not achieved 89.05%	Target since 09/10 is >90%
18week referral to treatment non admitted	Achieved- 87%	Achieved – 95.2%	Achieved – 95.2%	Achieved 95.1%	Achieved .95%	Achieved 95.24%	Target since 09/10 is 95%
92% incomplete pathway	Not applicable	Not applicable	Not applicable	Not applicable	Not achieved full year (achieved March 2013)	Achieved 93.5%	92%
Access to healthcare for people with learning disabilities	NA	Achieved	Achieved	Achieved	Achieved	Achieved	

3.15 Measuring quality as we move forward

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

The 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.

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

4.1 Response to The Royal Orthopaedic Hospital NHS Foundation Trust Quality Account and Report

Healthwatch Birmingham recognise that Quality Accounts are a useful contribution to ensuring NHS providers are accountable to patients and the wider public about the quality of the services they provide. We welcome the opportunity to comment on the draft Quality Account and Report for The Royal Orthopaedic Hospital NHS Foundation Trust.

As a specialist orthopaedic provider, the Trust's patients are drawn from all parts of the country, and as such may provide feedback to their local Healthwatch rather than the one most local to a provider. Healthwatch Birmingham has not received feedback on the Trust from other local Healthwatch.

The draft Quality Account was not fully populated with data on performance against targets for the year, so we are unable to comment on those areas of performance. We will look at this data with interest when the final version is produced.

We welcome the inclusion of improvement targets for 2014/15 in relation to some questions in the CQC National Patient Survey. We hope feedback gathered by Healthwatch Birmingham will also provide a useful source of information in the year ahead.

We are pleased to see the developments to the monthly Patient Quality report to the Trust Board, and the reintroduction of patient stories to share patient experience directly with Board members.

Healthwatch Birmingham notes that the Trust was found to be compliant in all areas by the CQC in its inspections this year. We were pleased to be able to accompany the CQC in the inspection on the Care and welfare of people who use services, Safeguarding people who use services, Supporting workers, and Assessing and monitoring the quality of service provision. This gave us a chance to hear feedback directly.

The Clostridium difficile performance rate continues to be good and we note the performance compares favourably with that of other specialist orthopaedic providers.

The 28% decrease in patient falls compared with the previous year is welcomed. We note that there are still 7% of falls risk assessments not being completed within six hours of admission, and would recommend that the data on the 70 falls is cross-referenced with the uncompleted falls risk assessments, to look for possible correlation, and ask the Trust to continue to strive towards a 100% completion rate.

Healthwatch Birmingham looks forward to The Royal Orthopaedic Hospital NHS Foundation Trust continuing delivering its quality improvement plans, particularly in relation to patient engagement, through the year ahead.

4.2 Overview and Scrutiny Committee

4.3 Statement of Birmingham Cross City Clinical Commissioning Group

Royal Orthopaedic Hospital NHS Foundation Trust, Quality Account 2013/14
Statement of assurance from Birmingham CrossCity CCG May 2014

As lead commissioner Birmingham CrossCity CCG welcomes the opportunity to provide this statement for the Royal Orthopaedic Hospital NHS Foundation Trust's Quality Account for 2013/14. This Quality Account has been reviewed in accordance with the Department of Health guidance and Monitor's requirements. The statement has been developed in consultation with neighbouring CCGs, the Birmingham, Solihull and Black Country Area Team and commented on by the Birmingham CrossCity CCG Patient Council.

Birmingham CrossCity CCG is committed to ensuring that the services it commissions provide the very highest of standards in respect to clinical quality, patient safety and patient experience, and therefore we have worked closely during 2013/14 with the Trust's clinicians and managers, monitoring service delivery and performance through monthly Clinical Quality Review Group meetings and addressing any issues around the quality and safety of patient care with the Trust. In addition to this we have maintained ongoing monitoring regarding the delivery of care on the frontline by conducting visits to clinical areas within the Trust to obtain greater assurance that standards of quality and safety of patient care are being met. Our thoughts on the Quality Account are;
The Quality Account generally appears to be balanced and comprehensive, reflecting the activity of the Trust, and we were pleased to note the obvious efforts that have been put into the document in order to make it clear, concise and very user friendly to read.

We acknowledge that 2013/14 has seen a great deal of change within the Trust with a number of appointments at Board level including: a new Chief Executive, Director of Finance and Director of Nursing and Governance and Medical Director, and we were encouraged to read of the steps that this new team at the Trust have taken to ensure highly visibility. We also welcomed the positive use of the Quality Round Tool used by the Matrons to ensure regular checks within all clinical areas.

We noted the development of the new Admission and Day Case (ADCU) facility which has been recognised as a positive improvement for patients utilising the services.
We note the Trust continues to make considerable efforts to improve its services and the quality of the care it provides, and welcomed the examples offered within the Quality Account. We welcome the work that the Trust is doing around reducing potential harm to patients who fall during their stay in hospital and measures being taken to reduce the incidence of pressure ulcers.

We felt that some areas could have been described in greater detail e.g. the actions taken so far within the service to implement the 6Cs (Care, Compassion, Competence,

Communication, Courage and Commitment) and nursing metrics, the improvements made to medicines management such as the development of electronic prescribing, and the improvements made in promoting opportunities of education and training for staff.

Some mention is made of capturing patients' experience and it is encouraging to see, for example, that the Trust is obtaining high scores for privacy and dignity from its patients. More examples illustrating patient experience and feedback would be welcome including how the Trust is meeting the needs of patients from protected characteristic groups, as defined within the Equality Act. However we accept that these gaps in information will be addressed within the final published document.

We note that this draft of the Quality Account does not currently contain detail of the progress the Trust has made against their quality improvement priorities for 2013 /14, however accept that this information will be available within the final published document.

We welcome the assurances that the Trust has gained from CQC assurance visits undertaken in June 2013 and January 2014 but note that there is little detail offered in respect to the three CCG assurance visits undertaken during 2013/14 in respect to the findings and resulting actions.

The quality improvement priorities identified for 2014/15 relating to safety appear appropriate given reported serious incidents, and those for effectiveness and experience also appear appropriate and suitably challenging for the service.

The section of the Quality Account concerning participation in clinical audit whilst interesting, was found to have included a high number of abbreviations within this section e.g. NJR (National Joint Registry) and PROMS (Patient Reported Outcome Measures) not explained. Also the local audit section of the report is a little confusing to read as it includes so many improvements and recommendations from the 51 local audits completed. This section could potentially be improved by reformatting the information into a table detailing the audit, scope, key findings and improvements made to patient care.

We noted that the NRLS (National Reporting and Learning System) data presented identified that the overall rate of patient safety incidents per 100 admissions has risen from 5.3 for the data reporting period between April 2012 to September 2012, to 6.3 between October 2012 and March 2013, however, no explanation appears to have been offered to explain this increase.

In respect to the Staff Survey it would be useful to have further details as to how the Trust intends to tackle the bottom five ranking scores namely: fairness and effectiveness of incident reporting procedures, the percentage of staff feeling pressure in last 3 months to attend work when feeling unwell, support from immediate managers, effective team working, and the percentage of staff believing the trust provides equal opportunities for career progression and promotion.

Currently the Quality Account does not appear to make any direct reference to key national reports such as Winterbourne View and only minimal reference is made to how the Trust is responding to the Francis recommendations.

In respect to safeguarding currently there is a lack of appropriate detail and evidence concerning feedback from children, young people and vulnerable adults who use the service, and the key strategic issues and challenges for the Trust, either as a result of specific local or national safeguarding priorities. Additionally there is no specific reference made to the importance of ensuring that the Mental Capacity Act and the Deprivation of Liberty Safeguards are being implemented effectively in practice across the Trust. This is important in light of the recent parliamentary scrutiny report and the findings of local Serious Case Reviews.

In summary, we consider that overall, this Quality Account is a comprehensive and balanced description of the quality of the services the Trust delivers to its patients and the work it has been undertaking over the past year to improve quality and safety, and we will continue to work in partnership with the Trust in 2014/15.

Barbara King
Accountable Officer
Birmingham CrossCity Clinical Commissioning Group

2013/14 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 NHS 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*;

☐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 2013 to April 2014**;**

papers relating to quality reported to the board over the period April 2013 to April 2014**;**

feedback from the commissioners, dated 21.05.2014;

feedback from governors, dated 23.05.2014;

feedback from local Healthwatch organisations, dated 07.05.2014

the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 06.2014;

the latest national patient survey, dated 08.04.2014; the

latest national staff survey, dated 24.02.2014;

the Head of Internal Audit's annual opinion over the trust's control environment, dated 23.05.2014;

Care Quality Commission quality and risk profiles, dated 13.03.2014;

- ☐ 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.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (available at www.monitor.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/ openTKFile.php?id=3275).

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

Chairperson

Date……23 May 2014

Chief Executive

Date……23 May 2014

Note: sign and date in any colour ink except black

Feedback

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

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

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

Appendix One- Published Papers

1: Hwang N, Nandra R, Grimer RJ, Carter SR, Tillman RM, Abudu A, Jeys LM. Massive endoprosthetic replacement for bone metastases resulting from renal cell carcinoma: Factors influencing patient survival. Eur J Surg Oncol. 2014 Apr;40(4):429-34. doi: 10.1016/j.ejso.2013.08.001. Epub 2013 Sep 21. PubMed PMID: 24063967.

2: Davis ET, Pagkalos J, Gallie PA, Macgroarty K, Waddell JP, Schemitsch EH. Defining the errors in the registration process during imageless computer navigation in total knee arthroplasty: a cadaveric study. J Arthroplasty. 2014 Apr;29(4):698-701. doi: 10.1016/j.arth.2013.06.034. Epub 2013 Aug 21. PubMed PMID: 23972297.

3: Puls F, Niblett AJ, Mangham DC. Molecular pathology of bone tumours: diagnostic implications. Histopathology. 2014 Mar;64(4):461-76. doi: 10.1111/his.12275. Epub 2013 Oct 31. PubMed PMID: 24428620.

4: Houghton OP, Sumathi VP, Loyson SA, McCluggage WG. Myoepithelioma of the ovary: first reported case. Int J Gynecol Pathol. 2014 Mar;33(2):191-6. doi: 10.1097/PGP.0b013e3182995209. PubMed PMID: 24487475.

5: Reddy KI, Sinnaeve F, Gaston CL, Grimer RJ, Carter SR. Aneurysmal Bone Cysts: Do Simple Treatments Work? Clin Orthop Relat Res. 2014 Feb 15. [Epub ahead of print] PubMed PMID: 24532435.

6: Pérez-Muñoz I, Grimer RJ, Spooner D, Carter S, Tillman R, Abudu A, Jeys L. Use

of tissue expander in pelvic Ewing's sarcoma treated with radiotherapy. Eur J Surg Oncol. 2014 Feb;40(2):197-201. doi: 10.1016/j.ejso.2013.09.001. Epub 2013 Sep 18. PubMed PMID: 24084085.

7: Thomas M, Davies AM, Stirling AJ, Grimer RJ, Grainger M, James SL. Imaging appearances and clinical outcome following sacrectomy and ilio-lumbar reconstruction for sacral neoplasia. Skeletal Radiol. 2014 Feb;43(2):179-89. doi: 10.1007/s00256-013-1762-9. Epub 2013 Nov 17. PubMed PMID: 24240323.

8: David M, Gardner A, Jennison T, Spilsbury J, Marks D. The impact of revision of one or more rods on refracture rate and implant survival following rod fracture in instrumentation without fusion constructs in the management of early-onset scoliosis. J Pediatr Orthop B. 2014 Jan 30. [Epub ahead of print] PubMed PMID: 24487951.

9: Arbajian E, Puls F, Magnusson L, Thway K, Fisher C, Sumathi VP, Tayebwa J, Nord KH, Kindblom LG, Mertens F. Recurrent EWSR1-CREB3L1 Gene Fusions in Sclerosing Epithelioid Fibrosarcoma. Am J Surg Pathol. 2014 Jan 16. [Epub ahead of print] PubMed PMID: 24441665.

10: Shahid M, Saunders T, Jeys L, Grimer R. The outcome of surgical treatment for peri-acetabular metastases. Bone Joint J. 2014 Jan;96-B(1):132-6. doi: 10.1302/0301-620X.96B1.31571. PubMed PMID: 24395324.

11: Wijsbek AE, Vazquez-Garcia BL, Grimer RJ, Carter SR, Abudu AA, Tillman RM, Jeys L. Giant cell tumour of the proximal femur: Is joint-sparing management ever

successful? Bone Joint J. 2014 Jan;96-B(1):127-31. doi: 10.1302/0301-620X.96B1.31763. PubMed PMID: 24395323.

12: Evans S, Ramasamy A, Marks DS, Spilsbury J, Miller P, Tatman A, Gardner AC. The surgical management of spinal deformity in children with a Fontan circulation: The development of an algorithm for treatment. Bone Joint J. 2014 Jan;96-B(1):94-9. doi: 10.1302/0301-620X.96B1.32581. PubMed PMID: 24395318.

13: Mangham DC, Kindblom LG. Rarely metastasizing soft tissue tumours. Histopathology. 2014 Jan;64(1):88-100. doi: 10.1111/his.12310. Epub 2013 Nov 28. Erratum in: Histopathology.2014 Mar;64(4):608. PubMed PMID: 24117966.

14: Ghani Y, Thakrar R, Kosuge D, Bates P. 'Smart' electronic operation notes in surgery: an innovative way to improve patient care. Int J Surg. 2014;12(1):30-2. doi: 10.1016/j.ijsu.2013.10.017. Epub 2013 Nov 14. PubMed PMID: 24239938.

15: Pailhe R, Matharu GS, Sharma A, Pynsent PB, Treacy RB. Survival and functional outcome of the Birmingham Hip Resurfacing system in patients aged 65 and older at up to ten years of follow-up. Int Orthop. 2013 Dec 28. [Epub ahead of print] PubMed PMID: 24370976.

16: Matharu GS, Mehdian R, Sethi D, Jeys L. Severe pelvic bone loss treated using a coned acetabular prosthesis with a stem extension inside the ilium. Acta Orthop Belg. 2013 Dec;79(6):680-8. PubMed PMID: 24563974.

17: Botchu R, Douis H, Davies AM, James SL, Puls F, Grimer R. Post-traumatic heterotopic ossification of distal tibiofibular syndesmosis mimicking a surface osteosarcoma. Clin Radiol. 2013 Dec;68(12):e676-9. doi: 10.1016/j.crad.2013.07.020. Epub 2013 Sep 10. PubMed PMID: 24034551.

18: Thakrar RR, Snow M. Influence of tibial slope asymmetry on femoral rotation in patients with lateral patellar instability. Knee Surg Sports Traumatol Arthrosc. 2013 Nov 12. [Epub ahead of print] PubMed PMID: 24217717.

19: Alholle A, Brini AT, Gharanei S, Vaiyapuri S, Arrigoni E, Dallol A, Gentle D, Kishida T, Hiruma T, Avigad S, Grimer R, Maher ER, Latif F. Functional epigenetic approach identifies frequently methylated genes in Ewing sarcoma. Epigenetics. 2013 Nov;8(11):1198-204. doi: 10.4161/epi.26266. Epub 2013 Sep 4. PubMed PMID: 24005033.

20: MacLean SB, Evans S, O'Hara JN. A comparison of reversed locking compression-distal femoral plates and blade plates in osteotomies for young adult hip pathology. Hip Int. 2013 Nov-Dec;23(6):565-9. doi: 10.5301/hipint.5000069. Epub 2013 Sep 3. PubMed PMID: 23813173.

21: Albergo JI, Gaston CL, Davies M, Abudu AT, Carter SR, Jeys LM, Tillman RM, Grimer RJ. Hoffa's fat pad tumours: what do we know about them? Int Orthop. 2013 Nov;37(11):2225-9. doi: 10.1007/s00264-013-2041-z. Epub 2013 Sep 3. PubMed PMID: 24000088; PubMed Central PMCID: PMC3824884.

22: Nakamura T, Grimer R, Gaston C, Carter S, Tillman R, Abudu A, Jeys L, Sudo A. The relationship between pretreatment anaemia and survival in patients with adult soft tissue sarcoma. J Orthop Sci. 2013 Nov;18(6):987-93. doi: 10.1007/s00776-013-0454-6. Epub 2013 Aug 14. PubMed PMID: 23943226.

23: Dotlic S, Gatalica Z, Wen W, Ghazalpour A, Mangham C, Babic D, Zekan J, Vranic S. Extraskeletal Myxoid Chondrosarcoma of the Vulva With PLAG1 Gene Activation: Molecular Genetic Characterization of 2 Cases. Appl Immunohistochem Mol Morphol. 2013 Oct 31. [Epub ahead of print] PubMed PMID: 24185117.

24: Shahid M, Wu F, Deshmukh SC. Operative treatment improves patient function in recalcitrant medial epicondylitis. Ann R Coll Surg Engl. 2013 Oct;95(7):486-8. doi: 10.1308/003588413X13629960048479. PubMed PMID: 24112494.

25: Jeys L, Matharu GS, Nandra RS, Grimer RJ. Can computer navigation-assisted surgery reduce the risk of an intralesional margin and reduce the rate of local recurrence in patients with a tumour of the pelvis or sacrum? Bone Joint J. 2013 Oct;95-B(10):1417-24. doi: 10.1302/0301-620X.95B10.31734. PubMed PMID: 24078543.

26: Matharu GS, McBryde CW, Pynsent WB, Pynsent PB, Treacy RB. The outcome of the Birmingham Hip Resurfacing in patients aged < 50 years up to 14 years post-operatively. Bone Joint J. 2013 Sep;95-B(9):1172-7. doi: 10.1302/0301-620X.95B9.31711. PubMed PMID: 23997127.

27: Nakamura T, Abudu A, Murata H, Grimer RJ, Carter SR, Tillman RM, Jeys L. Oncological outcome of patients with deeply located soft tissue sarcoma of the

pelvis: a follow up study at minimum 5 years after diagnosis. Eur J Surg Oncol. 2013 Sep;39(9):1030-5. doi: 10.1016/j.ejso.2012.12.019. Epub 2013 Jan 21. PubMed PMID: 23347778.

28: Nakamura T, Grimer RJ, Carter SR, Tillman RM, Abudu A, Jeys L, Sudo A. Outcome of soft-tissue sarcoma patients who were alive and event-free more than five years after initial treatment. Bone Joint J. 2013 Aug;95-B(8):1139-43. doi: 10.1302/0301-620X.95B8.31379. PubMed PMID: 23908433.

29: Wu F, Shahid M, Deshmukh S. Cast immobilization does not confer additional functional benefits over immediate mobilization after trapeziectomy. J Hand Surg Eur Vol. 2013 Jul 22. [Epub ahead of print] PubMed PMID: 23877726.

30: Robb CA, Matharu GS, Baloch K, Pynsent PB. Revision surgery for failed unicompartmental knee replacement: technical aspects and clinical outcome. Acta OrthopBelg. 2013 Jun;79(3):312-7. PubMed PMID: 23926735.

31: Karkhanis S, Botchu R, James S, Evans N. Bilateral calcific myonecrosis associated with epilepsy. Clin Radiol. 2013 Jun;68(6):e349-52. doi: 10.1016/j.crad.2012.12.001. Epub 2013 Mar 26. PubMed PMID: 23541092.

32: Matharu GS, McBryde CW, Treacy RB, Pynsent WB, Pynsent PB. Impact of active patient follow-up on worst-case implant survival analysis. Hip Int. 2013 May-Jun;23(3):259-62. doi: 10.5301/hipint.5000026. Epub 2013 Mar 5. PubMed PMID: 23475418.

33: MacLean SB, Oni T, Crawford LA, Deshmukh SC. Medium-term results of arthroscopic debridement and capsulectomy for the treatment of elbow osteoarthritis. J Shoulder Elbow Surg. 2013 May;22(5):653-7. doi: 10.1016/j.jse.2013.01.030. PubMed PMID: 23590888.

34: Nakamura T, Abudu A, Grimer RJ, Carter SR, Jeys L, Tillman RM. The clinical outcomes of extracorporeal irradiated and re-implanted cemented autologous bone graft of femoral diaphysis after tumour resection. Int Orthop. 2013 Apr;37(4):647-51. doi: 10.1007/s00264-012-1715-2. Epub 2012 Dec 28. PubMed PMID: 23271688; PubMed Central PMCID: PMC3609977.

35: Wu F, Rajpura A, Shahid M, Sandher D. An Unrecognised Case of a Scapula Fracture Sustained through an Unusual Indirect Mechanism. Case Rep Orthop. 2013;2013:848953. doi: 10.1155/2013/848953. Epub 2013 Sep 25. PubMed PMID: 24187638; PubMed Central PMCID: PMC3800673.

Independent Auditor's Report to the Council of Governors of The Royal Orthopaedic Hospital NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of The Royal Orthopaedic Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of The Royal Orthopaedic Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Royal Orthopaedic Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Royal Orthopaedic Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Royal Orthopaedic Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 day referral to treatment of all cancers; and
- Patients readmitted to a hospital within 28 days of being discharged.

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

Respective responsibilities of the Directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified below:
    - Board minutes for the period April 2013 to March 2014;
    - Papers relating to quality reported to the Board over the period April 2013 to March 2014;
    - Feedback from the Commissioners dated May 2014;
    - Feedback from local Healthwatch organisations dated 7 May 2014;
    - The Trust's complaints reports presented to the Board over the period April 2013 to March 2014;
    - The latest national patient survey dated 2013;
    - The latest national staff survey dated 2013;

- Care Quality Commission Intelligence Monitoring Reports dated 21 October 2013 and 13 March 2014;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 23 May 2014; and
- Any other information included in our review.

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

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

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

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

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

Assurance work performed

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

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

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

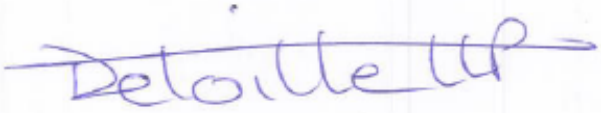
Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

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

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

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's Detailed Guidance for External Assurance on Quality Reports 2013/14; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*



Deloitte LLP
Chartered Accountants
Birmingham
27 May 2014

The Royal Orthopaedic Hospital NHS Foundation Trust carries out sustainability reporting in working towards meeting the Government's target of reducing its carbon footprint by 10% by the year 2015.

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

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

The Trust in 2013/14 was successful in its bid and was awarded £90,931.20 from the available £50 million national energy fund. This has enabled the Trust to install an insulation system to the roof of the building which accommodates our Paediatric and Therapy Services. The projected recurring savings have been calculated at £4,143.82 per annum for the Trust.

The Trust endeavours to reduce waste wherever possible and for 2014/15 it is focussing on further developing its recyclable waste streams. The Trust continues to develop its travel strategy and encourages reductions in staff travel. Contracts with non-emergency ambulance services have been agreed for 2014/15 and are reviewed on a regular basis.

The Trust's governance processes involve a Carbon Reduction Strategy Annual Report to the Trust Board enabling Executive Directors to receive updates on carbon reduction and its established Good Corporate Citizen Group. (GCCG) The GCCG ensures our carbon footprint reduction is managed on a daily and weekly basis at local level.

Greenhouse Gas Emissions – direct gas boilers

The target for 2013/14 was 1,278 tonnes. The Royal Orthopaedic Hospital did not achieve this for 2013/14 using 1,528 tonnes of gas; this is due to the opening of the new Admissions and Day Case Unit and the new Decontamination Unit as there are no carbon allowances for new developments on site.

Area:	**Greenhouse Gas Emissions**						
Type:	**Direct Gas Boilers**						
2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Tonnes							
1,420	1,546	1,406	1,366	1,368	1,170	1,471	1,528
Financial ((£)							
165,000	172,000	243,000	181,000	192,000	175,000	260,841	303,077

Greenhouse Gas Emissions – indirect Electricity

The target for 2012/13 was 1,385 tonnes. The Royal Orthopaedic Hospital did not achieve this for 2013/14 using 1,555 tonnes; again this is due to the opening of the new Admissions and Day Case Unit and the new Decontamination Unit as there are no carbon allowances for new developments on site. Despite not achieving the target, a number of initiatives have been introduced to support the reduced use of Electricity, including:

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

Area:	**Greenhouse Gas Emissions**						
Type:	**Indirect Electricity**						
2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Tonnes							
1,539	1,629	1,714	1,585	1,570	1,512	1,427	1,555
Financial ((£)							
266,000	256,000	422,000	358,000	314,000	326,000	389,994	415,268

Staff Travel to Work

The target for 2013/14 was 900 tonnes. The Royal Orthopaedic Hospital did not achieve this for 2013/14 using 974 tonnes for staff travel to work, however we are still achieving the 2015 national target of 990 tonnes.

Area:	**Travel**						
Type:	**Staff Travel**						
2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Tonnes							
-	-	-	-	1,180	900	845	974

Waste

The Trust continues to endeavour to reduce its waste and, wherever possible, recycles waste itself. The Trust does recycle aluminium cans, cardboard, printer cartridges and batteries. The Trust has invested in additional recycling containers and from 1 April 2013 has undertaken recycling collections throughout the Trust. In 2013/14 the Trust is moving forward with further segregation of its waste products. We continue to improve our data collection to distinguish between landfill (general), clinical, recycling, confidential waste and skip waste. The Trust is endeavouring to reduce its clinical and landfill waste, moving towards recycled (which includes confidential) waste.

The Trust's target for landfill waste in 2013/14 was 125 tonnes; the Trust met its target achieving 109 tonnes.

Area	**Waste**							
	2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
	Tonnes							
Landfill / general waste	-	-	139	152	148	125	115	109
Recycled waste	-	-	-	-	-	4	27	28
Confidential waste	-	-	-	-	-	171 (includes clinical waste)	40	TBC
Skip waste	-	-	-	-	-	27	26	39
Clinical waste	-	-	-	-	-	-	135	141

Area	**Waste**							
	2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
	Financial (£)							
Landfill / general waste			12,764	15,830	18,381	23,000	27,841	TBC
Recycled waste			0	0	0	0	0	0
Confidential waste						37,000	9,530	20,084
Skip waste							6,531	25,803
Clinical waste							59,780	67,457

Finite Resources – water consumption

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

In 2013/14 we set ourselves a revised target of 22,000 cubic metres of water. The Trust did not achieve the stretch target and used 24,691 m3 of water however it is still within the 2015 national target.

Area:	**Finite Resources**						
Type:	**Water Consumption**						
2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Cubic Metres							
29,374	24,737	26,950	23,039	22,967	20,424	22,314	24,691
Financial ((£)							
43,484	41,310	46,861	44,348	45,210	41,000	43,715	69,527

Green Apple Award

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

Valuing People, Diversity and Staff Engagement Report 2013/14

Staff Engagement

Feedback from staff during late 2013/14 indicated improvement is needed in the engagement of staff on issues that matter to them. As a result a significant piece of work was undertaken during the year to understand what had caused this. The findings from this work have provided some important insights into the priorities for action. Immediate changes have been made to internal communication, visibility of Executive Directors and Senior Managers, increased investment in areas such as radiology and nursing as well as improved external marketing of the Trust.

Our staff took part in the national staff opinion survey. This year our response rate increased to 53% which is average for acute specialist Trusts.

Our top five ranking scores were:

Key Factor	This Year's Score	National Average (Acute Specialist Trusts)	Comparison to Last Year
Percentage of staff having equality and diversity training in the last 12 months	71%	66%	Improved by 10%
Percentage of staff appraised in the last 12 months	88%	86%	Improved by 2%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	20%	22%	Unchanged
Percentage of staff receiving health and safety training in the last 12 months	84%	77%	Unchanged
Percentage of staff having well-structured appraisals in the last 12 months	46%	42%	Improved by 4%

Our bottom five ranking scores were:

Key Factor	This Year's Score	National Average	Comparison to Last Year
Fairness and effectiveness of incident reporting procedures	3.47	3.62	Decreased by 0.04
Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	29%	24%	Decreased by 5%
Support from immediate managers	3.66	3.74	Decreased by 0.07
Effective team working	3.73	3.81	Decreased by 0.01
Percentage of staff believing the Trust provides equal opportunities for career progression and promotion	86%	91%	Decreased by 1%

The number of staff who recommend the Trust as a place to work has improved by 4% and the number of staff who would be happy with the standard of care provided by this organisation has also improved by 2%, although the overall level of staff engagement remains worse than average, compared to other acute specialist Trusts. Significant steps have been taken during 2013/14 to improve the involvement of employees in the Trust's performance. A number of employee reference groups have been set up to support the development of the Trust's 5 year strategy, resulting in excellent feedback and engagement in the process. Other multi-disciplinary engagement took place to help understand any future implication of 7 day services for the Trust, and around the opening of additional ward capacity over the winter and early spring.

It is the intention of the Trust to focus on the following key areas during 2014/15 to improve overall staff engagement which should also improve overall staff satisfaction levels:

- Creation of a safety culture.
- Immediate Line Managers leadership and engagement with staff.
- Communication.
- Equality in Promotion and Progression.

Consultation with Staff

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

Equality and Diversity

Our Equality Objectives set out the way the Trust is meeting its Public Sector Equality Duties in the next four years. We have made some progress during 2013/14 in particular the number of staff who are reporting protected characteristics, the embedding of equality impact assessments in service reviews, and amending the Trust policy on equality.

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

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

Sickness Absence

Overall levels of sickness absence has reduced during the year with the underlying trend being 0.5% less than last year. In 2014/15 we will continue to actively support staff to improve their own well-being, with a particular focus on developing personal resilience and managing stress.

Workforce Statistics

	Staff 2012/13	%	Staff 2013/14	%	Membership 2012/13	%	Membership 2013/14	%
Age								
0-16	0	0.0	0	0.0	0	0.0	0	0.0
17-21	24	2.7	23	2.4	24	2.7	23	2.4
22+	876	97.3	930	97.6	876	97.3	930	97.6
Ethnicity								
White	696	77.3	744	78.1	696	77.3	744	78.1
Mixed	15	1.7	19	2.0	15	1.7	19	2.0
Asian or Asian British	108	12.0	110	11.5	108	12.0	110	11.5
Black or Black British	34	3.8	32	3.4	34	3.8	32	3.4
Other	47	5.2	48	5.0	47	5.2	48	5.0

	Staff 2012/13	%	Staff 2013/14	%	Membership 2012/13	%	Membership 2013/14	%
Gender								
Not Stated	0	0.0	0	0.0	0	0.0	0	0.0
Male	270	30.0	271	28.4	270	30.0	271	28.4
Female	630	70.0	682	71.6	630	70.0	682	71.6
Recorded Disability								
Not Declared	72	8.0	57	6.0	72	8.0	57	6.0
Undefined	443	49.2	323	33.9	443	49.2	323	33.9
Yes	5	0.6	12	1.3	5	0.6	12	1.3
No	380	42.2	561	58.8	380	42.2	561	58.8

The Board of Directors' Report 2013/14

This part of the report complements the description of the Trust's activity in the Strategic Report (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.

How governance operates in the Trust

The Royal Orthopaedic Hospital is constituted as a Foundation Trust and has a distinctive governance structure, designed to balance commercial behaviours with public accountability.

The Trust is a membership organisation which has several constituencies of public membership (open to patients and others). Staff are also members and these groups elect representatives to serve on the Council of Governors alongside a small number of stakeholder-appointed members. This Council of Governors holds the Non-executive directors to account for performance in their roles as leaders of the organisation and seeks to represent the views of the general public. Governors appoint and remove the Chair and NEDs and set their terms of office. Trust auditors are appointed by Governors; Governors and the board must, by majority, agree changes to the constitution.

The Trust Board is a unitary board where executive and non-executive directors are held equally to account. The role of the Board is to set strategy, monitor performance and identify opportunities to improve. Having had regard for the needs of Parliament, the Board delegates day to day management of the Trust to the executive team, whom they hold collectively responsible.

The Trust has used the quality governance framework to assess its own performance with regard to quality in 2013/14. Clinical directors lead sub specialty services and each is supported by a matron and directorate service manager and these triumvirates are responsible for performance across the dimensions of finance and quality. There are regularly programmed Directorate review meetings and Trust Business and Learning Days have been introduced on a regular basis where all staff can come together to discuss issues and be briefed face to face by the CEO (Chief Executive Officer).

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

The Board has undertaken workshops on several aspects of patient care and continues to receive a patient safety report which as a major monthly Board agenda item.

The work of the Trust in delivering high quality patient care

The Trust has several sub specialties each led by a Clinical Director.

Large Joint Directorate

As the financial year 2013/14 draws to a close the Directorate of Large Joints has cause to celebrate a number of significant achievements. In the current climate it is consistently challenging to recruit good quality nursing staff and is an issue that many of our neighbouring organisations are also grappling with. The Large Joints Directorate has been integral to the organisation of bi-monthly recruitment assessment centres which aim to pro-actively fill our nursing vacancies with the best staff available. At the latest assessment centre on 22 March 2014 we successfully recruited 8 qualified nurses thereby filling all general orthopaedic vacancies. This is an area we will continue to develop along with the initiatives we have implemented to retain and develop our current nursing workforce.

A further area of achievement has been the establishment of Ward 7 – Extra Capacity Ward from January to April 2014. The unit was established on a very short timescale with all wards contributing to the staffing workforce and resources required to run the 10-bedded male ward. The leadership and team morale on the ward has been exemplary, as has the extremely positive patient feedback. There has been an exceptionally high quality of nursing illustrated by the fact that during this period, there have been no incidents of patient harm such as patient falls. The team are to be congratulated and we will certainly be looking at the learning that can be taken from this experience and shared across the Trust.

A theme identified in patient complaints during 2012/13 was the difficulty patients experience in contacting the medical secretaries and consultants. Considerable effort this year has gone in to ensuring that telephone coverage is improved to enable patients to contact their consultant's secretaries and as a result we have seen a significant decline in PALS and patient complaints. The team have also worked extremely hard to reduce the delay for clinic and discharge letters to be sent to patients and GPs. Letters are now being sent within 5 – 7 days as opposed to 5 – 8 weeks one year ago. The Large Joints Admin Team have worked extremely hard to improve their processes over the year, and as a result of their commitment they won the Team of the Year Staff Award 2013/14.

Since March 2012 the Arthroplasty team have been integral to the recall of patients with metal on metal hip replacements. A total of 3,500 patients have been contacted and were indicated, patients are now reviewed through specific nurse led clinics and/or prompt consultant review. In addition, a number of research papers have been accepted by international orthopaedic conferences where the Royal Orthopaedic Hospital will be represented by medical and nursing colleagues within the next 12 months.

All in all 2013/14 has been a period of challenge, yet continuing improvement. The focus for the next 2 years is to continue our journey to excellence in all that we provide for our patients and in doing so become the partner of choice to patients, relatives, GPs and Commissioners.

Directorate of Out-Patient and Clinical Support Services

The first full year as a Directorate has seen the diverse non-surgical teams working together to deliver high standards of care. The Directorate has achieved several innovative successes including:

- Introduction of a new pre-operative pathway
- Partnership working with Sandwell and West Birmingham Hospitals
- Establishment of a phlebotomy clinic
- Imaging equipment replacement
- Refurbishment of Pharmacy and orthotic departments
- Musculoskeletal marketing

The teams have continued to have a positive and can-do attitude to dealing with increased referrals and delivery of performance targets. The management team are especially proud of the staff's response in providing additional clinical support for the Trust weekend theatre activity.

The coming year will see the Directorate focus on out-patient experience, expansion of partnership working, further investment in improving imaging equipment and the introduction of e-prescribing.

Paediatrics

In year we successfully appointed a new consultant in shared post with Birmingham Children's Hospital.

The Young Adult Hip service has developed with the increased input from an ESP (Extended Scope Practitioner) who is now training to give injections to free up more consultant time to undertake surgical cases.

Ward 11 (paediatrics) has temporarily relocated for a period of 5 months to enable refurbishment and upgrading to facilities to improve patient privacy and dignity and provide a play room for the younger children. In the coming year we hope to secure a further consultant post to meet demand and implement an innovative service to provide botulinum treatment for adults and children with neuromuscular conditions.

Spinal

We have appointed two additional spinal deformity surgeons and this has enabled reduction of our waiting times for surgery to be under 52 weeks for the first time in a number of years. We have developed a brochure for GPs and referrers to identify the services we offer and enable them to contact the department more easily if required. The CQuINs initiatives for the year include spinal MDT (Multi-disciplinary Team) development and PROMs data. These have been successfully implemented

We are advertising for a new non deformity surgeon with the option to appoint someone with neurosurgical experience to enhance the skills available within the service and develop a sciatica pathway to facilitate easier and quicker treatment for patients.

Oncology

The service met all annual cancer waiting times standards and the inpatient survey results showed almost 100% patient satisfaction with the service. Following a successful bid to MacMillan Cancer Relief we obtained funding to support the provision of a Macmillan support and counselling service to patients which has already seen an increase in patients

taking up this support. The service undertook a successful pilot of operating a Pre-diagnostic MDT to improve planning of patient care and efficiency of the overall pathway and implemented minimum cancer outcomes data-set reporting. The Clinical Director was awarded a professorship from the University of Birmingham.

For 2014/15 it is intended to roll out the pre-diagnostic MDT to include all teams and develop improved pathway for treatment of patients shown to have benign condition.

Small joints (hand and foot and ankle service)

During 2013/14 the Small Joint service has embedded the practice of two new Consultants and the Podiatry service supporting the Foot and Ankle Service. The Directorate has over-achieved its activity plan, exceeding the baseline plan and the 10% planned growth. Referrals into the Hand and Feet service have remained constant over the last 12 months, which is an indication of a recurring demand.

The Directorate has improved operating theatre utilisation throughout the year and has endeavoured to utilise available sessions to maximise the number of patient treatments.

The Directorate has not managed to consistently achieve the 18 week waiting time targets, however it should be recognised that a high proportion of patients require diagnostic imaging and neurophysiology before a decision to treat can be made; this inevitably causes delays in the patient pathway.

The Hand service hopes to continue to provide the revolutionary new injection treatment for a specific hand condition, the Trust is the only NHS Trust in the local area that has been commissioned by the CCGs (Clinical Commissioning Groups) to provide this service. The Foot and Ankle Service aims to continue to provide the new heel pain service introduced this year.

Theatres, Anaesthetics and Critical Care

It has been an eventful time for the directorate with the early part of the financial year spent working towards the opening of our new Admissions and Day Case Unit (ADCU) in August 2013. The unit occupied the space left by the recently opened Outpatients Department and delivers hugely improved patient experience through purpose built modern facilities. The ADCU team received the Chairman's Award for their excellent work in developing improvements in the patients' surgical pathway including the introduction of staggered admission times which significantly reduce the amount of time patients wait in the unit before going to theatre. We would like to thank the Charitable Funds Committee for enabling us to purchase specialist Day Case trollies that are used in the theatres themselves, meaning that patients do not have to be moved onto theatres tables and back again afterwards. Patients have expressed their appreciation of ADCU through excellent feedback in the Friends and Family questionnaires and the many letters of compliments about the unit and staff.

Our learning from implementing the unit has resulted in a new way of managing projects across the Trust and has set new standards for staff consultations.

Our new state of the art Decontamination Unit opened in October 2013, delivering compliance with national standards for cleaning scopes and enabling us to bring this vital service back on-site. Additionally, we are now able to sterilise other tools and equipment

resulting in faster turnaround time between operations and cost savings amounting to around £15,000 to date.

We have seen the introduction of three new permanent consultant anaesthetists and will soon be recruiting a further consultant and a clinical fellow. This has given us the opportunity to develop anaesthetic led pre-operative assessment clinics as well as ensure long-term stability and a reduction in locum payments.

A new organisational structure was introduced into the directorate in 2012/13, supporting development and accountability for all staff. This team working approach has been developed further through the last year and has resulted in more staff being able to take opportunities around the Trust. A new model of medical leadership, introducing a Clinical Service Lead for Anaesthetics and HDU and a Clinical Service Lead for Theatres and ADCU is already showing signs of building into a robust and effective 'quintet' of management alongside clinical and managerial colleagues.

We would like to congratulate our Matron, Lisa Pim for her recent appointment to Deputy Director of Nursing & Governance and our Interim Theatre Manager, Rachel Bradley for winning the Chief Executive's Staff Award.

The Board of Directors' activity 2013/14

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

The Board of Directors was chaired by Dr Bryan Jackson, CBE until his resignation in January 2013 due to pressure of other engagements. The Vice Chairman, Mr Tim Pile, was asked to assume the role pending a substantive appointment and he served as Chairman for the remainder of the 2013/14 financial year.

The Interim Chief Executive, Mr Graham Bragg Held the role until the substantive appointment in December 2013 of Mrs Jo Chambers.

Other than the Chairman, at the end of March 2014 there were six Executive Directors and five Non-Executive Directors. The Directors do not have material interests in organisations where those organisations or related parties are likely to do business, or are possibly seeking to do business, with The Royal Orthopaedic Hospital NHS Foundation Trust.

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

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

The Board of Directors considers that throughout the year 2013/14 it was fully compliant with the Principles of the NHS Foundation Trust Code of Governance as it was applicable. The table at the end of this document confirms compliance with all aspects of the code.

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

The Council of Governors supported the appointment to the role of SID (Senior Independent Director) of Professor Tauny Southwood until the end of March 2013. He also became Vice Chairman. Following the resignation of Mr Jackson, Governors agreed that Mr Tim Pile act as Interim Chairman and, owing to pressure on Professor Southwood's time, that Mrs Frances Kirkham become Vice Chairman until substantive appointments were made.

NEDs have met before board meetings and outside these to consider Trust and executive performance.

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

Members and Governors have direct access to all members of the Board. In addition to having direct access on request, all the members of the Board are invited to attend every Council of Governors meeting and participate fully in discussion with members of the Council. Members of the Board or Trust Senior Managers who might have issues, where contact through the normal channels with Chairman, Chief Executive or Director of Finance is inappropriate, have right of direct access to the Chairman of the Audit Committee and the Vice Chairman. In addition, the Board designates two Board meetings per annum as joint meetings with the full Council of Governors. In 2013/14 the Board met 10 times and ad hoc as necessary.

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

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

The Board considers that all Non-Executive Directors (with the exception of the Trust Chairman, to whose office Provision A.3.1 of the Foundation Trust Code of Governance

does not apply) are independent in character and judgment and there are no relationships or circumstances which are likely to affect, or appear to affect, their judgment.

Directors holding office during 2013/14

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

Dame Yve Buckland – Appointed as Chair 1st April 2014

Dr Bryan Jackson – Resigned 1st January 2014

Formerly MD Toyota Motor Manufacturing and current Chair of Wesleyan Insurance, Mr Jackson has held several significant public and private sector roles.

Professor Taunton Southwood – Non-Executive Director (2nd term of office expires 31/01/2017)

Professor Southwood is a professor at Birmingham University and also works at Birmingham Children's Hospital.

Mr Robert Millinship - Non-Executive Director (2nd term of office expired 04/10/2013)

Mr Millinship has a background in manufacturing and production businesses and acts as an interim director or consultant.

Mrs Frances Kirkham – Non-Executive Director (2nd term of office expires 10/02/2015)

Mrs Kirkham is a retired judge.

Mr Andrew Meehan – Non-Executive Director (appointed 01/01/2013, resigned 1st January 2014)

Mr Meehan holds several Chair and Non-Executive Director roles in both private and charitable sectors and is a qualified accountant.

Miss Elizabeth Mountford – Non-Executive Director (appointed 01/01/2013, 1st term of office expires 31/12/2015) - Miss Mountford is an HR professional who runs an independent consultancy business.

Mr Timothy Pile – Non-Executive Director (appointed 01/01/2013, 1st term of office expires 31/12/2015) - Mr Pile is currently Executive Chairman of Cogent and was formerly CEO of Sainsbury's Bank.

Mr Michael Flaxman - Interim Non-Executive Director (from 01/03/2014) - Mr Flaxman is a qualified accountant who runs an independent consultancy business.

Mr Donal O'Donoghue – Chief Executive Officer (held office but was on sick leave until his retirement on 1st July 2013)

Mr Graham Bragg - Acting Chief Executive Officer (until 1st December 2013)

Mrs Jo Chambers – Chief Executive Officer (from 1st December 2013)

Mr Paul Taylor – Interim Director of Finance (until 31st May 2013)

Mr Paul Athey – Director of Finance (appointed 01/06/2013)

Mrs Amanda Markall – Director of Operations (appointed 01/04/2012)

Mr Andy Pearson – Medical Director (appointed 11/03/2013)

Mrs Lindsey Webb - Director of Nursing and Governance (resigned 7 November 2013)

Mrs Helen Shoker – Interim then Substantive Director of Nursing and Governance (from 1st October 2013)

A Register of Directors' Interests is available for inspection on request from the Company Secretary, Royal Orthopaedic Hospital, Bristol Road South, Birmingham, B31 2AP.

No Directors in post during the time of this Annual Report held external directorships prejudicial to their performance as Non executives at the Royal Orthopaedic Hospital NHS Foundation Trust and all are independent directors.

The Board works within its code of conduct, maintaining the standards needed by those in public life.

Board Committees

The Board had five committees at the beginning of 2013/14 – Audit as the key scrutinising committee; Integrated Governance as its progress review committee; Nominations and Remuneration Committee to address Board capability, terms of employment for executive directors and staff pay awards; and Charitable Funds of which the Trust Board is a corporate trustee. The Investment Committee considered strategic investments that have major corporate, reputational or financial implications for the Trust. The Investment Committee ceased to meet after November 2013. 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 Andy Meehan (as Chair until 1st February 2014)
Mr Mike Flaxman (as Chair from 1st March 2014)
Ms Elizabeth Mountford
Mr R Millinship (until October 2013)
Mr T Pile
Mr P Athey as Director of Finance (from 1st June 2013)

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

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

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

Discharge of Responsibilities:
The Audit Committee has provided assurance to the Trust Board quarterly during 2013/14, focusing on the following key issues

- Ensuring that the financial statements for the year ending 31st March 2014 reflect a true and fair position and that there are no significant issues within the external auditors report to those charged with governance that need to be reported to the Trust Board;

- Ensuring that the Annual Governance Statement reflected the Committee's knowledge of the Trust and that no further disclosures were required. In doing so, the Committee considered in detail the Head of Internal Audit opinion on the 2013/14 financial year.

- A significant amount of work took place during 2013/14 to review the structure of the Board Assurance Framework and the way in which risks were reported to the appropriate assurance committees. Audit Committee confirmed to the Trust Board that a robust process was now in place to monitor the key risks for the organisation.

- During 2013/14, the Trust commissioned a wide ranging internal audit review of 18 week process and data quality. The review highlighted a number of potential process improvements that could be made, and progress against these recommendations was monitored in detail by the Audit Committee during Quarter 4 of 2013/14. The

Chair of Audit Committee reported to the Trust Board that positive progress was being made in all areas identified by Internal Audit

- Having received feedback on the effectiveness of the current external audit process from key stakeholders, Audit Committee recommended to the Council of Governors a one year extension to the existing external audit contract with Deloitte to cover the 2013/14 annual audit process. A competitive tender process will take place in 2014/15 to award the next external audit contract.

- The Audit Committee also approved the re-appointment of Baker Tilly as the Trust's internal auditors during 2013/14. Internal Audit are utilised to provide independent, objective assurance around our risk management, governance and control processes. Areas of review in 2013/14 included financial controls, waiting list management, CQC evidence and information governance.

Clinical Governance Committee

Membership:
Professor Taunton Southwood (Chair)
Ms Elizabeth Mountford
Mrs F Kirkham
Mr G Bragg until 01/12/13, then Mrs Jo Chambers
Mrs L Webb until 06/10/13 then Mrs H Shoker
Mr A Pearson

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 the National Institute for Clinical Excellence (NICE) Guidance is being adhered to.
- Oversee and review the governance processes within the Trust including corporate governance, information governance and research governance in the organisation
- Ensure the Trust is fulfilling its requirements under its Terms of Authorisation with Monitor.

The Committee has an annual work plan that ensures it receives effective reporting from appropriate executive sub-groups. A note of each meetings proceeding are prepared by the Chairman and presented at the next available Trust Board. The Committee was re-named from Integrated to Clinical Governance Committee in autumn 2013 to better reflect the key focus of its work.

Nominations and Remuneration Committee

Membership:
Mr Bryan Jackson (as Chair) and all other NEDs

Professional advice was provided from time to time by the Trust's Director of Workforce and Organisation Development, Mrs Anne Cholmondeley. Financial guidance was provided by Mr Paul Athey as Director of Finance from 01/06/13.

Purpose:
The Remuneration and Nominations Committee of the Board undertakes to:

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

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

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

The Committee addressed the need to fill the posts of Chief Executive, Director of Finance and Director of Nursing and Governance during 2013/14 and used external advisors in each case.

The committee has regularly considered the structure and composition of the senior management team in order to safeguard the performance of the organisation.

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

Investment Committee

Membership:
Mr R Millinship (as Chair until 6th October 2013)
Mr Tim Pile (as Chair from October 2013)
Mr Paul Taylor (until 31st May 2013)
Mr Paul Athey (from 1st June 2013)
Mr G Bragg (until 1st December 2013)
Mrs J Chambers (from 1st December 2013)

Purpose:
The work of the committee was 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 to business case, then to become reviewed as part of Trust business in the usual way.

Charitable Funds Committee

Membership:
Mrs Frances Kirkham (Chair)
All Executive and Non Executive Directors

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

Evaluation of Board Performance

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

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

In 2013/14 the Board did not undertake any external evaluation of its performance in light of the known and significant changes in the Board itself.

The Trust does not have a formal process for evaluating the performance of the Council of Governors or its members.

Non-Executive Directors' attendance at meetings

	Trust Board 10 meetings	**Audit Committee** 5 meetings	**Clinical Governance Committee (formerly Integrated Governance Committee)** 8 meetings	**Remuneration and Nomination Committee** 3 meetings	**Charitable Funds Committee** 4 meetings	**Investment Committee** 2 meetings
Chairman and Non-Executive Director Meeting Attendance						
Bryan Jackson	8/8	n/a	n/a	3/3	3/3	1/2
Chris Monk (until 1 June 2013)	2/2	n/a	n/a	n/a	1/1	n/a
Taunton Southwood	7/10	n/a	7/8	1/3	2/4	n/a
Robert Millinship (until 6th October 2013)	3/4	2/3	n/a	2/2	1/2	1/1
Frances Kirkham	6/10	n/a	7/8	1/3	3/4	n/a
Tim Pile	9/10	4/4	n/a	2/3	1/4	2/2
Elizabeth Mountford	8/10	4/5	6/8	2/3	1/4	n/a
Andrew Meehan (until 1st February 2014)	8/8	4/4	n/a	3/3	2/3	1/2
Michael Flaxman (from 1 March 2014)	1/1	1/1	n/a	n/a	1/1	n/a

Executive Director Meeting Attendance						
	Trust Board 10 meetings	**Audit Committee** 5 meetings	**Clinical Governance Committee (formerly Integrated Governance Committee)** 8 meetings	**Remuneration and Nomination Committee** 3 meetings	**Charitable Funds Committee** 4 meetings	**Investment Committee** 2 meetings
Donal O'Donoghue (until 1st July 2013)	-	-	-	-	-	-
Graham Bragg (until 1st December 2013)	7/7	n/a	5/6	n/a	2/2	2/2
Lindsey Webb (until 7th November 2013)	4/4	n/a	5/5	n/a	1/2	n/a
Amanda Markall	9/10	n/a	n/a	n/a	3/4	n/a
Paul Athey	8/8	5/5	n/a	n/a	3/3	1/2
Helen Shoker	6/6	n/a	2/3	n/a	2/2	n/a
Jo Chambers	4/4	n/a	1/2	n/a	2/2	n/a

Board of Directors' Discharge of Obligations 2013/14

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

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

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

Trust Contractual Arrangements

The Trust entered into contractual arrangements with Clinical Commissioning Groups and NHS England for the provision of health services. The Trust maintained one major capital construction contract for the building of its Admissions and Day Care Unit 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 auditor remuneration for 2013/14 was £44,000.

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

Valuation of fixed assets

During 2013/14 the Trust completed its annual revaluation of property. This has resulted in an overall revaluation loss of £2.96m, of which £2.66m is charged as expenditure with the balance offset against the revaluation reserve. The main factors influencing the impairment were the opening of the new Admissions and Day Care Unit (ADCU) and the planned demolition of Wards 5 and 7 in 2014/15.

£4.1m was spent on the development and upgrade of the old outpatients department into the new ADCU unit, however the value of the building only increased by £1.8m as the previous building was already valued as an appropriate healthcare facility.

£0.3m of residual value on Wards 5 and 7 was also written down to zero in the 2013/14 accounts following the formal sign off of funding for the demolition works in the 2014/15 capital plan.

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

Health and Safety at Work

The Trust takes its responsibilities for the health and safety of its staff and patients very seriously. During 2013/14, the Director of Operations has the responsibility for health and safety at board level and a full time permanent Health and Safety Advisor is employed.

A three year health and safety audit plan is now in place, this will audit every department and ward in the Trust. The second year on a two year environmental audit is now underway and this is being carried out by Derby Hospitals Manual Handling team. Environmental testing and inspections was carried out on air quality in theatres, plaster rooms and Histopathology Laboratory, the results were all negative and the Trust is compliant with the Control of Substances Hazardous to Health Regulations. The requirements to report injuries, accidents, diseases and dangerous occurrences was down from 9 reports during 2012 – 2013 to 2 report during 2013 – 2014. The focus for 2014 – 2015 for the health and safety department is Stress Management, Violence and Aggression and Slips, Trips and Falls.

Policies

Policy work continues with the following policies currently being reviewed – Security, Latex and Display Screen Equipment, a Ligature policy is being formulated. Following input from the Intensive Support Team and in light of internal audit and National Audit Office Recommendations, the Patient Access Policy has been updated is accessible to patients on our website.

Mandatory Training in Health and safety

Annual mandatory training for all non-clinical Trust staff continues to be provided by the Health and Safety Advisor on the Mandatory Training days, this includes health and safety policies and issues, general awareness, incidents and accidents and access to information. Health and Safety training for clinical staff was delivered by external trainers ARC during the load patient handling course. Derby Hospital staff deliver a high quality training covering patient handling information and techniques. This health and safety session has been added to the clinical mandatory training days.

Central Alerting System (CAS)

The Health and Safety Advisor continues to monitor the Medicine Healthcare Regulatory Authority (MHRA) alerts the Trust receives and disseminates information to relevant staff/departments. The status of all CAS alerts are reported at Quality Committee meetings and escalated to the Board where necessary. For 2013 – 2014 the Trust received 85 alerts from MHRA, 87 alerts from Facilities and Estates and 9 alerts from NHS England. 150 alerts required no action following the assessment process and 31 alerts required action following the assessment process. 2 outstanding reports concerning safer needles for anesthetics from 2009 and 2011 were closed following guidance from Central Alerting.

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 2013/14.

Emergency Planning

The Trust is classified as a Category 1 Responder under the Civil Contingencies Act 2004. The Major Incident preparedness and response plan was approved by Trust Board in December 2013. Training of executives, junior clinical managers and bleep holders occurs twice per year in the form of table top exercise and inclusion in region wide exercises. Trust Business Continuity plans have been robustly tested during the response and recovery following the fire in December 2012.

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

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

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

Better Payment Practice
The Trust paid 99.2% of invoices within 30 days against the target of 95%. The Trust did not incur any late payment penalties during 2013/14 under the Late Payment of Commercial Debts (Interest) Act 1998.

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

Freedom of Information (FOI) Act
The Trust continued to meet the requirements of the act and responded to requests in a compliant fashion.

Use of Information Technology
The Trust has made the development of Information Management and Technology one of the key priorities in its strategic plan.

During 2013/14, a range of investments in IT infrastructure have taken place to address the system capability and capacity required to support future IT developments. Greatly strengthened server capacity and increasingly robust business continuity and disaster recovery capabilities have been procured and will be implemented by June 2014. The Trust has also taken the decision to replace all desktop PCs throughout the hospital with thin clients which will greatly speed up processes, reducing the time taken to access IT systems by 90%.

The last 12 months also saw the successful introduction of Electronic Document Transfer of discharge letters to GP practices across Birmingham Cross City CCG. This provides GPS with a quicker, easier process for accessing discharge letters, allowing them to provide appropriate post-discharge care to patients in primary care. The pilot is expected to be rolled out across other CCGs in 2014/15.

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

Over £8m has been set aside in capital plans over the next 2 years to start the transformation of clinical services through the use of IT, with priorities including the implementation of Electronic Prescribing, replacement of the Trust's Patient Administration System and smaller developments around outcomes reporting, referral management and digital dictation.

Serious untoward incidents relating to data loss and breaches of confidentiality

During 2014/15 the Trust had 4 serious incidents relating to Information Governance. In two instances, casenotes went missing leading to the cancellation of the patients' operations. One set fell off a patient's bed in transit and have never been found. Procedures were changed to ensure all notes are carried safely by an accompanying member of staff when patients are being moved around the Trust. One set went missing and were found a week later. This was caused by poor casenote tracking procedures between Pre-operative Assessment Clinic and Anaesthetists which have now been rectified. In the third SIRI a letter containing sensitive information about one patient ended up in the personal belongings of another patient. This was caused by an untidy work area and not following safe haven fax processes. Changes have been made to the work environment and both patients affected received explanations and apologies. In the fourth SIRI, the Trust sent patient identifiable information about 1,329 patients to a GP representing the commissioners believing that it was supporting an approved audit. However it emerged that it was not approved. This was caused by lack of awareness in both the Trust and the commissioner of rules for providing patient identifying information for secondary use. Training and awareness had been carried out and guidance now in place. This SIRI was also reported to the Information Commissioner due to the number of patients involved but not sensitivity of the information.

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.

The Trust has considered all aspects of compliance with the Code of Governance and, for completeness, includes below a table indicating this.

Disclosures of Corporate Governance Arrangements

Reference	Statutory requirement –in summary	Trust assurance of compliance
A.5.10	Governors' duty to hold NEDs to account	Narrative in Chapter 8
A.5.11	Governors receipt of annual accounts; auditor's report; the annual report	Reports received on September 28th 2013 for prior year accounts. September 2014 for 2013/14 accounts
A.5.12	Governors' receipt of board agendas and minutes	All papers are made available to governors and they have joint meetings with the board.

A.5.13	Governors may require director attendance at meetings	Directors attend meetings according to agenda
A.5.14	Governors may refer a query to the independent panel established by Monitor	This power was not used during 2013/14
A.5.15	Governors should use their voting rights on major decisions taken by the board	This power was not used during 2013/14
B.2.11	The Chair, NEDs and CEO (as appropriate) appoint executive directors	The Trust has complied with this throughout 2013/14
B.2.12	Non-executives, with approval of governors, appoint the Chief Executive	The Trust complied with this in 2013/14
B.2.13	Governors appoint, re-appoint or remove the chair and NEDs	The Trust complied with this in 2013/14
B.4.3	The board has taken steps to ensure governors can discharge duties	Training and workshops have been held during 2013/14
B.5.8	The board must have regard to governor views on the Annual Plan	The governors were consulted on the plan and the board discussed and took account of their views
B.7.3	Governor approval for appointment of CDEO and executives appointed by a committee of CDEO, chair and NEDs	The Trust complied with this in 2013/14
B.7.4	NEDs/Chair should be appointed by governors for specified terms	Governors have appointed NEDs in a fully compliant way
B.7.5	Elected governors must be subject to re-lection at least every three years	The Trust has complied with this
C.1.4	Governors should be made aware of major new developments. Governors and Monitor should be made aware of significant material changes in finance, performance and predicted performance	The Trust shares all board papers and discloses for discussion at governor meetings.
D.2.4	Governors set the remuneration of NEDs/Chair	The Trust has complied
E.1.7	Board meetings and the annual meeting must be open to the public	The Trust has complied
E.1.8	There must be an annual meeting where a	The Trust held a compliant

	director presents accounts and annual report to members	AGM in September 2013
A.1.1	There is a requirement to disclose how any disagreements between governors and the board will be resolved. The types of decisions taken by each should be disclosed.	In 2013/14, there were no matters of disagreement. Such matters would be resolved through joint governor/board discussions, meetings between the lead governor and Senior Independent Director or with support from the Company Secretary. Governors are aware of their rights to refer matters, in extremis, to the independent panel. Decision- making powers are discussed in Chapter 7 and 8 of the annual report.
A.1.2	The annual report should identify the chair, deputy chair, CEO, SID and others, including their attendance at meetings	This is disclosed in full in Chapter 7 of the annual report
A.5.3	Details of the governors, their constituency, their term of office and the lead governor	This is disclosed in Chapter 8 of the Annual Report
B.1.1	The report should identify the independence of NEDs	This is disclosed in Chapter 7 of the Annual report
B.1.4	Directors' skills should be described and the completeness of the board should be described	This is disclosed in full in Chapter 7 of the annual report
B.2.10	The work of the nominations committees should be described in relation to board appointments	This is disclosed in full in Chapter 7 of the annual report
B.3.1	Chair's other commitments should be disclosed to governors and updated	This is disclosed in full in Chapter 7 of the annual report
B.5.6	Governors should canvass the opinion of members on the Trust's annual plan	Members have been invited to consider the Annual Plan at workshops and via e-mail circulation
B.6.1	The board should state how performance evaluation is done.	Due to ongoing changes in the board, no formal

		evaluation was undertaken in 2013/14. The board did, however, hold workshops to assess its ongoing ability to consider aspects of the Trust's business.
B.6.2	Where an external facilitator is used for reviews of governance, any connection with the Trust should be noted	No external facilitator was used at any time during 2013/14
C.1.1	Directors should explain their responsibility for preparing the annual report and accounts – that they present a balanced view and provide sufficient information for patients, regulators and stakeholders to assess the performance of the Trust. There should be a statement to the external auditor about reporting responsibilities. The approach to quality governance should be explained.	This is disclosed in full in Chapter 7 of the annual report, with detail on quality assurance in Chapter 4
C.2.1	The report should contain a statement that the board has conducted a review of its effectiveness	This is disclosed in full in Chapter 7 of the annual report
C.2.2	The Board should disclose how its internal audit function is structured	This is disclosed in full in Chapter 7 of the annual report
C.3.5	If the governors do not accept the recommendations on the appointment, re-appointment, removal of trust auditors the reasons should be disclosed	Governors approved the re-appointment of auditors for a fixed period in 2013/14
C.3.9	The work of the audit committee should be described, including any significant matters in relation to financial statements, operations and compliance; how it has assessed the competence of the external auditor ,the value of audit services, auditor tenure and last review, the value of non-audit services.	This is disclosed in full in Chapter 7 of the annual report
D.1.3	Where the Trust releases an executive director for duties elsewhere, any remuneration received the by this person should be disclosed.	No executive director was so released in 2013/14
E.1.5	The board should disclose how it has taken steps to hear governor and member views	This is disclosed in full in Chapter 7 of the annual

		report
E.1.6	The board should assess how representative is Trust membership	This is disclosed in full in Chapter 8 of the annual report
A.1.3; B.1.4; B2.10; B3.2; C.3.3; D.2.1; E.1.1; E.1.4	The code requires information to be available via the Trust's website	The Trust complies with this requirement
B.7.2	Proposals for re-appointment of a NED should follow satisfactory formal performance evaluation	The Trust has been compliant with this in 2013/14
The following list embraces all other aspects of the code :A.1.4; A.1.5; A.1.6; A.1.7; A.1.8; A.1.9; A.1.10; A.3.1; A.4.1; A.4.2; A.4.3; A.5.1; A.5.2; A.5.4; A.5.5; A.5.6; A.5.8;A.5.9; B.1.2; B.1.3; B.2.1; B.2.3; B.2.5; B.2.6; B.2.7; B.2.8; B.2.9; B.3.3; B.5.1; B.5.2; B.5.3; B.5.4; B.6.3; B.6.6; B.8.1; C.1.2; C.1.3; C.3.3; C.3.7; C.3.8; D.1.1; D.1.2; D.1.4; D.2.2; D.2.3;E.1.2; E.1.3; E.2.1; E.2.2		The Trust is fully compliant with these requirements.
B.2.2;		The Trust has applied the fit and proper persons test to Directors and Governors during 2013/14, as required under its licence.
B.2.4	The chairperson should chair nominations committees	The nominations and remuneration committee of governors (for the appointment of chair/NEDs) is chaired by the lead governor with agreement of the Trust Chair and Vice Chair in order to facilitate the appointment of the Trust chairman
B.6.4	The chair and secretary should use performance evaluations for determining individual and collective development needs.	Partially compliant. In 2013/14, the Chair resigned part way through this process. Following a second NED resignation It was therefore halted, pending

		new appointments. Development sessions have since been held on strategic planning.
B.6.5	Led by the chairman, the council should periodically assess collective performance.	A formal review was anticipated in Q4 of 2013/14, however, following the resignation of the chair this did not occur. It is expected that, following the planned adoption of a revised constitution in Q1 or 2 of 2014/15, a baseline assessment will be undertaken of the new council.
C.3.1	The Board should establish an audit committee composed of at least three members who are all independent non-executive directors	The Trust has been fully compliant with this throughout 2013/14
Additional FT ARM	The governors' exercise of power under paragraph 10C of schedule 7 of the NHS Act 2006.	Governors have not exercised this power during 2013/14
Additional FT ARM	Statement of no of meetings and attendance of Council of Governors	This is provided in Chapter 8
Additional FT ARM	Brief description of length of appointment of NEDs and how they may be terminated	This is provided in Chapter 7
Additional FT ARM	Description of work of nominations committees and processes used for board appointment	Covered in Chapters 7 and 8
Additional FT ARM	Nominations committee should disclose if neither a search company nor advertising was used in relation to board appointments	A search Company has been used in all cases. Chapters 7 and 8

Going concern

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

Research and development

Information on the Trust's activity in this area is covered in Chapter 4 on Quality.

Retirement benefits and employees' remuneration

The accounting policies for pensions and other retirement benefits are set out in note 1.4 to the accounts. Details of senior employees' remuneration can be found in page 123 of the remuneration report.

Financial Instruments

The Trust has considered its exposure to price, credit, liquidity and cash flow risk, and considers that this risk is minimal and appropriately managed. Further detail on the Trust's financial risk management objectives and policies and the risk assessments performed can be found in Note 23 to the accounts.

Tim Pile

Interim Chairman

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

Executive Director Salaries are determined by the Nominations and Remuneration Committee of the Trust Board, informed by benchmark salary derived from established national NHS pay surveys. Where possible, all Executive Directors are employed on permanent contracts of employment with a six month notice period. Where the Trust has requirement to use off-payroll or seconded Executive and Non-Executive Directors, they are usually employed for a fixed-term basis, and the Trust acts to ensure a permanently employed appropriate replacements are identified as soon as possible.

No Executive Directors have provision for other payments over and above their statutory entitlement, to be made on termination of employment. In determining whether or not to agree an annual uplift of salary for Executive Directors, the Committee had due regard to the national pay awards made to other staff groups.

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

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

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

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

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

Remuneration
The chair and non-executive members are entitled under the Act to be remunerated by the Trust for so long as they continue to hold office as chair or non-executive member. They are

entitled to receive remuneration only in relation to the period for which they hold office. There is no entitlement to compensation for loss of office. Non-executive remuneration does not include any element of performance-related pay.

Current rate for chair and non-executives
The rate of remuneration payable to the Chairman of the Trust is £38,000 pa (2012-13: £35,700 pa) for up to 2 days a week. The Chair of the Audit Committee, Chair of Clinical Governance Committee and the Senior Independent Director are remunerated at a rate of £14,000 pa (2012-13 £14,000 pa). The current rate of remuneration payable to other non-executives is £11,000 pa (2012-13: £10,200 pa) for approximately 3 days a month.

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

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

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

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

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

For executive directors of The Royal Orthopaedic Hospital NHS Foundation Trust Terms and Conditions

Basis for appointment
Executive directors are appointed on a permanent basis under a contract of service at an agreed salary, eligibility to claim allowances for travel and subsistence costs, at rates set by the Trust for expenses incurred necessarily on its behalf. Executive remuneration does not include any element of performance-related pay. Executive directors acting in an interim capacity are normally appointed on the basis of a fixed term agreement. They are not

entitled to a performance related award but would be entitled to all other allowances and benefits.

Termination of appointment

The notice period for any executive director is 6 months. During 2013-14 one payment was made to the previous Chief Executive. During 2012-13 year one payment was made to terminate a Director's contract of employment. Both payments reflected their contracted entitlement on termination and were not compensation payments.

Future policy

In relation to voting executive directors, the current future pay policy is expected to remain in line with current policy; each director's salary is based on a fixed salary determined with reference to market information.

Salaries and allowances (*This element of the annual report has been audited)

2013-14

	2013-14 (12 months to 31st March 2014)						
Name and Title	**Salary and fees (bands of £5,000) £000**	**Taxable Benefits Rounded to the nearest £100**	**Annual Performance - related bonuses (bands of £5,000) £000**	**Long-term performance-related bonuses (bands of £5,000) £000**	**Pension - related benefits (bands of £2,500) £000**	**Other Remuneration (bands of £5,000) £000**	**Total Remuneration (bands of £5,000) £000**
Mr T. Pile - Non Executive Director (from 1st January 2013) & Acting Chairman (from 1st February 2014)	15-20	0	0	0	0	0	**15-20**
Mr B. Jackson - Non Executive Director and Chairman (from 1st April 2013 to 1st February 2014)	30-35	300	0	0	0	0	**30-35**
Mr. C. Monk – Non Executive Director (from 15th November 2012 to 1st June 2013) and Acting Chairman (to 30th March 2013)	5-10	0	0	0	0	0	**5-10**
Mrs J. Chambers – Chief Executive (from 1st December 2013)	50-55	0	0	0	***note 6***	0	**50-55**

Name and Title	2013-14 (12 months to 31st March 2014)						
	Salary and fees **(bands of £5,000) £000**	**Taxable Benefits** **Rounded to the nearest £100**	**Annual Performance - related bonuses** **(bands of £5,000) £000**	**Long-term performance-related bonuses** **(bands of £5,000) £000**	**Pension - related benefits** **(bands of £2,500) £000**	**Other Remuneration** **(bands of £5,000) £000**	**Total Remuneration** **(bands of £5,000) £000**
Mr. G. Bragg - Director of Strategic and Business Development (from 13th September 2012 to 1st December 2013) and Acting Chief Executive (to 30th November 2013)	130-135	300	0	0	***note 7***	0	**130-135**
Mr. D. O'Donoghue – Chief Executive (to 1st July 2013) ***note 1***	120-125	0	0	0	***note 7***	0	**120-125**
Mrs. H Shoker – Interim and Substantive Director of Nursing and Governance (from 1 October 2013) (Substantive from 1st April 2014) **note 4**	40-45	0	0	0	5-7.5	0	**45-50**
Mrs. L. Webb – Director of Nursing and Governance, and Deputy Chief Executive (to 7th November 2013)	55-60	0	0	0	***note 7***	0	**55-60**
Mr A. Pearson – Medical Director (from 11th March 2013)	20-25	0	0	0	***note 6***	115-120	**135-140**

Name and Title	2013-14 (12 months to 31st March 2014)						
	Salary and fees **(bands of £5,000) £000**	**Taxable Benefits** **Rounded to the nearest £100**	**Annual Performance - related bonuses** **(bands of £5,000) £000**	**Long-term performance-related bonuses** **(bands of £5,000) £000**	**Pension - related benefits** **(bands of £2,500) £000**	**Other Remuneration** **(bands of £5,000) £000**	**Total Remuneration** **(bands of £5,000) £000**
Mrs. A. Markall – Director of Operations (from 1st April 2012)	95-100	0	0	0	25-27.5	0	**120-125**
Mr. P. Athey – Director of Finance (from 1 June 2013)	80-85	0	0	0	***note 6***	0	**80-85**
Mr. P. Taylor – Interim Director of Finance (from 3rd December 2012 to 31st May 2013) ***note 2***	35-40	0	0	0	0	0	**35-40**
Mr. R. Millinship - Non Executive Director (to 6th October 2013)	5-10	200	0	0	0	0	**5-10**
Mrs. F. Kirkham – Non Executive Director	10-15	0	0	0	0	0	**10-15**
Mr. T. Southwood – Non Executive Director	10-15	0	0	0	0	0	**10-15**
Miss. E. Mountford – Non Executive Director (from 1st January 2013)	10-15	0	0	0	0	0	**10-15**

Name and Title	2013-14 (12 months to 31st March 2014)						
	Salary and fees **(bands of £5,000) £000**	**Taxable Benefits** **Rounded to the nearest £100**	**Annual Performance - related bonuses** **(bands of £5,000) £000**	**Long-term performance-related bonuses** **(bands of £5,000) £000**	**Pension - related benefits** **(bands of £2,500) £000**	**Other Remuneration** **(bands of £5,000) £000**	**Total Remuneration** **(bands of £5,000) £000**
Mr. A. Meehan – Non Executive Director and Audit Committee Chair (from 1st January 2013 to 1st February 2014)	10-15	200	0	0	0	0	**10-15**
Mr. M. Flaxman – Non Executive Director and Audit Committee Chair (from 1st March 2014) **note 5**	0-5	0	0	0	0	0	**0-5**

2012-13

Name and Title	2012-13 (12 months to 31st March 2013)						
	Salary and fees **(bands of £5,000) £000**	**Taxable Benefits** **Rounded to the nearest £100**	**Annual Performance - related bonuses** **(bands of £5,000) £000**	**Long-term performance-related bonuses** **(bands of £5,000) £000**	**Pension - related benefits** **(bands of £2,500) £000**	**Other Remuneration** **(bands of £5,000) £000**	**Total Remuneration** **(bands of £5,000) £000**
Mr T. Pile - Non Executive Director (from 1st January 2013) & Acting Chairman (from 1st February 2014)	0-5	0	0	0	0	0	**0-5**
Mr. C. Monk – Non Executive Director (from 15th November 2012 to 1st June 2013) and Acting Chairman (to 30th March 2013)	15-20	0	0	0	0	0	**15-20**
Mr. L. James - Chairman (Left 14th November 2012)	20-25	300	0	0	0	0	**20-25**
Mr. G. Bragg - Director of Strategic and Business Development (from 13th September 2012 to 1st December 2013) and Acting Chief Executive (to 30th November 2013)	65-70	0	0	0	***note 7***	0	**65-70**

Name and Title	2012-13 (12 months to 31st March 2013)						
	Salary and fees **(bands of £5,000) £000**	**Taxable Benefits** **Rounded to the nearest £100**	**Annual Performance - related bonuses** **(bands of £5,000) £000**	**Long-term performance-related bonuses** **(bands of £5,000) £000**	**Pension - related benefits** **(bands of £2,500) £000**	**Other Remuneration** **(bands of £5,000) £000**	**Total Remuneration** **(bands of £5,000) £000**
Mr. D. O'Donoghue – Chief Executive (to 1st July 2013) ***note 1***	160-165	0	0	0	***note 7***	0	**160-165**
Mrs. L. Webb – Director of Nursing and Governance, and Deputy Chief Executive (to 7th November 2013)	95-100	0	0	0	87.5-90	0	**185-190**
Mr A. Pearson – Medical Director (from 11 March 2013)	0-5	0	0	0	***note 6***	0	**0-5**
Mr. A. Thomas - Medical Director (stepped down 8th March 2013)	20-25	0	0	0	***note 7***	120-125	**145-150**
Dr. A. Okubadejo – Medical Director ***note 3***	20-25	0	0	0	***note 7***	0	**20-25**
Mrs. A. Markall – Director of Operations (from 1st April 2012)	65-70	0	0	0	***note 6***	0	**65-70**
Mr. P. Taylor – Interim Director of Finance (from 3rd December 2012 to 31st May 2013) ***note 2***	45-50	0	0	0	0	0	**45-50**

Name and Title	2012-13 (12 months to 31st March 2013)						
	Salary and fees **(bands of £5,000) £000**	**Taxable Benefits** **Rounded to the nearest £100**	**Annual Performance - related bonuses** **(bands of £5,000) £000**	**Long-term performance-related bonuses** **(bands of £5,000) £000**	**Pension - related benefits** **(bands of £2,500) £000**	**Other Remuneration** **(bands of £5,000) £000**	**Total Remuneration** **(bands of £5,000) £000**
Mr. S. Bloomer – Director of Finance and IM&T (left 9th December 2012)	70-75	100	0	0	***note 7***	0	**70-75**
Dr. E. Hensel - Non Executive Director (left 31st December 2012)	5-10	0	0	0	0	0	**5-10**
Mr. R. Otto - Non Executive Director (left 31st December 2012)	10-15	100	0	0	0	0	**10-15**
Mr. R. Millinship - Non Executive Director (to 6th October 2013)	10-15	0	0	0	0	0	**10-15**
Mrs. F. Kirkham – Non Executive Director	5-10	0	0	0	0	0	**5-10**
Mr. T. Southwood – Non Executive Director	10-15	0	0	0	0	0	**10-15**
Miss. E. Mountford – Non Executive Director (from 1st January 2013)	0-5	0	0	0	0	0	**0-5**

Name and Title	2012-13 (12 months to 31st March 2013)						
	Salary and fees **(bands of £5,000) £000**	**Taxable Benefits** **Rounded to the nearest £100**	**Annual Performance - related bonuses** **(bands of £5,000) £000**	**Long-term performance-related bonuses** **(bands of £5,000) £000**	**Pension - related benefits** **(bands of £2,500) £000**	**Other Remuneration** **(bands of £5,000) £000**	**Total Remuneration** **(bands of £5,000) £000**
Mr. A. Meehan – Non Executive Director and Audit Committee Chair (from 1st January 2013 to 1st February 2014)	0-5	0	0	0	0	0	**0-5**

*This element of the annual report has been audited.

Notes

1. In 2012/13, Mr. D. O'Donoghue was on long term sick leave, resulting in Mr. G Bragg performing the role of Acting Chief Executive with Mrs. L Webb as the Deputy Chief Executive. In 2013/14, Mr. D. O'Donoghue left the organisation on the basis of ill-health retirement. On leaving, contractual payments were made to Mr. O'Donoghue; these did not constitute a compensation payment, and received appropriate HM Treasury approval.

2. Mr. P. Taylor commenced his post on 3 December 2012 and was remunerated for two days a week through contract arrangements with Taylor Moore Associates Ltd until 30th June 2013. He was Director of Finance until 31st May 2013.

3. In 2012/13 there was an instance of a termination of employment payment relating to the appointment of a new Medical Director. This payment related to contractual obligation and did not relate to a compensation payment.

4. Mr. M. Flaxman commenced his post on 1st March 2013. He has been remunerated through contract arrangements with In Form Solutions Ltd.

5. Mrs. H. Shoker was seconded to the Trust from 1 October 2013 in the role of Interim Director of Nursing & Governance. Mrs Shoker was subsequently substantively appointed to the role post year end on 1 April 2014. Her salary and pension related benefits for the current financial year therefore relate to the costs paid to her employing Trust during this period.

6. Pension-related benefits is a new disclosure required this year. It is calculated by taking 20 times multiples of Director's annual rate of pension, plus their lump sum entitlement, and subtracting the equivalent figures for the previous year. The Directors indicated joined the Trust in either the current or prior year. As a result, the calculation would give a misleading result to the readers of the financial statements, and it has therefore been omitted from the financial statements for the current year. This figure has therefore also been excluded from the 'Total Remuneration' column.

7. Pension-related benefits is a new disclosure required this year. It is calculated by taking 20 times multiples of Director's annual rate of pension, plus their lump sum entitlement, and subtracting the equivalent figures for the previous year. The Directors indicated left the Trust in either the current or prior year. As a result, the calculation would give a misleading result to the readers of the financial statements, and it has therefore been omitted from the financial statements for the current year. This figure has therefore also been excluded from the 'Total Remuneration' column.

Salary and Pension Entitlements of Senior Managers

B) Pension Benefits*

Name and title	Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2013 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real Increase/ (decrease) in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Mrs. J. Chambers – Chief Executive (from 1st December 2013) ***note 1***	57.5-60	175-180	816	0	272	0
Mr. D. O'Donoghue – Chief Executive (to 1st July 2013) ***note 2***	0	0	0	1,173	0	0
Mr. G. Bragg - Director of Strategic and Business Development and Acting Chief Executive (from 13th September 2012) ***note 3***	N/A	N/A	N/A	N/A	N/A	N/A
Mrs. H Shoker – Interim and Substantive Director of Nursing and Governance (from 1 October 2013) (Substantive from 1st April 2014) **note 4**	0	0	0	0	0	6,000
Mrs. L. Webb – Director of Nursing and Governance, and Deputy Chief Executive (to 7th November 2013)	12.5-15	130-135	565	419	69	0

Name and title	Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2013 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real Increase/ (decrease) in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Mr. A. Thomas – Medical Director (stepped down 8th March 2013)	0	0	0	1,344	0	0
Mr. A. Pearson – Medical Director (from 11th March 2013)	40-42.5	170-175	796	572	213	0
Mrs. A. Markall – Director of Operations (from 1st April 2012)	2.5-5	110-115	448	411	29	0
Mr. P. Athey – Director of Finance (from 1 June 2013) ***note 5***	55-57.5	65-70	203	0	169	0
Mr. S. Bloomer - Director of Finance and IM&T (to 9th December 2012)	0	0	0	374	0	0

*This element of the annual report has been audited

Notes

8. Mrs. J. Chambers did not hold an executive position at the Trust prior to 1 December 2013 and so no comparatives have been provided in this report.

9. Mr D. O'Donaghue retired on the basis of ill-heath retirement during 2013/14. As a result, he does not have an accrued pension, lump sum or CETV to report as at 31 March 2014.

10. Mr. G Bragg had previously retired but had since returned to work. He therefore did not have accrued pension benefits during the time period he was performing the role of Acting Chief Executive.

11. Mrs. H. Shoker was seconded to the Trust from 1 October 2013 in the role of Interim Director of Nursing & Governance. Mrs Shoker was subsequently substantively appointed to the role post year end on 1 April 2014. Therefore, her accrued pension, lump sum and cash equivalent transfer are shown as nil for 2013-14. From 2014-15, these amounts will be shown by the Trust. The payments made by the Trust to Mrs Shoker's employing Trust in relation to her pension are shown in the 'Employer's contribution to stakeholder pension' column.

12. Mr. P. Athey did not hold an executive position prior to 1 June 2013 and so no comparative numbers have been provided in this report.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

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

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

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

Highest paid director ratio

Trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the financial year 2013/14 was £175-180k (2012/13: £160-165k). This was 5.5 times (2012/13: 6.3 times) the median remuneration of the workforce, which was £32k (2012/13: £26k).The highest-paid director salary does not necessarily match the tables above, as all salaries are required to be annualised before inclusion in the ratio calculation.

In 2013/14, 0 (2012/13: 2) employees received remuneration in excess of the highest-paid director. Annualised remuneration ranged from £3k to £173k (2012/13: £3k to £198k), with individuals at the lower end of the salary range including apprentices used by the Trust and individuals performing bank work on an ad-hoc basis.

The multiple has decreased this year due to an increase in the median remuneration of the workforce included in the calculation. This number has increased largely as a result of including agency staff costs within the calculation in 2013/14; these were not included in the calculation in 2012/13.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Directors and Governors in office and expense claims

This information is not subject to audit

The total number of Directors and Governors in office in the financial year, and their expense claims, has been shown below;

	2013-14	**2012-13**
Number of Directors in office	18	19
Number of Directors with expense claims	7	5
Financial value of expense claims made by Directors (£00)	56.11	71.66
Number of Governors in office	15	18
Number of Governors with expense claims	2	1
Financial value of expense claims made by Governors (£00)	3.48	1.87

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

This information is not subject to audit

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, the Trust is required to publish information in relation to the number of off payroll engagements.

Off-payroll engagements as of 31 March 2014, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2014	4
Of which…	
No. that have existed for less than one year at time of reporting	4
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for between four and five years at time of reporting	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, assurance has been sought.

New off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014,	7
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	3
No. for whom assurance has been requested	4
Of which…	
No. for whom assurance has been received	4
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received	0

Those individuals where contractual clauses were not included in their contracts were instead requested to complete the off-payroll engagements assurance statement provided by HMRC in their guidance on IR35 arrangements. The Trust continues to review its procedures with regards to the use of off-payroll contractors to reflect the evolution in guidance as it is received from HMRC.

Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2013 and 31 March 2014

No. of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	2
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	18

The off-payroll engagements are in relation to Mr P. Taylor and Mr. M. Flaxman.

Mr. P. Taylor was contracted as Interim Director of Finance for 2 days a week through Taylor Moore Associates Ltd, until a substantive replacement for Mr. S. Bloomer could be identified. Mr Taylor was under contract with the Trust between 3 December 2012 and 31st May 2013 as Interim Director of Finance, and worked with the Trust until 30th June 2013.

Mr M. Flaxman has been contracted as a non executive director from 1st March 2014 through In Form Solutions Ltd. The Trust felt that, due to Board changes, Mr Flaxman's services were necessary in order to provide the Trust with an appropriately skilled Audit Committee Chair, in addition to ensuring there are sufficient numbers of Non-executive Directors on the Board. His contract is expected to last 3 months, by which time it is expected that a substantive replacement will be identified.

Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
23 May 2014

The Council of Governors' report on its work, elections and membership

The work of the Council of Governors 2013/14

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

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

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

The Council of Governors appointed Mr Alan Last as their Lead Governor. He has had no cause to exercise this role during the year in regard to dialogue with Monitor regarding performance of non-executive directors. Mr Last may be contacted through the Trust's Company Secretary, Royal Orthopaedic Hospital NHSFT, Bristol Road South, B31 2AP.

In September 2013, the Trust Board and the Council of Governors jointly agreed to amend the constituencies within the constitution, suspending further elections until the new constituencies were in place. It is the Trust's intention to amend the constitution from 1st June 2014, after which elections will take place where necessary.

Doing its job – as a whole Council

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

Council of Governors involvement in strategy

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

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

Governors have now agreed a way of working with members that feels appropriate for the Trust. On recruitment, members are asked about their areas of interest and preferred level of involvement. Governors receive feedback from members who have registered interest in particular areas – through surveys and focus groups – an on occasion, all members are invited to comment. In this way, the Trust has developed a focused engagement strategy, rather than one which is ad-hoc. Governors feed the information into their own meetings and at their joint Trust Board meetings.

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

Constituencies

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

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

There are five public constituencies within Public membership:

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

There are two constituencies within Staff membership:

- Clinical
- Non-clinical

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

organisations that work closely with the Trust appoint representatives for the Council of Governors.

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

Elections

There was 1 set of elections results to report during 2013/14

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

South Birmingham:	1 seat
Rest of West Midlands:	1 seat
Heart of Birmingham:	1 seat
Northern and Eastern Birmingham:	2 seats
Rest of England and Wales	1 seat
Staff Clinical:	1 seat
Staff non-clinical	1 seat

In the two smallest constituencies, there were no nominations for election. The existing Governor for Northern and Eastern Birmingham resigned in April 2013 therefore the 2 seats in Birmingham East and North the seat within Heart of Birmingham remain unfilled. The two staff seats were filled uncontested. The remainder of the seats in the three other constituencies were contested. In addition, a further South Birmingham Governor resigned in February 2013, so this seat is still empty.

Results

Elections to our Council of Governors for vacancies arising in 2013/14 have been overseen by the Electoral Reform Society.

Public: South Birmingham April 2013

Number of eligible voters:	**2,873**
Total number of votes cast:	**561**
Turnout:	**19.5%**
Number of votes found to be invalid:	**2**
Blank or Spoilt Declaration form received	
Total number of valid votes to be counted:	**559**

Result (one to elect):

The following candidate was elected:

ROOKES, Jean

Public: Rest of West Midlands April 2013

Number of eligible voters:	**1,760**
Total number of votes cast:	**374**
Turnout:	**21.3%**
Number of votes found to be invalid:	**5**
Blank or Spoilt Declaration form received	**5**
Total number of valid votes to be counted:	**369**

Result (one to elect):

The following candidate was elected:

NOON, Stella

Public: Rest of England and Wales April 2013

Number of eligible voters:	**379**
Total number of votes cast:	**69**
Turnout:	**18.2%**
Number of votes found to be invalid:	**0**
Blank or Spoilt Declaration form received	
Total number of valid votes to be counted:	**69**

Result (one to elect):

The following candidate was elected:

TALBOYS, Rob

Staff: Clinical July 2013

Uncontested Election

TREACY, Ronan

Staff: Non-Clinical July 2013

Uncontested Election

LO COCO, Susan Mary

Elected Members serving during the year 2013/14 meeting attendance

South Birmingham (5 seats)

1.BLACKLEDGE, Joseph – resigned Feb 2014.

(attended 4 out of 4 council meetings)

2.BETTERIDGE, Marion – appointed for 3 years until end July 2015

(attended 2 out of 2 council meetings)

3.ARNOLD, Peter – appointed for 3 years until end July 2015

(attended 0 out of 4 council meetings)

4.MARTIN, Dia – appointed for 3 years until end July 2015

(attended 2 out of 2 council meetings)

5.ROOKES, Jean – appointed for 3 years until end April 2016

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

Rest of the West Midlands (4 seats)
1. SCOTT, Yvonne - appointed on re-election (third term) for 3 years until July 2015
(attended 4 out of 4 council meetings and serves on the Patient Experience Committee)
2. LAST Alan, appointed for 3 years until end January 2015.
(attended 4 out of 4 council meetings and serves on the Membership Engagement Committee)
3. WILLIAMS, Kenneth – appointed for 3 years until end January 2014.
(attended 1 out of 4 council meetings)
4. **NOON, Stella – appointed on re-election for 3 years (third term) until April 2016** currently out for election

East and North Birmingham (2 seats)
1. BHARA, Kulwant – resigned April 2013
2. VACANT SEAT(failure to secure nominations from a very small constituency membership)

Rest of England (1 seat)

1. TALBOYS, Robert – appointed on re-election (second term) for 3 years until end April 2016.

Clinical Staff Representatives
1. HUGHES, Karen – appointed for 3 years until end July 2015
(attended 2 out of 2 council meetings)
2. PEARSON, Andrew – resigned May 2013
2. TREACY, Ronan – appointed for 3 years until end July 2016

Non-Clinical Staff Representatives
1. LOCOCO, Susan – appointed for 3 years until end of July 2016

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

Birmingham City Council- no nominee in year

University of Birmingham – Nominated **Professor Andy Clarke** from May 2013
Birmingham City University - Marion Thompson
Bournville Village Trust - **Paul Sabapathy** (from October 2013)
Patient Support Groups - **Sue Arnott**
Member of Parliament - **Richard Burden MP**
Birmingham Council of Faiths - **Parwez Hussain**

Board of Governors Meeting Attendance

On appointment, governors are asked to commit to attendance at 4 meetings a year. Several governors have business commitments which can make this difficult but may have been able to attend workshops. Not all governors were in office throughout the year.

Name	Constituency	Meeting attendance 7 meetings
Rob Talboys	Public	5/7
Alan Last	Public	7/7
Stella Noon	Public	5/7
Yvonne Scott	Public	6/7
Jean Rookes	Public	5/7
Peter Arnold	Public	1/7
Marion Betteridge	Public	5/7
Dia Martin	Public	6/7
Karen Hughes	Staff	7/7
Ronan Treacy	Staff	4/7
Sue Lococo	Staff	3/7
Andrew Clark	University of Birmingham	2/7
Marion Thompson	Birmingham City University	5/7
Sue Arnott	Patient groups	4/7
Richard Burden	Member of Parliament	3/7
Parwez Hussain	Council of Faiths	0/7
Paul Sabapathy	Bournville Village Trust	2/7

The Council of Governors Register of Interests

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

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

Engaging Our Membership

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

The Trust has looked to diversify the ways in which members can become involved and feel that their contribution has made a difference to the services that we offer. Existing initiatives focussing on members who wish to engage in person have continued to develop and the department has continued to work on finding more opportunities to engage from home. Examples include:

- Invitation to members to take part in the Trust PLACE assessments.
- Invitation to members to become involved in Task and Finish groups looking at the Francis Report.
- Focus Groups for Research and Development opportunities, including the chance to provide feedback on the reasons why patients might become involved with research.
- Invitations to attend strategy days along with staff, patients and stakeholders.

- Increase in the use of the virtual patient and carers' council for proof-reading patient information and papers to ensure readability.

Members continue to:

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

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

Members wishing to contact the Governors can do so by emailing roh-tr.Governor@nhs.net

Membership size and movements

Public constituency	**2013 – 14**	**2014 - 15 (estimated)**
At year start (April 1)	6,003	5,913
New members	43	130
Members leaving	133	120
At year end (March 31)	5,913	5,923
Staff constituency		
At year start (April 1)	900	953
New members	102	0
Members leaving	49	28
At year end (March 31)	953	925

Analysis of current membership

At the end of 2013/14 the Trust had maintained an approximate membership of 6,000. The Trust will continue to develop its membership base in 2014/15 but again, will not seek significant growth and continue to focus on more varied opportunities for engagement with existing members.

Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	1	627,963
17-21	110	199,604
22+	5,433	1,953,523
Not stated	369	

Ethnicity		
White	4,130	1,919,138
Mixed	115	96,204
Asian or Asian British	409	514,981
Black or Black British	289	164,069
Other	80	42,068
Not Stated/Do not wish to state	890	

Public constituency	**Number of members**	**Eligible membership**
Socio-economic Category		
AB	1,434	137,275
C1	1,622	233,834
C2	1,223	172,516
DE	1,388	266,603
Data not available		
Gender		
Male	2,261	1,370,522
Female	3,567	1,410,568
Unspecified	85	

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 the 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 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 Annual 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;
- *ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance*; 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 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…….

Jo Chambers
Chief Executive

Date: 23 May 2014

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Royal Orthopaedic Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

The Trust reviewed its committee structure in the year, in order to ensure risk is appropriately managed within the organisation, and there are sufficiently robust governance arrangements in place.

As a result of this review, the Trust Board now has three main committees to govern risk; the Executive Management Team (EMT), the Audit Committee, and the Clinical Governance Committee. The Integrated Governance Committee, which was previously responsible for risk management across the organisation, was discontinued.

The Trust also set up four new Programme Boards, which are responsible for reviewing in detail specific areas of risk, and reporting the findings into the Executive Management Team meetings as appropriate. These Programme Boards are the Clinical Programme Board, Cost Improvement Programme Board, IM&T Programme Board and Estates Programme Board. Each Programme Board is chaired by an Executive Director, and has other Executive Directors in attendance.

The Clinical Governance Committee has designated responsibility for clinical risk management and is chaired by a Non-Executive Director of the Trust; the Chief Executive is a member of this committee. The Committee meets a minimum of 10 times per year and will review national risk management priorities and delegate responsibility for further analysis/action and review the Corporate Risk Register.

Sub-Committees reporting to the Clinical Governance Committee also meet regularly and review the risks attributed to their respective committee, scrutinising and ensuring that appropriate ratings have been attributed and appropriate mitigation undertaken. This process includes the evaluation of mitigation actions that have taken place to understand and assess the outcomes of these actions. The Trust Board also receives the risks attributed to them on a regular basis.

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

The Trust has a web based risk register that facilitates both local and Corporate risk registers and the Board Assurance Framework.

The education and training of all staff in the principles of risk management is an essential element of the Trust's Risk Management Strategy. Risk management update training is provided to new staff as part of the induction programme to the organisation and all existing staff receive annual updates on key elements as per the mandatory training programme identified through the Trust Training Needs Analysis. Enhanced training in root cause analysis, investigations and risk registers is also included.

The risk and control framework

A review of the Risk Management Strategy has been performed, with final approval due to occur in the next few months. The purpose of the risk management strategy is to:

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

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

The Trust recognises the importance of collecting meaningful and relevant data in a statistical format so that it can be analysed and trends can be monitored and appropriate action taken. Quarterly reports highlighting trends and pertinent risk issues are made to the Clinical Governance Committee and Audit Committee; these committees also receive quarterly summary reports of the combined corporate risk register and board assurance framework including the detail of all red rated risks. The committees then provide assurance to the Trust Board.

The Quality Governance Framework assesses the combination of structures and processes in place, both at and below Board level, which enables a Trust Board to assess the quality of care it provides.

The Trust Board has reviewed the Quality Governance Framework (QGF) in September 2013 to ensure it reflects a true position. The Clinical Governance Committee review the QGF on a quarterly basis to give assurance to the Trust Board that risks are being monitored and any weaknesses resolved.

Information on serious incidents is shared with key staff. Once completed serious incident investigation reports are anonymised and circulated to key stakeholders including the Virtual Serious Incident Review Investigation Group (VSIRI) for comments and feedback. The VSIRI Group is a multi-disciplinary co-opted group of senior staff who review clinical reports and provide scrutiny of findings, recommendations and action plans. Meetings are arranged where necessary to discuss the findings of serious incident investigation reports. Monthly reports on new serious incidents and actions resulting from on-going incident investigations are provided to the Trust Board and Operational management teams via the Patient Safety Report. Key learning points are also shared at the Trust's combined surgical and anaesthetic audit meeting.

Information on clinical incidents and claims is collated and incorporated in the Trust quality governance reports on a quarterly basis, along with actions and learning. This is discussed at the Clinical Governance Committee. Once approved the Trust report is submitted to the local commissioning bodies and scrutinised as part of the contract review process. Directorates receive localised reports which are discussed as part of Directorate meetings at the bi-monthly Trust Business and Learning day. In the forthcoming year feedback from these local meetings will be shared at the Quality committee.

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

The Board Assurance Framework provides a framework for reporting key information to the Board. It identifies which of the Trust's objectives are at risk because of inadequacies in the operation of controls and at the same time it provides structured assurances about where risks are being managed effectively and objectives are being delivered. The Board Assurance Framework draws together the key corporate risks from the Corporate Risk Register and is considered by the Clinical Governance and Audit Committees during the year to ensure a bottom up and top down approach to capturing key corporate risks. Each reported risk has a lead officer, lead executive, action plan and comments on performance to date which assure the Board on progress and management of corporate risks within the organisation. The Board has amended the layout of the Board Assurance Framework in the year to enable it to be more focussed on the fundamental risks faced by the Trust. These are then matched against individual specific risks, and pinpointed to a particular committee to monitor on an ongoing basis and act accordingly to put plans and mitigations in place where appropriate.

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

- The management of change challenge in meeting the transformational change required to support the delivery of the Trust's long term plans.
- Risk of ineffective patient administration due to the impact of organisation change.

- Insufficient assurance around robust implementation of infection prevention strategies in theatres.
- Ability to demonstrate learning consistently from serious events, claims and complaints.
- The ability to control the use of unfunded medical temporary or agency staffing.
- Completion of WHO safety procedures.
- Accuracy and timeliness of prescribing of medications on admission.

Red risks are managed through the Executive Management Team, Audit and Clinical Governance Committees throughout the year and they provide assurance to the Trust Board on status and progress.

In addition to the key risks highlighted above, the Board continuously considers;

- the appropriateness of the portfolio split between directors, and the responsibilities assigned to Directors and subcommittees; and
- the effectiveness of the governance structures of the Trust, and how the subcommittees report to the executive team, in order to ensure that there is adequate governance and the availability of accurate and timely information.

This has been evidenced in the year through the cessation of the Integrated Governance Committee (which previously was responsible for risk management across the organisation), the introduction of a Clinical Governance Committee, and four Programme Boards which report into the Executive Management Team; Clinical, Cost Improvement, Estates and IM&T.

These committees were introduced to improve the governance and reporting arrangements around ongoing projects within the Trust, to ensure that they are clinically fit for purpose, and deliver consistent or improved quality of care, whilst achieving the financial efficiency improvements required of all Trusts. The Trust continues to monitor these arrangements, and is currently reviewing other governance structures, including the relationship between Quality Committee and Clinical Outcomes & Effectiveness Committee.

There has been considerable activity during the year to improve the engagement of all staff, including the medical workforce. This has included regular communication with the medical staff committee, visible senior leaders and involvement of staff in key decisions and issues such as the development of strategy. The number of staff who would recommend the Trust as a place to work has increased by 4% (from 61% to 65%) compared to last year. The issue of staff engagement remains a risk for the Trust and this is being managed by the Executive and overseen by EMT via the Board Assurance Framework.

The Trust has a detailed action plan aimed at treating all patients waiting over 52 weeks (mainly in Spinal Deformity). The plan is very challenging as the issues relating to its delivery are multifactorial. However, the plan is being achieved, and as a result improvements are being observed.

The Internal Auditors have undertaken audit work around the current risk management systems including the Trust Board Assurance Framework and risk management. The overall Head of Internal Audit Opinion states that they are able to give 'significant assurance…that there is a sound system of Internal Control which is designed to meet the organisation's objectives, and that controls are being consistently applied in all the areas reviewed'. However, Internal Audit did highlight some issues that, if not addressed, increase the likelihood of risk materialising. The key issues raised were around the Trust's Data Quality in relation to the management of the 18 week Patient Waiting Lists. In a small number of cases, Internal Audit had identified that there

was insufficient data included on the Patient Administration System (PAS) to confirm that a patient had not breached the 18 week target, although none of the particular cases were found to have actually breached. Internal Audit recognises that management have put an action plan in place to address the issues identified.

The Trust reviews external reports produced by various bodies and has reviewed the findings of the Francis report to ensure full engagement of operational and management staff. The Trust Board has considered the issues identified, has performed a gap analysis and action plan, which focusses on the key priorities identified.

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

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

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

During the year the Trust had four serious incidents relating to Information Governance, with one incident being reported to the Information Commissioner. This related to the Trust sending out patient identifiable information about 1,329 patients to a GP representing the Trust's commissioners in the belief that it was supporting an approved audit. However it emerged that it was not approved. This was caused by lack of awareness in both the Trust and the commissioner of rules for providing patient identifying information for secondary use. Training and awareness has been carried out and guidance is now in place.

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

General awareness of the Trust's Strategy is achieved through its presentation to the Council of Governors, explicit references within the Trust's Annual Plan and Annual Report and by ensuring the general availability of the strategy on the Trust's website, in addition to updates I provide to the Trust in my Chief Executive's briefings and my monthly bulletin. Annual plans and annual reports are also made available via the website of Monitor the Foundation Trust Independent Regulator.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission following two unannounced routine inspections of the Trust. The first was in June

2013, and focussed on Care and Welfare of people who use our services and Management of Medicines. The second was in January 2014, and reviewed Care and Welfare of people who use our services, Safeguarding people who use our services, supporting workers, and assessing and monitoring the quality of our services.

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 Royal Orthopaedic Trust monitors its energy usage and has developed a Carbon Reduction Plan in accordance with Emergency Preparedness and the Civil Contingency requirements, as based on UKCIP 2009 weather projects, this ensures the organisation meets its obligations under the Climate Change Act and the Adaption Reporting requirements. The Trust has an established Good Corporate Citizens Group whose 'Green Champions' promote energy/carbon reduction.

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

The Trust robustly reviews performance throughout the organisation to ensure that resources are used economically, efficiently and effectively. There is a robust budget setting and financial management control system which includes activity related budgets, monthly budget manager meetings, Directorate performance meetings and regular reports to the Executive Management Team and the Trust Board. The budgetary control system is complemented by a clear scheme of delegation and financial approval limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis.

The Trust is structured into Clinical Directorates, with 5 surgical and 2 clinical support Directorates which are in line with the Trust's clinical sub-specialties. This structure has enabled greater involvement and integration with clinical managers, putting the responsibility and control of resources into the hands of the people who use them. Each Directorate is subject to formal quarterly reviews with Executive Directors. These reviews combine outcomes with efficiency, effectiveness, use of resources, quality and governance to ensure a holistic view of performance is taken.

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

A component of the Trust's financial planning is the implementation and delivery of a cost improvement programme. During 2013/14 the Trust introduced a Cost Improvement Programme Group. This is attended by Executive Directors and Directorate Managers, with significant issues being raised to Executive Management Team and Board meetings as appropriate.

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 is being used to develop Service Line Reporting, which will be circulated to management and clinical directors on a quarterly basis. This will further develop the understanding of the link between income and costs and will provide clinical management with a greater depth of information to support their decision making. Financial contribution from Service Line Reporting is reported quarterly to Directorates within their performance reports.

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

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

The Continuity of Services Rating of 4 awarded by Monitor, the independent regulator, represents a strong and robust financial performance in 2013/14. This is the highest rating that can be achieved. The Trust has achieved a very positive financial performance in the year, with a surplus before technical adjustments for impairments of £2,258k.

The governance rating of Green awarded by the independent regulator represents full achievement of all Monitor governance indicators in 2013/14 with the exception of the 18 Week RTT target for admitted patients. The Trust has failed to meet this target since November 2013, and as such, has agreed an action plan with Monitor and its commissioners. The target was met in April 2014, and is expected to continue to be met on an ongoing basis.

Annual Quality Report

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

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

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

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

The Trust has a large number of policies and plans which are in place to ensure the quality of care provided. These include the “Policy on Policies”, which ensures consistency of approach when developing, monitoring and auditing policies. To enhance the policy developmental process, and ensure best practice, additional guidance policies such as the “NICE” policy, and the “Clinical Audit and Service Evaluation” policy are also in use. The Trust have recently been assessed by the NHSLA and are noted to be compliant at Level 1 with regards to the policies it has in place. Whilst the Trust will not be assessed on its policies by the NHSLA in the future, it has chosen to continue to use the guidelines as a measure of best practice.

The Trust also has a number of methods of both collecting and reporting data for inclusion in the Quality Report. Collection systems are at both a local level and Trust level, and monitoring is performed through a number of key committees within the Trust. Examples include the Quality metrics which are included monthly within the Trust’s Corporate Performance Report and the Quality Report; these reports are then received and reviewed by Executive Management Team, Clinical Governance Committee and the Trust Board, in addition to being shared with the Trust’s partner commissioners. Other examples of outcome specific data that are reviewed and shared include Patient Reported Outcome Measures (PROMs) and NJR (National Joint Registry), which is reported to the Executive Management Team, Audit Committee, Trust Board, Clinical Governance Committee and Quality Committee.

Review of effectiveness

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

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

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

- The Board regularly reviewing progress against a number of action plans including the red risks on the Board Assurance Framework to ensure that identified actions are implemented in a timely manner.
- The Audit Committee receiving regular reports on reviews undertaken by the Internal and External Auditors and monitoring the system of internal 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 Clinical 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 Clinical Governance Committee having a programme for reviewing clinical audit and outcomes including the use of comparative benchmark data and the National Joint registry.
- Quality rounds undertaken by the Director of Nursing & Governance and her team of matrons.
- Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems.
- Executive and Non-Executive Directors having been allocated specific areas within the Trust to visit and gain feedback on safety and experience issues.
- Staff listening events being hosted by the Chief Executive and the Director of Workforce and Organisational Development to gain direct feedback from staff on a wide variety of issues.
- Staff opinions shared bi-monthly at the Trust Business and Learning Day Executive Question Time.
- The Clinical Outcomes and Effectiveness Committee (COEC) provides assurance to the Clinical Governance Committee on Clinical Audit, including agreeing the Clinical Audit Plan and monitoring progress against the plan in year.

Conclusion

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

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;

- the local Counter Fraud Reports;
- the National Patient Satisfaction Survey;
- the National Joint Register and PROMS data;
- Healthcare Evaluation Data (HED) outcome data;
- the National Staff Opinion Survey and Patient Survey;
- Data Quality Audits;
- the Independent Regulator's assessment of the Trust as part of the Risk Assessment Framework;
- the Council of Governors meetings;
- Health & Safety Executive reviews;
- the review meetings held with the Clinical Commissioning Groups on a monthly basis; and
- the Fire Group and Improvement Action Plan.

Signed……..

Jo Chambers

Chief Executive Date: 23 May 2014

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

We have audited the financial statements of the Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2014 which comprise the Consolidated Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayer's Equity and the Consolidated Statement of Cash Flows and the related notes 1 to 28. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

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

Respective responsibilities of the accounting officer and auditor

As explained more fully in the 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 for 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 Group's and the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2014 and of the Group's and the Trust's 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 Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

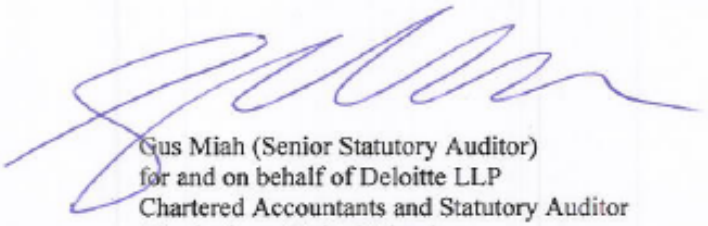
Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls; or
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

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



Gus Miah (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
27 May 2014

FOREWORD TO THE ACCOUNTS

The accounts for the year ended 31 March 2014 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.

Jo Chambers
Chief Executive

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2014

	Notes	Year Ended 31 March 2014 £000	Restated Year Ended 31 March 2013 £000
Operating Income	3	75,966	70,929
Operating Expenses	4	(72,522)	(67,174)
Net impairment on land and buildings	9.3	(2,660)	(291)
Operating Surplus		**784**	**3,464**
Finance Costs			
Finance income	6	103	224
Finance expense - financial liabilities	6	(24)	(50)
Finance expense - unwinding of discount on provisions	17	(1)	(32)
PDC Dividends payable		(1,280)	(1,280)
Gain on investment	6, 10	16	59
Net Finance Costs		**(1,186)**	**(1,079)**
(DEFICIT) / SURPLUS FOR THE YEAR		**(402)**	**2,385**
Other comprehensive income			
(Impairments)/gains on land and buildings	9.3	(296)	67
TOTAL COMPREHENSIVE (EXPENSE) / INCOME FOR THE YEAR		**(698)**	**2,452**

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

The Trust has been subject to a valuation of its land and buildings during the current financial year. As a result, an impairment has been identified, and recognised in the accounts. The full impact of this impairment has been described in further detail in note 9.3. The element recognised in the Statement of Comprehensive Income is £2,660k (2012/13: £291k) as shown above. This is a technical or non-cash adjustment. The overall surplus excluding this impairment is £2,258k (2012/13: £2,676k).

The figures for 2012/13 have been restated to reflect the consolidation of the Trust Charity in 2013/14. Prior to 2013/14, the FT ARM permitted the Trust not to consolidate the charitable fund. From 2013/14 the application of IAS 27 has been enforced and the Trust has consolidated the charitable fund and has applied the change in accounting policy. For more information please refer to note 1.2 on page 165.
The notes on pages 164 to 204 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2014

		Consolidated			Trust only		
		31 March 2014	31 March 2013	31 March 2012	31 March 2014	31 March 2013	31 March 2012
Non-current assets	**Notes**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Intangible assets	8	438	70	120	438	70	120
Property, Plant and Equipment	9	40,122	40,872	39,046	40,122	40,872	39,046
Investments	10	781	765	706	0	0	0
Trade and other receivables	12	0	0	27	0	0	27
Total non-current assets		**41,341**	**41,707**	**39,899**	**40,560**	**40,942**	**39,193**
Current assets							
Inventories	11	3,922	2,841	2,927	3,922	2,841	2,927
Trade and other receivables	12	2,942	1,888	3,329	2,942	1,888	3,329
Other non-financial assets	12	532	335	456	530	335	456
Other current assets	12	1,126	1,091	689	1,126	1,085	681
Short term investments and deposits	13.1	106	76	47	0	0	0
Cash and cash equivalents	14	19,484	21,560	19,737	19,357	21,448	19,711
Total current assets		**28,112**	**27,791**	**27,185**	**27,877**	**27,597**	**27,104**
Current liabilities							
Trade and other payables	15	(9,760)	(8,887)	(8,346)	(9,656)	(8,840)	(8,306)
Borrowings	15.2	(153)	(148)	(164)	(153)	(148)	(164)
Provisions	17	(116)	(76)	(177)	(116)	(76)	(177)
Other liabilities	15.1	(640)	(870)	(1,202)	(640)	(780)	(1,122)
Total current liabilities		**(10,669)**	**(9,981)**	**(9,889)**	**(10,565)**	**(9,844)**	**(9,769)**
Total assets less current liabilities		**58,784**	**59,517**	**57,195**	**57,872**	**58,695**	**56,528**
Non-current liabilities							
Borrowings	15.2	(541)	(693)	(842)	(541)	(693)	(842)
Provisions	17	(285)	(259)	(240)	(285)	(259)	(240)
Total non-current liabilities		**(826)**	**(952)**	**(1,082)**	**(826)**	**(952)**	**(1,082)**
Total assets employed		**57,958**	**58,565**	**56,113**	**57,046**	**57,743**	**55,446**
Financed by taxpayers' equity							
Public Dividend Capital		38,996	38,905	38,905	38,996	38,905	38,905
Revaluation reserve		2,416	2,712	2,645	2,416	2,712	2,645
Charitable Fund reserve		912	822	667	0	0	0
Income and expenditure reserve		15,634	16,126	13,896	15,634	16,126	13,896
Total taxpayers' equity		**57,958**	**58,565**	**56,113**	**57,046**	**57,743**	**55,446**

In the current year the Trust has been required to consolidate its results with that of The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund, as explained in note 1.2 to the accounts. As a result the Trust has shown its Financial Position for the last three years in both the Statement of Financial Position and the relevant associated notes.

The financial statements were approved by the Audit Committee on behalf of the Board of Directors on 23rd May 2014 and are signed on its behalf by:

Jo Chambers – Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2014

	Consolidated					Trust only			
	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Charitable Fund Reserve £000	Income and Expenditure Reserve £000	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2011	55,623	38,905	3,268	799	12,651	54,824	38,905	3,268	12,651
Surplus for the year	1,113	0	0	(132)	1,245	1,245	0	0	1,245
Impairment losses on property, plant and equipment	(624)	0	(624)	0	0	(624)	0	(624)	0
Other reserve movements	1	0	1	0	0	1	0	1	0
Taxpayers' Equity at 31 March 2012	**56,113**	38,905	2,645	667	13,896	**55,446**	38,905	2,645	13,896

	Consolidated					Trust only			
	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Charitable Fund Reserve £000	Income and Expenditure Reserve £000	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2012	56,113	38,905	2,645	667	13,896	55,446	38,905	2,645	13,896
Surplus for the year	2,385	0	0	155	2,230	2,230	0	0	2,230
Impairment gains on property, plant and equipment	67	0	67	0	0	67	0	67	0
Taxpayers' Equity at 31 March 2013	**58,565**	38,905	2,712	822	16,126	**57,743**	38,905	2,712	16,126

	Consolidated					Trust only			
	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Charitable Fund Reserve £000	Income and Expenditure Reserve £000	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2013	58,565	38,905	2,712	822	16,126	57,743	38,905	2,712	16,126
Deficit for the year	(402)	0	0	90	(492)	(492)	0	0	(492)
Impairment losses on property, plant and equipment	(296)	0	(296)	0	0	(296)	0	(296)	0
Other reserve movements	91	91	0	0	0	91	91	0	0
Taxpayers' Equity at 31 March 2014	**57,958**	38,996	2,416	912	15,634	**57,046**	38,996	2,416	15,634

The other reserve movements for the year ended 31 March 2014 relates to income received from the Energy Fund held by the Department of Health in relation to funding a new roof for part of the Trust. This has been received in the form of public dividend capital.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2014

	Consolidated			Trust only		
	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000	Year Ended 31 March 2012 £000	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000	Year Ended 31 March 2012 £000
Cash flows from operating activities						
Operating surplus	784	3,464	2,350	739	3,397	2,430
Non-cash income and expense						
Depreciation and amortisation	2,143	2,361	2,319	2,143	2,361	2,319
Donated assets	(103)	0	0	(103)	0	0
Loss on disposal	37	1	0	37	1	0
Impairments	2,939	558	922	2,939	558	922
Reversal of impairments	(279)	(267)	(6)	(279)	(267)	(6)
Amortisation of government grants	0	0	61	0	0	61
(Increase)/Decrease in Trade and Other Receivables	(1,182)	1,156	2,117	(1,156)	1,166	2,103
Decrease/(Increase) in other assets	21	0	0	21	0	0
(Increase)/Decrease in Inventories	(1,081)	86	228	(1,081)	86	228
(Decrease)/Increase in Trade and Other Payables	(983)	511	1,624	(950)	511	1,620
Decrease in Other Liabilities	(140)	(164)	(166)	(140)	(164)	(166)
Increase/(Decrease) in Provisions	66	(115)	49	66	(115)	49
Other movements in operating cash flows	0	0	0	0	0	1
NET CASH GENERATED FROM OPERATING ACTIVITIES	**2,222**	**7,591**	**9,498**	**2,236**	**7,534**	**9,561**
Cash flows from investing activities						
Interest received	102	226	171	73	197	143
Purchase of intangible assets	(417)	(15)	(61)	(417)	(15)	(61)
Purchase of Property, Plant and Equipment	(2,466)	(4,497)	(3,216)	(2,466)	(4,497)	(3,216)
NET CASH USED IN INVESTING ACTIVITIES	**(2,781)**	**(4,286)**	**(3,106)**	**(2,810)**	**(4,315)**	**(3,134)**
Cash flows from financing activities						
Interest element of finance lease	(24)	(50)	(46)	(24)	(50)	(46)
Capital element of finance lease rental payments	(171)	(171)	(171)	(171)	(171)	(171)
PDC Dividend received	91	0	0	91	0	0
PDC Dividend paid	(1,413)	(1,261)	(1,302)	(1,413)	(1,261)	(1,302)
NET CASH USED IN FINANCING ACTIVITIES	**(1,517)**	**(1,482)**	**(1,519)**	**(1,517)**	**(1,482)**	**(1,519)**
(Decrease)/Increase in cash and cash equivalents	**(2,076)**	**1,823**	**4,873**	**(2,091)**	**1,737**	**4,908**
Cash and Cash equivalents at 1 April	**21,560**	**19,737**	**14,864**	**21,448**	**19,711**	**14,803**
Cash and Cash equivalents at 31 March	**19,484**	**21,560**	**19,737**	**19,357**	**21,448**	**19,711**

NOTES TO THE ACCOUNTS

1.1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual (FT ARM)* which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2013/14* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual (FREM)* to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Significant accounting policies, judgments and sources of estimation uncertainty

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

Leases

Leases are 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 and dwellings not scheduled for disposal/demolition are depreciated on their current value over the estimated remaining life of the asset as assessed by The Royal Orthopaedic Hospital NHS Foundation Trust's ("the Trust's") professional valuer.

Partially completed spells

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

Annual Leave provision

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

1.2 Consolidation
NHS Charitable Fund

The Royal Orthopaedic Hospital NHS Foundation Trust is the corporate trustee to The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund ("the Charitable Fund"). The Royal Orthopaedic Hospital NHS Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities.

Prior to 2013/14, the FT ARM permitted The Royal Orthopaedic Hospital NHS Foundation Trust not to consolidate the charitable fund. From 2013/14 The Royal Orthopaedic Hospital NHS Foundation Trust has consolidated the charitable fund and has applied the change in accounting policy.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles ("UK GAAP"). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to eliminate intra-group transactions, balances, gains and losses. The Charity's accounts under UK GAAP were considered to identify whether any adjustments were required to bring them in line with The Royal Orthopaedic Hospital NHS Foundation Trust's accounting policies under IFRS. No such adjustments were identified.

The Charitable Fund's main accounting policies are as follows:
Incoming resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following four factors can be met:

i) entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;
ii) certainty - when the trustees are virtually certain that the incoming resources will be received;
iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability;
iv) apportionment - incoming resources that are not specifically attributable to a fund are apportioned quarterly pro rata to the value of each fund.

Incoming resources from legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes virtually certain. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

Resources expended

The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Investment management costs

Investment management costs are the fees charged by Schroder's for the management of the investment portfolio and are apportioned on the basis of fund values. The Trust is not currently incurring any investment management costs as part of its arrangement with Schroder's.

Grants payable

Grants payable are payments, made to third parties (including NHS bodies) in the furtherance of the funds held on Trust's charitable objectives to relieve those who are sick. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant.

Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified funds.

Non-current asset investments

Non-current asset investments are shown at market value.

i) There are no property assets.

ii) Quoted stocks and shares are included in the balance sheet at mid-market price, ex div.

iii) Other non-current asset investments are included at Trustees' best estimate of market value.

iv) Non-current asset investments are program related investments.

Current asset investments

i) Comprise cash balances available for investment held in Capital or Income accounts.

ii) The investments generate dividends and interest, less administration costs.

iii) Investment current assets are program related investments.

Realised gains and losses

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

The Trust is required to disclose the impact of implementing the change in accounting policy, and has therefore summarised the Statement of Financial Activities and Statement of Financial Position below;

SUMMARISED STATEMENT OF FINANCIAL ACTIVITIES

	31 March 2014 Total Funds Pre Consolidation £000	Consolidation Adjustments £000	31 March 2014 Post Consolidation £000
Total incoming resources	**205**	**90**	**295**
Total resources expended	**223**	**(2)**	**221**
Net incoming/(outgoing) resources before other recognised gains and losses	**(18)**	**92**	**74**
Other recognised gains/losses			
Gains on investment assets	**16**	**0**	**16**
Net movement in funds	**(2)**	**92**	**90**
Fund balances brought forward at 31 March 2013	**912**	(90)	**822**
Fund balances carried forward at 31 March 2014	**910**	**2**	**912**

	31 March 2013 Total Funds Pre Consolidation £000	Consolidation Adjustments £000	31 March 2,013 Post Consolidation £000
Total incoming resources	227	(90)	137
Total resources expended	121	0	121
Net incoming/(outgoing) resources before other recognised gains and losses	106	(90)	16
Other recognised gains/losses			
Gains on investment assets	59	0	59
Net movement in funds	165	(90)	75
Fund balances brought forward at 31 March 2012	747	0	747
Fund balances carried forward at 31 March 2013	912	(90)	822

SUMMERISED BALANCE SHEET

	31 March 2014 Pre Consolidation £000	Consolidation Adjustments £000	31 March 2014 Post Consolidation £000
Total Fixed Assets	**781**	**0**	**781**
Total Current Assets	**233**	**2**	**235**
Creditors: Amounts falling due within one year	**104**	**0**	**104**
Net Current Assets	**129**	**2**	**131**
Total Assets less Current Liabilities	**910**	**2**	**912**
Total Net Assets	**910**	**2**	**912**
Total Funds	**910**	**2**	**912**

	31 March 2013 Pre Consolidation £000	Consolidation Adjustments £000	31 March 2013 Post Consolidation £000
Total Fixed Assets	765	0	765
Total Current Assets	194	0	194
Creditors: Amounts falling due within one year	47	90	137
Net Current Assets	147	(90)	57
Total Assets less Current Liabilities	912	(90)	822
Total Net Assets	912	(90)	822
Total Funds	912	(90)	822

The Charitable Fund Reserve included in the Consolidated Statement of Financial Position can be analysed between the following funds:

	Unrestricted Funds £000	Restricted Funds £000	Endowment Funds £000	31 March 2014 £000	31 March 2013 £000
Funds of the Charity	363	526	23	912	822
Total Funds	**363**	**526**	**23**	**912**	822

1.3 Income

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

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

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

1.4 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs

NHS Pension Scheme

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

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

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are

accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

1.4.1 Defined contribution scheme

Following the legal requirement for all employers' to offer employees a workplace pension and to automatically enrol eligible employees, the Trust arranged a defined contribution scheme during 2013/14 to account for those individuals who are not eligible to join the NHS Pension scheme. The scheme is run by the National Employment Savings Trust. The contributions are as follows:-

	To Oct-17
Employer contribution	1%
Total contribution	2%

To 31 March 2014 the Trust has made contributions of £403 to this fund.

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 utilising the following criteria:
    - individually have a cost of at least £5,000; or
    - form a group of assets which individually have a cost of more than £200, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
    - form part of the initial setting-up cost of a new building of a refurbishment of a ward or unit, irrespective of their individual or collective cost.
    - Professional fees such as legal costs, design costs, planning fees and feasibility studies incurred in the construction/bringing the asset into use.

Measurement

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

Land and buildings are 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 2014 by GVA Grimley international property advisers. The revaluation undertaken at that date has been accounted for in these accounts on 31 March 2014 as follows:

- Land £3,247,234
- Buildings and Dwellings £31,785,645

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.

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying value amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Trust and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Retentions that do not generate additional future economic benefits or service potential are charged to the Statement of Comprehensive income when final payment is made.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

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

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

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

- Buildings – as per Professional Valuer's estimate
- Plant and Machinery:
    - Engineering Plant and Equipment – short life 5 years
    - Engineering Plant and Equipment – medium life 10 years
    - Engineering Plant and Equipment – long life 15 years
    - Medical Equipment – short life 5 years
    - Medical Equipment – medium life 10 years
    - Medical Equipment – long life 15 years
    - Decontamination Equipment – short life 2 years

- Transport Equipment – 7 years
- Information Technology – individually assessed based on type of asset
- Furniture and Fittings:
    - Furniture – short life 3 years
    - Furniture – medium life 5 years
    - Furniture – long life 10 years

Revaluation gains and losses

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

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

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

Impairments

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

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

De-recognition

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

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

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

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

    - an active programme has begun to find a buyer and complete the sale;

- the asset is being actively marketed at a reasonable price;

- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and

- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

1.7 Donated assets

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

1.8 Intangible assets

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

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

Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;

- the Trust intends to complete the asset and sell or use it;

- the Trust has the ability to sell or use the asset;

- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

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

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

Software

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

Intangible fixed assets are capitalised when:

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

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

Measurement

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

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

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

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The Trust deems the expected useful lives of intangible assets to be individually assessed based on type of asset.

1.9 Government grants

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

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

- The option to deduct the grant from the carrying value of the asset is not permitted.
- Grant income relating to assets is recognised within income when the foundation trust becomes entitled to it, unless the grantor imposes a condition that the future economic benefits embodied in the grant are to be consumed as specified by the grantor and if it is not, the grant must be returned to the grantor.

- Where such a condition exists, the grant is recognised as deferred within liabilities and carried forward to future financial years to the extent that the condition has not yet been met.

1.10 Inventories

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

1.11 Cash and cash equivalents

Cash and cash equivalents comprise of cash in hand and demand deposits, together with short-term highly liquid investments with maturities of 100 days or less and bank overdrafts. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases bank overdrafts are shown within borrowings in 'current liabilities' on the Statement of Financial Position. In the Statement of Cash Flows, bank overdrafts which are repayable on demand and which form an integral part of an entity's cash management are also included as a component of cash and cash equivalents with the equivalent items reported in the Statement of Financial Position.

1.12 Finance income and costs

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

1.13 Financial instruments and financial liabilities

Recognition

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

The Trust holds a financial liability in respect of assets acquired or disposed of through a finance lease at 31 March 2014. The Trust has not entered into any regular way purchases or sales in the year to 31 March 2014.

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

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

De-recognition

All financial assets are de-recognised when the rights to the receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

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

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

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

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

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

The Trust does not hold any assets in this category.

Loans and receivables

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

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables and other receivables.

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

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

Available-for-sale financial assets

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

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

The Trust does not hold any assets in this category.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the

expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

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

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

Determination of fair value

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

Impairment of financial assets

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

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

1.14 Leases

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

1.15 Research and development

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

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

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It is re-valued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS foundation trusts disclose the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

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

1.16 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 17 on page 197 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 20 on page 198 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 20 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

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

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) *average daily* cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, *(iii) for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on 1 April 2013,* and (*iv*) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Value Added Tax

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

1.20 Corporation Tax

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

1.21 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

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

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

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

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

1.22 Third party assets

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

1.23 Losses and special payments

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

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

1.24 Application of International Financial Reporting Standards

The following standards and interpretations listed below have had amendments which have been issued by the IASB, 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.

- IFRS 9 Financial Instruments

- IFRS 10 Consolidated Financial Statements

- IFRS 11 Joint Arrangements
- IFRS 12 Disclosure of Interests in Other Entities
- IFRS 13 Fair Value Measurement
- IAS 27 Separate Financial Statements
- IAS 28 Associates and joint ventures.
- IAS 32 Financial Instruments: Presentation – amendment regarding offsetting financial assets and liabilities

1.27 Related Party Disclosures

IAS 24 requires inclusion of commitments with related parties among transactions to be disclosed. It allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures.

1.28 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:

	Consolidated			
	Year Ended 31 March 2014		Year Ended 31 March 2013	
	£000	%	£000	%
Income from whole HM Government	73,827	97.18%	68,592	96.71%
Income from non HM Government	2,139	2.82%	2,337	3.29%
	75,966	100.00%	**70,929**	100.00%

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

3 Income from activities arising from Commissioner Requested Services and all other activities.

3.1 Income by type

	Consolidated	
	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Elective income	43,672	39,653
Non elective income	1,833	2,543
Outpatient income	6,639	7,580
Other NHS clinical income	17,369	15,068
Private patient income	928	986
Total income from activities	**70,441**	**65,830**
Other operating income		
Research and development	564	426
Education and training	2,495	2,282
Charitable and other contributions to expenditure	266	188
Income in respect of staff costs where accounted on gross basis	1,071	1,064
Other	1,129	1,139
Total other operating income	**5,525**	**5,099**
TOTAL OPERATING INCOME	**75,966**	**70,929**

Other income includes £266,909 in relation to an insurance claim for a ward fire in 2011/12 (2012/13 £nil), £170,750 from onsite catering services (2012/13 - £128,480); staff accommodation rentals of £87,655 (2012/13 - £74,995); car park income of £60,517 (2012/13 - £61,837); clinical tests of £14,418 (2011/12 - £13,916) and private guests accommodation rentals of £27,123 (2012/13 - £26,778).

Other NHS clinical income includes £6,012,291 (2012/13 - £6,131,992) for oncology block contract income from the National Specialist Commissioning Team, £2,316,910 (2012/13 - £2,442,393) for critical care bed days, £1,259,109 for CQUIN (2012/13 £1,229,698), £1,602,965 (2012/13 - £1,266,092) for physiotherapy services, £672,797 for patient travel (2012/13 £691,669), £520,281 for pre-operative assessments (2012/13 £521,034), £270,599 in relation to high cost drugs (2012/13 £184,719) and £363,436 for hospital at home (2012/13 £307,746). Also included in this figure is £1,363,201 in relation to diagnostic imaging. The income in relation to diagnostic imaging has previously been included within 'outpatient income'. However in 2013/14 the tariff was unbundled, and as a result it can be separately identified, and is now more accurately disclosed as 'other clinical income'. Other NHS clinical income also includes and £907,191 for orthotic appliances (2012/13 £711,942).

The Trust has deemed all income from activities as being in relation to commissioner related services except for any private patient income.

3.2 Income by Source

	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
NHS Foundation Trusts	238	268
NHS Trusts	310	63
Strategic Health Authorities	(9)	6,140
CCGs and NHS England	68,000	0
Primary Care Trusts	0	57,322
NHS Other	0	17
Non NHS: Private patients	915	986
Non-NHS: Overseas patients (non-reciprocal)	13	0
NHS injury scheme (was RTA)	29	40
Non NHS: Other	945	994
TOTAL INCOME FROM ACTIVITIES	**70,441**	**65,830**

The income for the Charity is not included here as this has been classified as other operating income only.

4 Operating Expenditure

	Consolidated	
	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Services from NHS Foundation Trusts	18	1
Services from other NHS Trusts	563	498
Purchase of healthcare from non NHS bodies	1,676	1,078
Employee Expenses - Executive directors	678	653
Employee Expenses - Non-executive directors	114	102
Employee Expenses - Staff	40,452	37,913
Drug costs	423	425
Supplies and services - clinical (excluding drug costs)	8,966	7,924
Supplies and services - general	789	994
Establishment	954	742
Transport	16	57
Premises	2,968	2,970
Increase in bad debt provision	538	71
Inventories write down	11	12
Inventories consumed	9,042	8,907
Depreciation on property, plant and equipment	2,094	2,296
Amortisation on intangible assets	49	65
Audit services - statutory audit	44	44
Other auditor's remuneration - further assurance services	34	18
Internal audit and counter fraud fees	84	55
Clinical negligence	1,428	1,203
Loss on disposal of other property, plant and equipment	37	1
Legal fees	37	87
Consultancy costs	157	206
Training, courses and conferences	333	254
Patient travel	15	15
Hospitality	5	4
Insurance	77	78
Other services eg external payroll	218	216
Losses, ex gratia & special payments	133	(31)
Rentals under operating leases	68	47
Charitable Fund expenditure	216	121
Other	285	148
TOTAL OPERATING EXPENDITURE	**72,522**	**67,174**

5 Operating leases

5.1 Payments recognised as an expense

	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Lease payments	68	47
TOTAL PAYMENTS	**68**	**47**

This note relates to the main Trust only as the Charity does not hold any operating leases.

The Trusts operating leases for 2013/14 consists of £11k for the use of an offsite car park and £48k for Histopathology property lease. The remainder relates to a small amount of plant and equipment.

5.2 Total future minimum lease payments

	Land £000	Buildings £000	Other £000	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
- not later than one year;	11	48	10	69	14
- later than one year and not later than five years;	2	408	20	430	0
TOTAL FUTURE PAYMENTS DUE	**13**	**456**	**30**	**499**	**14**

This note relates to the main Trust only as the Charity does not hold any operating leases.

6 Finance income and costs

	Consolidated	
	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Interest from deposit account investments	103	224
Gain on investment	16	59
TOTAL FINANCE INCOME	**119**	**283**

	Consolidated	
	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Finance lease interest	24	50
TOTAL FINANCE COSTS	**24**	**50**

7 Employee costs and numbers – Trust only

	2013/14 Total £000	2013/14 Permanently Employed £000	2013/14 Agency £000	2012/13 Total £000	2012/13 Permanently Employed £000	2012/13 Agency £000
Salaries and wages	31,951	31,951	0	30,340	30,340	0
Social security Costs	2,756	2,756	0	2,615	2,615	0
Employers contributions to NHS Pensions	3,245	3,245	0	3,146	3,146	0
Agency and contract staff	3,178	0	3,178	2,465	0	2,465
TOTAL EMPLOYEE COSTS	**41,130**	**37,952**	**3,178**	**38,566**	**36,101**	**2,465**

7.1 Employee costs

The total Employer Pension contribution payable for the year is £3,244,446 (31 March 2013: £3,145,632).

7.2 Average number of persons employed

	2013/14 Total Number	2013/14 Permanently Employed Number	2013/14 Agency Number	2012/13 Total Number	2012/13 Permanently Employed Number	2012/13 Agency Number
Medical and dental	108	102	6	105	99	6
Administration and estates	249	243	6	236	230	6
Healthcare assistants and other support staff	81	81	0	82	82	0
Nursing, midwifery and health visiting staff	342	329	13	330	320	10
Nursing, midwifery and health visiting learners	3	3	0	1	1	0
Scientific, therapeutic and technical staff	134	125	9	133	125	8
Other	6	6	0	7	7	0
TOTAL PERSONS EMPLOYED	**923**	889	34	**894**	864	30

Note: the information above relates to Trust employees only as the associated charity which has been consolidated into these accounts does not employ any staff.

7.3 Exit packages

The Trust did not make any payments in the year in relation to exit packages (2012/13 £nil).

7.4 Retirements due to ill health

During the year to 31 March 2014 there were three early retirements from the Trust agreed on the grounds of ill-health costing £168k (31 March 2012 – £nil). This has been paid by NHS Pensions and not directly via the Trust.

8 Intangible assets

	Software licences (purchased) £000	Assets under construction	Total £000
Gross cost at 1 April 2013	352	0	352
Additions - purchased	27	390	417
Gross cost at 31 March 2014	**379**	**390**	**769**
Amortisation at 1 April 2013	282	0	282
Provided during the year	49	0	49
Amortisation at 31 March 2014	**331**	**0**	**331**
Net book value			
NBV - Purchased at 31 March 2014	48	390	438
NBV - Donated at 31 March 2014	0	0	0
NBV total at 31 March 2014	**48**	**390**	**438**

	Software licences (purchased) £000	Assets under construction	Total £000
Gross cost at 1 April 2012	337	0	337
Additions - purchased	15	0	15
Gross cost at 31 March 2013	**352**	**0**	**352**
Amortisation at 1 April 2012	217	0	217
Provided during the year	65	0	65
Amortisation at 31 March 2013	**282**	**0**	**282**
Net book value			
NBV - Purchased at 31 March 2013	70	0	70
NBV - Donated at 31 March 2013	0	0	0
NBV total at 31 March 2013	**70**	**0**	**70**

This note relates to the Trust only as the Charity does not hold any intangible assets.

For the year ended 31 March 2014 the Trust held intangible assets as under construction in relation to a major IT infrastructure project which commenced in March 2014 and is expected to be completed in the autumn of 2014/15.

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

9 Property, plant and equipment for the year ended 31 March 2014

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and POA £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2013	47,869	3,135	29,756	959	3,927	7,881	39	2,044	128
Additions - purchased	4,233	0	1,970	0	1,367	859	0	17	20
Additions - donated	103	0	0	0	0	101	0	2	0
Impairments charged to operating expenses	(2,939)	0	(2,939)	0	0	0	0	0	0
Reversal of impairments credited to operating income	279	0	187	92	0	0	0	0	0
Impairments charged to the revaluation reserve	(408)	0	(408)	0	0	0	0	0	0
Reversal of impairments credited to the revaluation	112	112	0	0	0	0	0	0	0
Reclassifications	0	0	3,808	0	(3,824)	16	0	0	0
Revaluations	(1,461)	0	(1,421)	(40)	0	0	0	0	0
Disposals	(838)	0	0	0	0	(765)	0	0	(73)
Cost or Valuation at 31 March 2014	**46,950**	**3,247**	**30,953**	**1,011**	**1,470**	**8,092**	**39**	**2,063**	**75**
Accumulated depreciation at 1 April 2013	6,997	0	70	0	0	4,879	15	1,920	113
Provided during the year	2,094	0	1,413	41	0	562	6	67	5
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	(1,462)	0	(1,421)	(41)	0	0	0	0	0
Disposals	(801)	0	0	0	0	(728)	0	0	(73)
Accumulated depreciation at 31 March 2014	**6,828**	**0**	**62**	**0**	**0**	**4,713**	**21**	**1,987**	**45**
Net book value									
NBV - Purchased at 31 March 2014	36,955	3,247	28,600	1,011	1,470	2,504	18	75	30
NBV - Finance lease at 31 March 2014	675	0	0	0	0	675	0	0	0
NBV - Donated at 31 March 2014	2,492	0	2,291	0	0	200	0	1	0
NBV total at 31 March 2014	**40,122**	**3,247**	**30,891**	**1,011**	**1,470**	**3,379**	**18**	**76**	**30**

This note relates to the Trust only as the Charity does not hold any property, plant and equipment.

9.1 Disposal of assets – Commissioner Related Services

The Trust has not disposed of any assets in the year which have impacted on its ability to deliver commissioner related services.

9.2 Property, plant and equipment for year ended 31 March 2013

	Total £000	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and POA £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000
Net book value									
NBV - Purchased at 31 March 2013	37,518	3,135	27,282	959	3,927	2,052	24	124	15
NBV - Finance lease at 31 March 2013	827	0	0	0	0	827	0	0	0
NBV - Donated at 31 March 2013	2,527	0	2,404	0	0	123	0	0	0
NBV total at 31 March 2013	**40,872**	3,135	29,686	959	3,927	3,002	24	124	15

9.3 Impairments

	31 March 2014 £000	Operating income £000	Operating expenses £000	Revaluation reserve £000
Changes in market place	3,235	0	2,939	296
Reversal of impairments	(279)	(279)	0	0
TOTAL IMPAIRMENTS AT 31 MARCH 2014	**2,956**	**(279)**	**2,939**	**296**

	31 March 2013 £000	Operating income £000	Operating expenses £000	Revaluation reserve £000
Changes in market place	491	0	558	(67)
Reversal of impairments	(267)	(267)	0	0
TOTAL IMPAIRMENTS AT 31 MARCH 2013	**224**	**(267)**	**558**	**(67)**

This note relates to the Trust only as the charity does not hold any assets subject to an impairment review.

10 Investments

	Consolidated		
	31 March 2014	31 March 2013	31 March 2012
Fixed Asset Investments:	**£000**	£000	£000
Market value at 31 March	**765**	706	733
Net gain/(loss) on revaluation	**16**	59	(27)
Market value at 31 March	**781**	765	706
Historic cost at 31 March 2014	**785**	785	785

Market value at 31 March	**31 March 2014 Total £000**	31 March 2013 Total £000	31 March 2012 Total £000
Securities - managed funds	**785**	765	706
	785	765	706

Analysis of gross income from investments **Total gross income**	**31 March 2014 Total £000**	31 March 2013 Total £000	31 March 2012 Total £000
Investments in a Common Deposit Fund or Common Investment Fund	**29**	29	28

Note: all investments are held by the Trusts associated charity which has been consolidated into these accounts.

11 Inventories

	Consolidated	
	31 March 2014	**31 March 2013**
	£000	£000
Consumables	3,922	2,841
TOTAL INVENTORIES	**3,922**	2,841

	31 March 2014	**31 March 2013**
	£000	£000
Inventories recognised in expenses	9,042	8,907
Write-down of inventories recognised as an expense	11	12
TOTAL	**9,053**	8,919

Note: all inventories are held by the Trust only and no balances are attributed to the associated charity which has been consolidated into these accounts.

12 Trade receivables and other receivables

	Consolidated						Trust only					
	Financial Assets			Non-Financial Assets			Financial Assets			Non-Financial Assets		
	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000
Current financial assets												
NHS Receivables	3,449	1,860	3,206	0	0	0	3,449	1,860	3,206	0	0	0
Other receivables with related parties	125	121	145	0	0	0	125	121	145	0	0	0
Provision for impaired receivables	(632)	(93)	(22)	0	0	0	(632)	(93)	(22)	0	0	0
	2,942	1,888	3,329	**0**	0	0	**2,942**	1,888	3,329	**0**	0	0
Prepayments	0	0	0	532	227	303	0	0	0	530	227	303
Accrued income	340	70	91	0	0	0	340	70	91	0	0	0
Interest receivable	5	4	2	0	0	0	5	4	2	0	0	0
PDC receivable	159	26	45	0	0	0	159	26	45	0	0	0
VAT receivable	155	108	153	0	0	0	155	108	153	0	0	0
Other receivables	467	991	551	0	0	0	467	985	543	0	0	0
	1,126	1,199	842	**532**	227	303	**1,126**	1,193	834	**530**	227	303
Total Current Financial Assets	**4,068**	3,087	4,171	**532**	227	303	**4,068**	3,081	4,163	**530**	227	303
Non-Current financial Assets												
Trade and other receivables	0	0	27	0	0	0	0	0	27	0	0	0
TOTAL TRADE AND OTHER RECEIVABLES	**4,068**	3,087	4,198	**532**	227	303	**4,068**	3,081	4,190	**530**	227	303

BAD DEBT PROVISION

	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000
Balance at 1 April	93	22	251	93	22	251
Increase/(decrease) in provision	539	93	(8)	539	93	(8)
Unused amounts reversed	0	(22)	(221)	0	(22)	(221)
Balance at 31 March	**632**	93	22	**632**	93	22

12.1 Impairment of receivables

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

	Consolidated			Trust only		
	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000
0 - 30 days	380	0	0	380	0	0
30 - 60 days	0	0	0	0	0	0
60 - 90 days	0	0	0	0	0	0
90 - 180 days	252	93	22	252	93	22
TOTAL AGEING OF IMPAIRED RECEIVABLES	**632**	**93**	**22**	**632**	**93**	**22**

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

	Consolidated			Trust only		
	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000
0 - 30 days	700	215	240	700	209	232
30 - 60 days	16	296	65	16	296	65
60 - 90 days	56	130	33	56	130	33
90 - 180 days	54	59	109	54	59	109
Over 180 days	215	238	435	215	238	435
TOTAL AGEING OF NON IMPAIRED RECEIVABLES	**1,041**	**938**	**882**	**1,041**	**932**	**874**

13 Other current assets

13.1 Current and Non-Current asset investments

The Trust did not hold any current asset investments or non-current asset investments in the year to 31 March 2014, (31 March 2012, £nil). The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund held short-term cash deposits within a multi-asset fund, £106k (2012-13 £76k)

14 Cash and cash equivalents

	Consolidated			Trust only		
	31 March 2014	**31 March 2013**	**31 March 2012**	**31 March 2014**	**31 March 2013**	**31 March 2012**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Cash and cash equivalents at 1 April	21,560	19,737	14,864	21,448	19,711	14,803
Net change in year	(2,076)	1,823	4,873	(2,091)	1,737	4,908
Cash and cash equivalents at 31 March	19,484	21,560	19,737	19,357	21,448	19,711
Broken down into:						
Cash at commercial banks and in hand	127	163	142	0	51	116
Cash with the Government Banking Service	19,357	21,397	19,595	19,357	21,397	19,595
Cash and cash equivalents as in Statement of financial position and Statement of Cash Flows	**19,484**	**21,560**	**19,737**	**19,357**	**21,448**	**19,711**

15 Trade and other payables

	Consolidated			Trust only		
	Financial liabilities			Financial liabilities		
	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000	31 March 2014 £000	31 March 2013 £000	31 March 2012 £000
NHS Payables	2,196	2,784	3,312	2,196	2,784	3,312
Amounts due to other parties	0	0	15	0	0	15
Trade payables - capital	2,064	298	446	2,064	298	446
Social security costs	386	388	361	386	388	361
Taxes payable	441	476	447	441	476	447
Other trade payables	3,942	4,196	3,258	3,838	4,149	3,218
Accruals	731	745	507	731	745	507
TOTAL TRADE AND OTHER PAYABLES	**9,760**	8,887	8,346	**9,656**	8,840	8,306

Other Trade Payables include £468,999 outstanding pension contributions at 31 March 2014 (31 March 2013: £419,977). There are no payments due in future years under arrangements to buy out the liability for early retirements over five years.

15.1 Other liabilities

	Consolidated				Trust only			
	Current		Non-Current		Current		Non-Current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Deferred income	640	870	0	0	640	780	0	0
TOTAL OTHER LIABILITIES	**640**	870	**0**	0	**640**	780	**0**	0

15.2 Borrowings

	Consolidated				Trust only			
	Current		Non-Current		Current		Non-Current	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Obligations under finance leases	153	148	541	693	153	148	541	693
TOTAL BORROWINGS	**153**	148	**541**	693	**153**	148	**541**	693

15.3 Finance lease obligations

	Consolidated				Trust only			
	Net lease liabilities		Gross lease liabilities		Net lease liabilities		Gross lease liabilities	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Within one year	153	148	190	172	153	148	190	172
Between one and five years	541	693	612	759	541	693	612	759
After five years	0	0	0	0	0	0	0	0
	694	841	**802**	931	**694**	841	**802**	931
Included in :								
Current borrowings	153	148	0	0	153	148	0	0
Non-Current borrowings	541	693	0	0	541	693	0	0
	694	841	**0**	0	**694**	841	**0**	0

16 Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required and have therefore been removed from the Trust accounts.

17 Provisions

	Legal claims	Other	Total
	£'000	£'000	£'000
At 1 April 2013	64	271	335
Arising during the year	41	84	125
Utilised during the year	(22)	(18)	(40)
Reversed unused during the year	(20)	0	(20)
Unwinding of discount	0	1	1
At 31 March 2014	**63**	**338**	**401**
Expected timing of cash flows:			
not later than one year	63	53	116
later than one year and not later than five years	0	54	54
later than five years	0	231	231
Total expected timing of cash flows	**63**	**338**	**401**

	Legal claims	Other	Total
	£'000	£'000	£'000
At 1 April 2012	157	260	417
Arising during the year	80	0	80
Utilised during the year	(14)	(12)	(26)
Reversed unused during the year	(160)	(8)	(168)
Unwinding of discount	0	32	32
At 31 March 2013	**64**	**271**	**335**
Expected timing of cash flows:			
not later than one year	64	12	76
later than one year and not later than five years	0	52	52
later than five years	0	207	206
Total expected timing of cash flows	**64**	**271**	**335**

This note relates to the main Trust only as the Charity does not hold any provisions.

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. The rates below have been applied for 2013/14: -

Short-term (less than one year) (1.9%)
Medium-term (one – five years) (0.65%)
Long-term (later than 5 years) 2.2%

The NHS Litigation Authority as at 31 March 2014 has £11,127,215 (£10,759,926 – 31 March 2013) in respect of clinical negligence liabilities of the Trust included in its accounts.

18 Contractual Capital Commitments

	31 March 2014 £000	31 March 2013 £000
Property, plant and equipment	3,654	902
TOTAL CONTRACTUAL CAPITAL COMMITMENTS	**3,654**	902

Capital commitments include £2.5m in relation to a major IT infrastructure upgrade which commenced towards the end of 2013/14, £0.2m in relation to upgrades to the paediatric facilities and £0.3m in relation to building works for a ward affected by fire damage, in addition to other commitments on a number of smaller schemes.

19 Revaluation Reserve

	Total Revaluation Reserve	Revaluation Reserve - property, plant and equipment
	£'000	£'000
Revaluation reserve at 1 April 2013	2,712	2,712
Impairments	(296)	(296)
Other reserve movements	0	0
Revaluation reserve at 31 March 2014	**2,416**	2,416
	£'000	£'000
Revaluation reserve at 1 April 2012	2,645	2,645
Impairments	67	67
Other reserve movements	0	0
Revaluation reserve at 31 March 2014	**2,712**	2,712

This note relates to the Trust only as the Charity does not hold and assets subject to revaluation.

20 Contingent Liabilities

There are no contingent liabilities or contingent assets for the year ending 31 March 2014 (2012/13 £nil).

21 Post Balance Sheet Events

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

22 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. In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. These entries are listed below.

	Receivables 2013/14 £'000	Payables 2013/14 £'000	Revenue 2013/14 £'000	Expenditure 2013/14 £'000
Birmingham and the Black Country Area Team	0	544	19003	0
Birmingham Childrens Hospital NHS Foundation Trust	110	382	318	1160
Birmingham Community Healthcare NHS Trust	0	83	0	530
Department of Health	0	80	0	0
Department of Health	159	0	0	0
Dept of Work and Pensions	63	0	0	0
Health Education England	0	0	2155	0
Heart Of England NHS Foundation Trust	0	0	0	109
HM Revenue & Customs - Other taxes and duties	0	441	0	0
HM Revenue & Customs - VAT	155	0	0	0
National Insurance Fund	0	386	0	2756
NHS Birmingham Crosscity CCG	604	52	16837	0
NHS Birmingham South And Central CCG	0	281	8327	0
NHS Cannock Chase CCG	0	0	380	0
NHS Coventry And Rugby CCG	0	0	318	0
NHS Dudley CCG	0	108	3128	0
NHS East Staffordshire CCG	0	0	255	0
NHS England	229	0	290	0
NHS Gloucestershire CCG	0	0	195	0
NHS Herefordshire CCG	0	0	406	0
NHS Litigation Authority	0	0	0	1428
NHS Pension Scheme	0	0	0	3245
NHS Redditch And Bromsgrove CCG	179	126	2936	0
NHS Sandwell And West Birmingham CCG	174	0	4301	0
NHS Shropshire CCG	0	0	134	0
NHS Solihull CCG	106	0	2057	0
NHS South East Staffs And Seisdon Peninsular CCG	163	0	1342	0
NHS South Warwickshire CCG	80	0	451	0
NHS South Worcestershire CCG	90	0	1753	0
NHS Southern Derbyshire CCG	0	0	138	0
NHS Stafford And Surrounds CCG	0	0	246	0
NHS Walsall CCG	0	62	1698	0
NHS Warwickshire North CCG	0	114	496	0
NHS West Leicestershire CCG	0	0	104	0
NHS Wolverhampton CCG	0	0	347	0
NHS Wyre Forest CCG	0	55	1178	0
Sandwell And West Birmingham Hospitals NHS Trust	66	73	126	250
University Hospital Birmingham NHS Foundation Trust	265	105	901	2483
Worcestershire Acute Hospitals NHS Trust	129	0	154	0

	Receivables 2012/13 £000	Payables 2012/13 £000	Revenue 2012/13 £000	Expenditure 2012/13 £000
Barnsley PCT	0	175	555	0
Birmingham Childrens Hospital NHS Foundation Trust	267	602	415	1,065
Birmingham Community Healthcare NHS Trust	0	0	0	441
Birmingham East And North PCT	0	0	14,070	0
Bristol PCT	0	0	634	0
Coventry Teaching PCT	0	160	278	0
Department of Health	0	356	170	0
NHS Supply Chain (Maidstone)	0	161	0	0
Dept of Work and Pensions	204	0	0	0
Dudley PCT	0	0	3,176	0
Heart Of Birmingham Teaching PCT	0	132	2,682	0
Heart Of England NHS Foundation Trust	0	0	0	126
Herefordshire PCT	0	0	452	0
HM Revenue & Customs - Other taxes and duties	0	864	0	0
HM Revenue & Customs - VAT	108	0	0	0
Leicestershire County And Rutland PCT	0	0	990	0
London Strategic Health Authority	0	0	6,104	0
NHS Blood and Transplant	0	0	0	186
NHS Litigation Authority	0	0	500	1,210
North Staffordshire PCT	0	0	101	0
Sandwell And West Birmingham Hospitals NHS Trust	0	0	0	139
Sandwell PCT	0	131	3,116	0
Shropshire County PCT	0	0	161	0
Solihull PCT	0	0	1,826	0
South Birmingham PCT	237	0	17,996	0
South Staffordshire PCT	0	0	2,093	0
South Staffordshire PCT	0	106	0	0
The Dudley Group Of Hospitals NHS Foundation Trust	0	0	106	0
University Hospital Birmingham NHS Foundation Trust	270	130	767	2,473
Walsall Teaching PCT	0	156	1,830	0
Warwickshire PCT	0	0	1,230	0
Welsh Assembly Government	0	0	988	0
West Midlands Strategic Health Authority	0	0	2,093	0
Western Cheshire PCT	0	465	498	0
Wolverhampton City PCT	0	0	421	0
Worcestershire PCT	380	0	4,937	0

The Trust has also received revenue payments from a number of charitable funds, certain 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 £13,848 during the year (£13,848 – 31 March 2013).

23 Financial Instruments

The Royal Orthopaedic Hospital NHS Foundation Trust seeks to minimise its financial risks and through its treasury management policy does not buy or sell financial instruments. 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 2014 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 Clinical Commissioning Groups 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. 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 2014. Fair value approximates to the book value because of the short maturity of these instruments.

Classification

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

23.1 Financial Assets

	Consolidated					
	Carrying value 31 March 2014	**Fair value 31 March 2014**	**Carrying value 31 March 2013**	**Fair value 31 March 2013**	**Carrying value 31 March 2012**	**Fair value 31 March 2012**
	£000	£000	£000	£000	£000	£000
Current financial assets						
Trade and other receivables	2,942	2,942	1,888	1,888	3,329	3,329
Other current assets	1,126	1,126	1,199	1,199	303	303
Short term investments and deposits	106	106	76	76	47	47
Cash and cash equivalents	19,484	19,484	21,560	21,560	19,737	19,737
TOTAL FINANCIAL ASSETS	**23,658**	**23,658**	24,723	24,723	23,416	23,416

	Trust only					
	Carrying value 31 March 2014	**Fair value 31 March 2014**	**Carrying value 31 March 2013**	**Fair value 31 March 2013**	**Carrying value 31 March 2013**	**Fair value 31 March 2013**
	£000	£000	£000	£000	£000	£000
Current financial assets						
Trade and other receivables	2,942	2,942	1,888	1,888	3,329	3,329
Other current assets	1,126	1,126	1,085	1,085	303	303
Cash and cash equivalents	19,357	19,357	21,448	21,448	19,711	19,711
TOTAL FINANCIAL ASSETS	**23,425**	**23,425**	24,421	24,421	23,343	23,343

23.2 Financial Liabilities

	Consolidated					
	Carrying value 31 March 2014	Fair value 31 March 2014	Carrying value 31 March 2013	Fair value 31 March 2013	Carrying value 31 March 2012	Fair value 31 March 2012
Current financial liabilities	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Finance leases	153	153	148	148	164	164
Trade and other payables	9,760	9,760	8,887	8,887	8,346	8,346
Provisions under contract	116	116	76	76	285	285
	10,029	10,029	9,111	9,111	8,795	8,795
Non-current financial liabilities						
Finance leases	541	541	694	693	693	693
Provisions under contract	285	285	258	259	259	259
TOTAL FINANCIAL LIABILITIES	**10,855**	**10,855**	10,063	10,063	9,747	9,747

	Trust only					
	Carrying value 31 March 2014	Fair value 31 March 2014	Carrying value 31 March 2013	Fair value 31 March 2013	Carrying value 31 March 2013	Fair value 31 March 2013
Current financial liabilities	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Finance leases	153	153	148	148	164	164
Trade and other payables	9,656	9,656	8,840	7,976	8,306	8,306
Provisions under contract	116	116	76	76	47	47
	9,925	9,925	9,064	8,200	8,517	8,517
Non-current financial liabilities						
Finance leases	541	541	694	693	693	693
Provisions under contract	285	285	258	259	259	259
TOTAL FINANCIAL LIABILITIES	**10,751**	**10,751**	10,016	9,152	9,469	9,469

25 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. The table below records the losses and special payments incurred by the Trust by the type of loss/special payment category:

	2013/14 Total number of cases Number	2013/14 Total value of cases £000's	2012/13 Total number of cases Number	2012/13 Total value of cases £000's
LOSSES:				
Losses of cash due to:	**Numbers**	**£000**	**Numbers**	**£000**
a. theft, fraud etc	1	2	0	0
Fruitless payments and constructive losses	1	12	0	0
TOTAL LOSSES	**2**	**14**	**0**	**0**
SPECIAL PAYMENTS:				
Compensation under legal obligation	13	23	22	76
Ex gratia payments in respect of:				
a. loss of personal effects	2	0	7	1
b. clinical negligence with advice	0	0	0	0
c. personal injury with advice	0	0	2	6
d. other negligence and injury	0	0	0	0
e. Other employment payments	1	94	1	
f. Patient referrals outside the UK and EEA Guidelines	0	0	0	0
g. other	22	2	0	0
h. maladministration, no financial loss	0	0	0	0
TOTAL SPECIAL PAYMENTS	**38**	**119**	**34**	**83**
TOTAL LOSSES AND SPECIAL PAYMENTS	**40**	**133**	**34**	**83**

In the year ending 31 March 2014 the Trust had 40 (31 March 2013: 34) separate losses and special payments, totaling £132,780 (31 March 2013: £83,178). Included within the "Other employment payments" are contractual payments to an employee. These did not constitute a compensation payment, and received appropriate HM Treasury approval.

There was one instance of fraud incurred by the Trust with a cash loss of £2,098. Processes have been implemented to protect the Trust against reoccurrence of this issue.

There were no clinical negligence, 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.

26 Third Party Assets

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

27 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.

28 Auditor's Liability

The auditors have a limitation of their liability in accordance with their engagement letter signed on the 20th March 2014 for the amount of £1 million.