The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

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Annual Report and Accounts 2014–2015

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

Chairman's Statement

I joined the Trust in May 2014 and was delighted to be appointed to lead the organisation at a time of great change and opportunity. I am proud to have been given the opportunity to lead a Trust which is so focused on patient care and on achieving the very best outcomes. I try to spend some time every time I am at the hospital talking to patients and visiting wards and theatres to learn about some of the Trust's work at first hand. This has given me a real feel of how patients appreciate the Trust and its staff and through their stories how important a highly specialised elective service is as part of the NHS.

The work of the Board involves keeping a balance between overseeing the day to day operations of the Trust and the most significant risks as well as maintaining a focus on strategy and realising the longer term vision for the organisation. During the year we made a number of key changes to the governance of the organisation including the creation of the Transformation Committee to assure the Board on the delivery of our five year strategy and the strengthening of clinical governance and clinical improvement knowledge among the non-executive directors through new appointments.

I am excited by our ambitions for the longer term: the Royal Orthopaedic Hospital (ROH) needs to build on its very solid foundations of good care and clinical practice but at the same time it also needs to undertake significant rapid strategic change to meet the increasing demands and pressures on NHS services generally and on specialist elective services in particular. Our strategic plan has been produced through careful dialogue with staff, patient groups, commissioners, providers and partner organisations within our health economy. The Board and Governors of the ROH have set the vision at the heart of this strategy. Quite simply, we want the ROH to be the First Choice for Orthopaedic Care in the local health economy and nationally. We want patients of the ROH to benefit from world class outcomes and exceptional patient experience delivered by highly motivated staff who work with us to continually improve the quality of our services. We also want the ROH to be at the forefront of innovation, learning and teaching.

I am under no illusion that the next five years are likely to be among the most challenging in the history of the ROH. However, I am very confident that we will build on solid foundations and not only meet the challenge but also position the hospital even more strongly as a centre of national and international excellence in orthopaedic medicine.

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. The Trust gets fantastic input from our volunteers and I want to continue to celebrate them. I would also like to thank colleagues on the Council of Governors who perform a vital role in representing the members and holding the Board to account and Board colleagues who provide leadership to the Trust as a whole.

Dame Yve Buckland, Chairman

Chief Executive's Statement

I am delighted to have completed my first full year with the Trust having joined in late 2013. The Trust has a great reputation, financial stability and transformational ambitions for the future. Early in the financial year we developed the Trust's vision, strategy and values with a wide number of our key stakeholders. This included a workshop with 100 people including staff, patients, commissioners and partners in April, who helped the Trust develop its ambition around what matters to it and to our patients.This strategy shows how we will grow as the First Choice for Orthopaedic Care in line with our vision.

The strategy sets out an ambitious suite of initiatives that will transform the way we provide healthcare and improve patients' experience of our services. Two of these will have greater prominence and will support and enable successful mobilisation of the rest. The first is about rapidly evolving the organisation's culture, with support to develop leadership, especially clinical leadership, a 'customer service' attitude and change management skills; the second is to ensure our patients receive an excellent patient experience every step of the way, without error, duplication or waste, so that every penny of taxpayer's money can be focussed on improving outcomes for patients, and a holistic approach to quality that places importance on every interaction with patients as well as world class clinical outcomes.

Our focus will be on delivering high quality care in a safe, efficient and effective organisation, building on our legacy and transforming our approaches to reflect the very best of modern healthcare and support systems, research and innovation.

The Research and Development team has won awards this year and built on the Trust's proud history of innovation. Earlier this year the Trust was featured on BBC News for ground breaking new surgical procedures. Their successes included ITAP, a new reconstructive technique following amputation between knee and hip. This is ground breaking work which could change the way patients are treated across the globe. Another world class innovation is the use of Denosumab in patients with Giant Cell Tumour - this work seeks to stop tumours destroying bone; ROH is the only Trust providing this treatment in the UK. A further example is the SHILLATM Growth Guidance System used for the correction and maintenance of spinal deformities associated with patients with severe, progressive, life-threatening, early-onset scoliosis to minimise the number of surgeries young children need to endure.

The executive team changed considerably over the year, refreshing its composition. This gives an opportunity to see things differently and do things differently as new perspectives and experiences bring new solutions to the Trust. At the end of August Mrs Amanda Markall, Director of Operations left ; following a period as interim Director of Operations, Mr Jonathan Lofthouse has been appointed substantively. Mrs Helen Shoker left in January as Director of Nursing and Governance and Garry Marsh was appointed as an interim Director. Phil Begg joined the executive team as Director of Strategy and Transformation in November. This last post is a reconfiguration of posts within the executive team reflecting the need to strengthen the Trust's change capability over the next few years

Key to our success is our workforce and we are working to increase engagement and support for the process of change, encouraging our staff to suggest ways in which our services and processes can

improve. Every member of the staff, whatever their job, has a role to play in helping our patients, in creating a therapeutic environment and in changing for a successful and sustainable future. I would like to congratulate and thank staff for doing an excellent job and regularly going the extra mile for our patients and colleagues.

I should also like to thank Board colleagues as they have supported the executive team through some challenging times while maintaining our focus on delivering the vision for the long term. I would like to recognize the contribution of our members, volunteers and governors who work tirelessly to support our patients and help improve services and, finally our patients for their continued support of the Trust in coming to the hospital as the first choice for orthopaedic care.

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.

Mrs Jo Chambers, Chief Executive

A. Strategic Report 2014/15

1.0 Introduction

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 main hospital location is five miles from Birmingham City Centre and two 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.

The accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

2.0 Review of the Business for 2014/15

2014/15 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.

2.1 Patient Care

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

The Care Quality Commission undertook an inspection in June 2014. The Trust participated as one of a number of pilot sites for the new inspection regime. The CQC report was published on 16 October 2014 and the Trust was allocated an overall rating of “Requires Improvement”. The Trust was delighted to receive an “Outstanding” rating in Children and Young People services and a “Good” rating across the board for the caring domain. Key areas highlighted within the inspection were the safety domain in critical care which was rated as “Inadequate” and the responsive domain in Outpatients which was also rated as “Inadequate”. As part of the inspection the Trust was issued with five legally enforceable actions which related to the lack of a chaperone policy, a controlled drugs cupboard which was left open, confidential information found unsupervised, equipment that was found to be without evidence of maintenance, and inconsistent view of the oversight and management of Outpatient Services.

The Trust has welcomed the findings of the CQC inspection and this has proven to be a catalyst for change. The Trust took a number of actions working in partnership with the CQC to raise performance in all of the key domains inclusive of the legally enforceable actions. An overarching action plan has been developed with focus and attention in the areas of underachievement. A number of these actions have already been completed. The action plan remains under the review of the Board. The CQC will carry out a limited re-inspection on 28th/29th July 2015 focusing on Critical Care and Outpatients.

The Trust is extremely valued by our patients, as evidenced by our excellent results in the Friends and Family Test which was introduced in 2013.

In our latest data collection, in March 2015, 99% of our inpatients stated they were 'extremely likely' or 'likely' to recommend our services to their friends and family

We have also made progress in a number of our key quality priorities for 2014/15:

- Over 95% of patients are assessed for the risk of VTE (venous thromboembolism) upon admission to hospital.

- Improved results in both of the CQC National Patient Survey questions, this being "Do you think hospital staff did everything to control your pain?" and "Did you get enough help from staff to eat your meals?"

- Mapping of the patient's journey through the organization, improving patient experience and taking opportunity to develop services.

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

- The number of complaints received by the Trust has reduced substantially from 150 in 2013/14 to 105 in 2014/15. The management of complaints was reviewed by the CQC during their inspection in June 2014, no concerns were noted and good practice of personally making contact with and agreeing timescales with complainants was noted.

- 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.

- Reduction of Pressure Ulcers from 22 in 2013/14 to 20 in 2014/15, considerable work has been undertaken in the areas of training and documentation.

- In 2014 we re-opened the Paediatric Ward following extensive refurbishment including the creation of more single occupancy rooms and improved facilities.

- The Trust also invested in replacement of Radiology diagnostic equipment including a mobile MRI scanner to visit the site, enabling us to meet clinical demands of the service.

2.2 Operational performance

During 2014/15, the strategic and operational performance of the Trust was delivered through our clinical directorate structure comprising of five surgical directorates (Large Joints, Small Joints, Spinal surgery, Oncology & Histopathology and Paediatrics) and two support directorates (Theatres & Anaesthetics and Clinical Support). These directorates, led by a Clinical Director and supported by a Directorate Manager and Matron, were responsible for the delivery of safe and effective patient centred care, high quality outcomes and compliance with national and local finance and performance targets.

The Trust treated 15,300 admitted patients and 73,969 outpatients in 2014/15, an increase of 2% and 12% respectively as compared to the previous financial year.

	Performance against Plan			**Performance against 2013/14 actual**	
	Actual Treated 2014/15	**Plan to Treat 2014/15**	**Variance**	**Actual Treated 2013/14**	**Variance**
Elective	6813	6987	-174	6695	118
Non-Elective	301	391	-90	383	-82
Day Cases	8186	7576	610	7301	885
Total Admitted Patient Care	15300	14954	346	14379	921
First Appointment	19416	18213	1203	18766	650
Follow Up Appointment	47059	40442	6617	42373	4686
Outpatient Procedures	7494	7376	118	7447	47
Total Outpatients	73969	66031	7938	68586	5383

Demand for our services continued to grow in 2014/15, with referrals from West Midlands GPs growing by 6.1% over a 12 month period. This demand was felt across a range of services, with particular growth in paediatrics and musculoskeletal health (MSK).

The NHS faced unprecedented challenges in 2014/15 with regards to access to elective services, as the growing A&E and urgent care pressures across the sector led to saturated capacity in many acute centres.

As a largely elective centre, the Royal Orthopaedic Hospital avoided many of these direct pressures; however we were able to play our part in a sector-wide solution by supporting other providers to manage their waiting time demands.

From November 2014, the Trust undertook approximately 20 procedures per month from other acute partners across the West Midlands, and it is anticipated that this support will increase to approximately 50 patients per month in 2015/16.

In addition to this surgical growth, the Trust continued to see an increase in demand for our preventative and non-surgical MSK services. Growth in our nationally renowned Bone Infection Service, offering services across both acute and community settings, led to around 60 patients being under the care of the team at any one time by the end of the year, whilst growth in our Heel Pain and Functional Restoration services also demonstrated the important role that the Trust plays in the conservative management of musculoskeletal pain.

Growth in demand inevitably places additional pressure on the delivery of care within the national agreed waiting time windows; however the Trust achieved full compliance with all 18 weeks referral to treatment targets in all applicable months. The only exception to this came in October and November of 2014, when a national amnesty was put in place to enable Trusts to actively reduce their backlog of long-waiting patients. The Trust were successful in treating an additional 210 patients during this period who would otherwise have continued to wait for treatment.

The management of our highly specialised paediatric spinal deformity patients within national waiting time targets continues to be a major challenge for the Trust, in line with other providers of this service. National shortages of paediatric intensive care beds, along with other national capacity constraints such as the availability of suitably trained specialist staff, have led to continued long waits for this patient group, with five patients waiting over 52 weeks for treatment by the end of 2014/15. A more detailed explanation is given in the Regulatory Ratings Report. The Trust continues to work with NHS England's specialist commissioning team, the West Midlands Strategic Clinical Network and other provider partners to find both short-term and strategic solutions to this ongoing issue.

All other annual Monitor performance targets were achieved in 2014/15, as shown in the table below:

Target	Target performance	Actual performance %			
		Q1	Q2	Q3	Q4
18 weeks RTT – Admitted	90%	**91.8**	**92.3**	**86.3**	**91.3**
18 weeks RTT – Non Admitted	95%	**95.3**	**95.4**	**92.7**	**95.3**
18 weeks RTT – Incomplete	92%	**94.8**	**94.3**	**95.3**	**94.3**
Cancer – 2 week wait to be first seen following urgent GP referral	93%	**100**	**100**	**99.1**	**100**
Cancer – 31 day wait from diagnosis to first treatment	96%	**100**	**97.2**	**100**	**100**
Cancer – 31 day wait for second or subsequent treatment - surgery	94%	**100**	**97.1**	**100**	**100**
Cancer – 62 day wait for first treatment (from urgent GP referral)	85%	**100**	**88.2**	**86.1**	**95.8**

2.3 Financial Performance

2014-15 has been a particularly challenging year for the Trust's finances, with the Trust finishing the year in deficit for the first time since gaining Foundation Trust status. The final deficit of £432,000 (before impairments and consolidation of the charitable funds accounts) against a planned surplus of £500,000 was driven by a number of contributory factors, many of which have been areas of concern for the NHS as a whole.

The biggest single driver for the deterioration in financial performance has been the increased reliance, and associated cost, of temporary staffing. Expenditure on locum and agency staffing increased from £2.8m in 2013/14 to £4.7m in 2014/15, with costs spread across a number of clinical and non-clinical areas. A major factor in this increase has been difficulties in recruiting to key staffing groups such as junior doctors, specialist theatre practitioners and qualified nurses, many of which are facing national shortages. The Trust has also taken active steps to address changes in national guidelines, such as those driven by the Francis Report and pressures around seven day services, to ensure that clinical staffing levels are appropriate for the needs of our patients. In some cases, this has led to additional temporary staffing being utilised whilst substantive posts are recruited to.

The Trust continued to tackle the challenge of ensuring that the NHS delivers value for money through efficient services, delivering £2.1m of cash releasing savings and efficiencies in 2014/15.

This equated to 2.7% of the Trust's turnover, however this was below the target of £2.8m set by the Trust.

The Trust Board are committed to delivering our vision to be the first choice for orthopaedic care and has invested in a wide ranging transformation programme in support of this. £1m of investment was put in place in 2014/15, on areas such as leadership development, communication, IT and informatics solutions and change management, and this level of investment has been retained in our financial plan moving forwards into 2015/16.

Despite the in-year financial challenges, the Trust remains in a strong financial position, with £13.7m of cash supporting our overall financial resilience. The Trust received a Continuity of Services rating of four from Monitor for 2014/15, representing the lowest level of financial risk as measured by their two financial indicators. The table below shows these ratings by quarter:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Capital Service Cover	3	4	4	3
Liquidity	4	4	4	4
Overall Continuity of Services Risk Rating	4	4	4	4

2.4 Capital Investment

The Trust invested £4.3m in capital schemes in 2014/15, 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 2014/15 included:

- £1.2m investment in radiology equipment and associated build costs, including new Fluoroscopy and DR X-ray equipment, image intensifiers and mobile machines.
- £0.5m replacing the fire-damaged areas on Ward 12
- £0.5m on the new Learning & Development training suite, and other minor estates rationalisation schemes
- A further £0.3m on environmental and structural improvements on our paediatric ward

2.5 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 into account the Trust's five year strategic plan, and our one year operational plan. Consideration has also been given to the trust's liquidity position and our Continuity of Services risk rating. 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.

The accounts have been prepared under a direction issue by Monitor under the National Health Service Act 2006.

2.6 The Impact of the business on the environment

The Trust embraces sustainability working through its staff to reduce its carbon footprint and help with controlling its environment impact. With our 'Green Champions' the Trust promotes carbon reduction through good housekeeping, this we consider will make a contribution in driving down the energy usage at the Trust. Engagement and encouragement at work fosters a culture of carbon efficiency which will lead to carbon reductions at work and in peoples own personal lives.

Through modification and replacement of directly fired energy plant we continue to investment in saving greenhouse gas emissions. We continue to invest in electrical energy saving investments such as LED lamps and better controls for our building management systems. Where appropriate, we apply meters and energy saving devices to control electrical usage.

The Trust continues to invest in energy saving initiatives such as super insulating buildings and installing energy efficient double glazed windows and doors to external locations.

The Trust has recently fitted meters to its incoming water supplies; these are monitored on a daily basis. Our waste streams are monitored and the Trust is looking to further develop its recyclable waste stream.

The Trust is the proud owner of a 'Green Apple Award' as a result of our effort 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 as a vibrant part of our community.

2.7 Social Community and Human Rights issues

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.

2.8 The Trust's Employees

We began the year by working with staff to develop the Trust's new five year strategy. There was extensive engagement with staff, both in small groups and with a large scale event at the end of April 2014 that confirmed our aspirations and created a commitment to change.

Staff have continued to be involved in improving services for patients including improvements to the patient experience in outpatients and on the day of treatment. This work will continue into 2015/16.

Two key elements of the strategy are to create a culture of innovation and service alongside fully engaged staff. During the year the Trust has invested heavily in improving internal communications, staff learning and development and increasing the visibility of senior leaders.

As part of creating a culture of innovation and service, the key policies that create the framework for staff, have been revised to support the Trust's strategy. The appraisal policy for all staff except doctors is now aligned to delivery and behaviours; the recruitment policy has selection on the basis of values and pay progression for all staff except doctors is linked to delivery of agreed objectives. These are key enablers to the achievement of our aims.

In order to better understand the barriers and enablers to medical staff participating in leadership roles in the Trust we commissioned the Kings Fund to undertake some work with us in this area, the results of which are awaited. These will be used to inform our approaches to medical leadership roles and development during 2015/16.

During the year we made progress in the area of Equalities, with improvements in the areas of learning and development, capturing relevant data for staff and patients and our Equality and Diversity Policy. Our full Equality Duty report can be found on the Trust's website.

The Trust continues to support the development of staff, with particular focus this year on staff who receive the lowest pay. Over 33 existing staff are now engaged in an apprenticeship programme and a further 11 staff are in apprenticeship roles to enable young people to access health careers. Our work in this area has received national recognition.

The final four months of 2014/15 were focused on supporting staff to adapt to the enhanced expectations in relation to controlled drug administration, to facilitate compliance with external requirements.

The key workforce challenges for 2015/16 are to increase overall staff engagement, improve leadership capacity and capability and reduce expenditure on medical locums. These are key features of the Trust's transformation programme.

As at 31/03/2015	Male	Female	Total
Directors	7	4	11
Other senior managers	0	0	0
Employees	287	701	988

2.9 Strategy and Business Model

In the first year of the five year the current strategic plan, the Trust has made good progress towards the delivery of the its seven strategic initiatives, namely:

- Creating a culture of excellence, innovation & service
- Exceptional patient care every step of the way
- Safe and efficient processes
- Fully engaged patients and staff
- Clinical services development
- Information for excellence
- ROH – the knowledge leader

The infrastructural work required to deliver the transactional component is well underway with significant changes in processes and material hardware such as IT investment and a clear IM&T strategy developed in support of delivering a modern fit for purpose organisation. The overarching focus of the Trust is positioning ourselves in the wider health economy as the preferred provider of exceptional orthopaedic patient care.

The transformational initiatives have been more challenging, but have still developed well, and the Trust Board has full engagement and oversight of the change agenda and plans. This has largely been achieved with the establishment of a Transformation Committee of the Board being implemented and chaired by a Non-Executive Director. The singular focus of the committee is to hold to account, monitor and challenge strategic developments within the organisation that materially improve the patient experience within the Trust.

Following extensive stakeholder engagement these seven ambitious and challenging strategic initiatives were launched and work has been steady, towards the achievement of these, mindful of the importance of engaging with staff, or patients and colleagues within our local health economy.

Set within an economic context that has challenges around tariff changes and budget restraints, the Trust is determinedly committed to improving services and infrastructure, and planning for future growth, through our local CCG and provision of clinical services to other acute providers.

The transformation agenda is purposely ambitious, and we continue 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. We also are focused on ensuring our outcomes and patient satisfaction figures are amongst the highest in the sector.

The Trust's strategy highlights a business model that is built upon the fundamental principle of delivering NHS healthcare. Whilst the Trust intends to investigate avenues for additional commercial growth, the vast majority of our turnover over the five year period of our financial plan will continue to come from traditional NHS routes. The Trust has targeted growth in three key domains:

- General orthopaedics – Responding to the growing demand for orthopaedic care as a result of the aging population, and supporting the health economy to maintain appropriate waiting times for orthopaedic patients.

- Specialist orthopaedics – Addressing the capacity constraints within our highly specialised services to respond to the increase in referrals into our service

- MSK & preventative care – Using our highly skilled workforce and specialist expertise to ensure that appropriate and effective preventative and non-surgical care is offered to patients within the local health economy.

2.10 Planning for the future

In addition to the internal direction of travel described within the Trust's five year strategy and implemented through our transformation programme, there are a number of other factors that will influence the Trust's future development, performance and position. These include:

Developments in the national tariff and NHS funding model – The majority of the Trust's income flows through the payments by results system, so changes in this tariff system can have a big impact on our financial standing, In 2015/16, the Trust stands to lose approximately £1.5m due to changes in the funding model for orthopaedic care. We are continuing to work with Monitor and NHS England, in conjunction with the Specialist Orthopaedic Alliance, to address areas within the national tariff where the resources required to deliver specialist orthopaedic care are not being fully recognised.

Effective and sustainable staffing models – Our clinical teams are in the process of reviewing staffing models in a number of clinical areas, including our wards, theatres and junior medical cover to ensure that these models are fit for purpose in the modern NHS, and that the skills required can be effectively sourced and retained. We are looking at a range of new and developing roles, such as Physicians Associates, Advanced Nurse Practitioners and Extended Scope Practitioners to provide our workforce of the future.

Capacity and Demand management – The Trust continues to see a growth in demand for our services, and we must ensure that we have appropriate capacity to deal with this demand. Investment in these areas needs to be considered alongside the ongoing financial constraints within the NHS, with a growing population needing to be treated within a finite financial envelope. The Trust will be looking to maintain and build upon our existing good relationships within the health economy to ensure that it is actively participating in the local health economy system planning, led by local Clinical Commissioning Groups. This is in order that we can work with partners to develop a sector-wide solution to meeting the needs of our patients in the future.

The size of the challenge should not be underestimated, and a number of solutions to our current financial pressures will take some time to develop, implement and embed, however the Trust is confident that the steps being taken will ensure the long term success of the Royal Orthopaedic Hospital.

3.0 Risks and Uncertainties facing the Trust

The Trust manages its internal risks through the Board Assurance Framework, which highlights eight 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.
- Inadequate staff engagement.
- Organisational leadership.
- Long-term viability.

The most significant risks underlying these categories are as follows:

- **Risks to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff reductions** – these risks have become especially significant because of the very demanding financial settlement for 2015/2016 and internal challenges for example associated with controlling the use of unfunded medical temporary/agency staffing.

- **The risk that the Board and organisation does not have adequate capacity or capability to change or does not organise its resources to change effectively** – this risk is especially significant because of the critical importance and scale of the Transformation Programme in delivering the Trust's long term strategy.

As well as the above risks there are some wider uncertainties which impact the Trust. Many of these, such as the impact of the result of the 2015 general election on NHS policy, the continued challenge of growing NHS demand driven by demographic growth, patient expectations, technological advances and the economic environment of static or shrinking financial resources, are relevant to NHS providers as a whole.

Approved by the Board of Directors on 26 May 2015.

Mrs Jo Chambers

Chief Executive

26th May 2015

B. The Board of Directors' Report 2014/15

This part of the report complements the description of the Trust's activity in the Strategic Report. It describes the governance and conduct of the Board and provides assurance that the Board effectively discharges its compliance obligations.

1.0 Summary statement of how the Board of Directors and the Council of Governors operate

The Royal Orthopaedic Hospital is constituted as a Foundation Trust which is a membership organisation which has two 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.

The Council of Governors holds the non-executive directors (NEDs) 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 Board is collectively responsible for the performance of the Trust. The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the Trust as a whole and for the public.

The Chair holds meetings with NEDs without executives being present before each public Board meeting.

The Board of Directors:

- provides entrepreneurial leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.

- is responsible for ensuring compliance by the Trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

- develops and articulates a clear "vision" for the Trust

- sets the Trust's strategic aims at least annually taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place for the NHS foundation trust to meet its priorities and objectives and, then, periodically reviewing progress and management performance.

- as a whole is responsible for ensuring the quality and safety of health care services, education, training and research delivered by the Trust and applying the principles and

standards of clinical governance set out by the Department of Health (DH), NHS England, the Care Quality Commission (CQC) and other relevant NHS bodies.

- ensures that the Trust functions effectively, efficiently and economically.

- sets the Trust's vision, values and standards of conduct and ensures that its obligations to its members are understood, clearly communicated and met.

Informal and frequent communication between the governors and the directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides. The Senior Independent Director and Chairman encourage informal methods of communication on behalf of the Board of Directors including: discussions between governors and the Chairman, the Chief Executive or a Director, through the office of the Chief Executive or any other person appointed to perform the duties of the Chief Executive to the Board.

Formal communications are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively. Communications initiated by the Council of Governors, and intended for the Board of Directors, will be conducted as follows:-

i. Specific requests by the Council of Governors will be made through the Chairman, to the Board of Directors;

ii. Any governor has the right to raise specific issues at a duly constituted meeting of the Council of Governors through the Chairman. In the event of disagreement, two thirds of the governors present must approve the request. The Chairman will raise the matter with the Board of Directors and provide the response to the Council of Governors.

iii. Joint informal meetings will take place between the Council of Governors and the Board of Directors as and when necessary.

2.0 Members of the Board of Directors

2.1 Directors holding office during 2014/15

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

Dame Yve Buckland – Chairman (first term of office from 1st May 2014 to 31st March 2017)

- Awarded DBE in 2003 for services to Public Health

- First National Chair of the Consumer Council for Water.

- Former National Chair of the NHS Institute for Innovation and Improvements.

- Honorary Member of the Warwick Business School's Faculty of Public Health and Medicine and a fellow of their Institute of Governance and Public Management

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

- Consultant in Paediatrics at Birmingham Children's Hospital
- Head of the Department of Paediatrics at the University of Birmingham and Head of e-learning at the College of Medical & Dental Sciences
- Previous roles have included Chair at EULAR Standing Committee on Paediatric Rheumatology; Head of Division of Reproductive & Child Health and Member of Medical School Board; Clinical Director and Director of Research & Development and Member of Executive Board.

HH Frances Kirkham – Non-Executive Director (2nd term of office expires 10/02/2017)

- Arbitrator, adjudicator and mediator. Justice of the Qatar International Court and Dispute Resolution Centre. Former senior circuit judge, Technology & Construction Court.
- Member of Professional Conduct Committee of Chartered Institute of Arbitrators. Trustee, University Women's Club.

Mrs Elizabeth Chignell née Mountford – Non-Executive Director (1st term of office was due to expire 31/12/2015). Tendered resignation of her post in March 2015, with immediate effect.

- Professional Executive Interim, with multi-client experience, transacting various HR and Change assignments within both public and private sectors.
- Previous Board member of Cleaning & Support Services Association, Asset Skills Sector Council and Chair of HR Committee for Business Services Association.
- Various HR roles held including Director of HR at Rentokil Initial Facilities Services, Head of Ground Employee Relations at British Airways and Divisional HR Director at Granada Group.

Mr Timothy Pile – Vice Chairman, Senior Independent Director (1st term of office expires 31/12/2015) Acting Chairman from April 1st 2014 until 30th April 2014.

- Executive Chair of Cogent Elliott. Past President of the Birmingham Chamber of Commerce.
- Previously Chief Executive of Sainsbury's Bank and Non-Executive Director of Cancer Research UK.
- Various management positions held at Alliance & Leicester (now Santander) and Lloyds.
- Other roles include Trustee of the Library of Birmingham, and Board member of Marshalls PLC. Governor of Bromsgrove School.

Mr Michael Flaxman - Interim Non-Executive Director (term of office completed on 31st May 2014) - Mr Flaxman is a qualified accountant who runs an independent consultancy business.

Mr Rod Anthony - Non-Executive Director and Chairman of the Audit Committee (first term of office from 1st June 2014 to 31st May 2017) -

- Mr Anthony is a qualified accountant, experienced finance professional, board director and management consultant with many years of experience working in both the public and private sectors.

- Previously was a board member of the NHS Institute for Innovation and Improvement initially as Director of Finance and Corporate Services and latterly as Interim Managing Director. Has a deep knowledge and understanding of the healthcare sector and healthcare innovation and improvement.

- Currently Director at the Innovations at Healthcare Gateway Ltd, Advisor to the Social Care Improvement Group and consultant to Health Data Insight CIC.

Mrs Jo Chambers – Chief Executive Officer

- Previously Associate Director of Delivery at University Hospitals Birmingham NHS Foundation Trust, Chief Executive at Shropshire Community Health NHS Trust and Shropshire County Primary Care Trust.

- Former Deputy CEO/ Director of Finance & Performance at Good Hope Hospital NHS Trust and Heart of Birmingham (Teaching) Primary Care Trust

- Over 30 years NHS experience in acute, community and primary care services.

- Member of the West Midlands Academic Health Science Network Board, and Chair of the Central Spoke Council.

- Former Chair of the Healthcare Financial Management Association (West Midlands).

- MBA, ACMA, CGMA qualified.

Mr Paul Athey – Director of Finance

- Appointed in May 2013 after spending four years as the Trust's Deputy Director of Finance.

- Member of the National Payment by Results Technical Working Group and Foundation Trust Technical Issues Group.

- 14 years of NHS experience in a variety of roles in both provider and commissioning organisations.

- Former National Financial Management Trainee.

Mrs Amanda Markall – Director of Operations (until 31st August 2014)

- Joined the Trust as Director of Operations in July 2012.

- Commenced in the NHS in 1985 as a Student Nurse and worked at Selly Oak Hospital as a Staff Nurse and Ward Sister.

- Joined the Queen Elizabeth New Hospital project team in 1999 assisting in developing the clinical brief for the new hospital.

- Started in General Management in 2002 firstly at University Hospital Birmingham NHS Trust and then moving to Heart of England Foundation Trust in 2004.

- Has had responsibility for numerous specialties across both surgical and medical units.

- Became Director of Operations for Ambulatory Care across Heart of England and later Director of Operations for Good Hope Hospital in 2010.

Mr Jonathan Lofthouse – Director of Operations (from 1th September 2014)

- Joined the ROH from Barts Health NHS Trust where he was one of three Hospital Directors.

- Since 2011 provided interim director support to the NHS, working with 5 other Acute Trusts both in England and Scotland.

- In 2008 became a Director with Barnet and Chase Farm Hospitals before being seconded to the Department of Health and then as Executive Director of Delivery for Great Western Ambulance Service.

- Over 20 years NHS experience working with providers and the Modernisation Agency (centred on the original introduction of the Four Hour Emergency Care performance standards).

Mr Andrew Pearson – Medical Director

- Consultant Orthopaedic Surgeon specialising in lower limb arthroplasty – appointed 2004.

- Former Clinical Director for Large Joints.

- Clinical Lead for Bone Infection Unit.

Mrs Helen Shoker – Director of Nursing and Governance (until 31 January 2015)

- Joined the Trust as Interim Director of Nursing & Governance in October 2013 for a six month period and was appointed substantively after this.

- Seconded from Sandwell & West Birmingham Hospitals NHS Trust as Director of Nursing for Surgery A, Theatres and Critical Care leading a team of 12 senior nurses.

- A registered nurse with a clinical background as a Consultant Nurse in wound healing and tissue viability.

- Experience of working in the commercial sector and 18 months as the national lead for a number of wound healing research studies.

Mr Garry Marsh – Interim Director of Nursing and Governance (from 16 February 2015)

- Appointed in February 2015 following 4 years as Deputy Chief Nurse at United Lincolnshire Hospitals NHS Trust.

- Holds a wide range of nursing and operational experience gained from multiple roles across his 22 years NHS service.

- Awarded MSc Health Policy & Management and BSc (Hons) Health Studies.

Changes after year end

Mrs Elizabeth Chignell submitted her resignation from the Trust in April 2015 and this took effect from the Board Meeting on 6th May 2015.

Mrs Kathryn Sallah was appointed as Non-Executive Director with effect from 1st April 2015 with a three year term.

2.2 Process for appointing or removing non- executive directors

The appointment of the chairman and non-executive directors typically follows the following process:

- The Trust Board reviews the skills, composition and balance of the Board and advises the Council of Governors

- The Nominations and Remuneration Committee of Council of Governors discusses the skill-set required and the time commitment of the role and recommends the process of appointment to the full Council. A search consultant is usually appointed.

- Selection of a candidate to be nominated to Council of Governors takes place Background checks including those required to meet the Fit and Proper test take place

- The Council of Governors meet to consider and appoint candidate.

Removal of the chairman or another non-executive director requires the approval of three-quarters of the members of the Council of Governors.

Some administrative issues were identified during the year regarding the appointment of three NEDs. One issue was identified and rectified in Quarter 2 and the other was identified and rectified in October 2014. None of these issues related to the suitability of the non-executive directors to fulfil their roles. The Trust believes there are no further actions to take relating to these appointments.

3.0 The Board of Directors' summary of activity for 2014/15

3.1 Principal activities of the Trust in the course of the year

The Royal Orthopaedic Hospital NHS Foundation Trust is a single specialty orthopaedic hospital offering routine elective and specialist treatment. It offered spinal services to the region and soft tissue and bone tumour services to the Midlands, the North of England and Wales during the course of the year.

3.2 Board of Directors' Discharge of Obligations

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. The Directors also confirm that the board has conducted a review of the effectiveness of its system of internal controls. Please see section L, 4.3 for more detail on this.

The Directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

3.3 Directors' interests and independence

The Trust maintains a register of directors' interests which is open to the public: access is available by writing to:

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

The Board considers that all NEDs are independent in character and judgment and there are no relationships or circumstances which are likely to affect, or appear to affect, their judgment.

3.4 Working with Governors and Members

Members of the Board, and in particular the NEDs, develop an understanding of the views of governors and members about the NHS foundation trust through a number of means including:

Attendance at Council of Governors meetings by Directors- the CEO and executive team colleagues brief governors about the Trust's strategy and current developments, and answer questions to ascertain their views. NEDs regularly attend Council meetings and at each meeting of the Council at least one NED gives a detailed presentation regarding their role on the Board and conducts a question and answer session.

Members of the Council are invited to attend public Board meetings and the Chairman encourages them to ask questions and to communicate their views and the views of members.

The members and governors communication strategy has been revised to raise the profile of the Trust and the role of the governors among members and encourage members to share their views.

Members' surveys have been carried out so that Board members are aware of members' priorities.

Members who wish to communicate with governors and/or directors should refer to the contact procedures on the Trust's website.

3.5 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 carried by a combination of reflective workshops during the year and a self-assessment questionnaire. During the year there were two externally facilitated activities which included a focus on Board and Committee performance. One was an external review of governance, and the second was a Board workshop exploring the Board's role using the "Well Led" framework as a model. The external review was carried out by the Good Governance Institute; the workshop was facilitated by Outhentics Consulting neither of which have any other connection to the Trust.

Executive Directors are set objectives which are evaluated by the CEO; the CEO's own performance is evaluated by the Chairman of the Trust. NEDs' objectives are set by the Chairman; their evaluation is carried out by the Chairman and the results are shared with the Council of Governors. The Chairman's appraisal is carried out by the Senior Independent Director with input from the Lead Governor. The results are shared with the Council of Governors. The results are also used as a basis of a development plan for NEDs

The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. Both the Board and the Council of Governors considered that there was a need to strengthen clinical governance and clinical improvement knowledge among the NEDs. A NED with improvement knowledge was recruited in June 2014 and the recruitment of an additional NED with a clinical background was initiated towards the end of 2014/2015.

4.0 Board Committees

The Board had the following committees during 2014/15:

- **Audit Committee**: to provide scrutiny and oversight of Trust controls
- **Clinical Governance Committee**: to provide oversight and scrutiny of all aspects of quality, patient safety, clinical outcomes, effectiveness and experience
- **Nominations and Remuneration Committee**: to address Board capability, terms of employment for executive directors and staff pay awards; during the year this Committee's functions were replaced by separate Nominations and Remuneration Committees
- **Investment Committee**: to assure the Board that new service developments which present a material financial or reputational risk have been assessed for potential impact prior to Board for approval. This committee did not meet during 2014/2015 and was abolished during the year. While the function was important, the Board considered this essentially the responsibility of the sponsoring executive director to provide such assurance. In those cases where NED input is felt desirable before a Board meeting it should be possible to do this by an informal arrangement. The Board therefore abolished the Investment Committee.
- **Transformation Committee** which was created during 2014/2015 to provide assurance to the Board with regards to progress on the delivery of the Trust's Transformation programme.
- There is also a **Charitable Funds Committee**: the Trust is a corporate trustee for these funds.

The role and function of each committee is kept under regular review

4.1 Audit Committee

Membership

Mr Michael Flaxman (as Chair from 1st April 2014 until 29th May 2014)
Mr Rod Anthony (as Chair from 1st June 2014)
Mrs Elizabeth Chignell née Mountford
Mr Timothy Pile
Mr Paul Athey (until Oct 29th 2014)

Purpose
The work of the Audit Committee is to provide the Board with a means of independent oversight and scrutiny of compliance and effectiveness across the whole organisation and all its functions. The Committee also serves to provide an objective review of the Trusts financial management, corporate governance and risk management arrangements. To do this the committee seeks assurances and reviews performance across a range of areas, primarily:

- Reviewing evidence of the effective operation of internal controls and risk management processes

- Ensuring that there is an effective internal audit function established by management that provides appropriate independent assurance to the Audit Committee, Chief Executive and Board

- Receiving reports on counter-fraud work within the Trust.

- Considering the nature and scope of the external audit, reviewing all external audit reports and ensuring co-ordination, as appropriate, with other external audit functions in the local health economy.

- Reviewing audit and management reports, and monitoring progress with the implementation of improvement actions across the Trust

- Reviewing the standing orders, standing financial instructions and standards of business conduct for the organisation

- Receiving reports from executive managers across the Trust on areas of assurance and risk management of interest to the Committee.

In addition, the Committee;

- 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 the Trust Board meeting. The committee has an annual work plan that ensures it embraces the necessary range of activities, including relating to 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 reported assurance to the Trust Board quarterly during 2014/15, focusing on the following key matters:

- Ensuring that the financial statements for the year ending 31st March 2015 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 2014/15 financial year as well as other sources of assurance.

- A significant amount of work took place during 2014/15 to continue to review and support the development of the Board Assurance Framework and the way in which risks were reported to the appropriate assurance committees.

- During 2014/15, the Trust commissioned a number of internal audit reviews in line with the approved internal audit plan. The committee has been closely reviewing the progress made by internal audit in delivering this plan, and has reviewed the reports arising from these audits. The committee has also been tracking the progress management have made in implementing agreed improvement actions, with an emphasis on ensuring that they are dealt with in a timely manner.

- As a follow-up to audit work completed in 2013/14, the committee also received regular reports from executive managers, and monitored closely the implementation of the improvement plan, in relation to the management of waiting lists.

- During 2014/15, the committee has also given a priority to developing a closer and more supportive working relationship with the Clinical Governance Committee (CGC). The committee recognise that in fulfilling its duties to provide assurance over matters of clinical governance, it relies on the work of the CGC and its own sub-committees.

- The Audit Committee reviews arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

- The committee has also monitored closely the matters of compliance with specific clinical policies and procedures, as noted in the Annual Governance Statement, and has worked with the CGC to strengthen controls and compliance in this area. As a result the internal audit plan for 2015/16 will be directed to provide assurance in this area.

- Following a competitively tendered procurement exercise, the Audit Committee recommended to the Council of Governors the reappointment of Deloitte as external auditors to the Trust from 2014/15. This was approved by the Council of Governors.

- The Trust's internal audit function is provided by Baker Tilly Risk Advisory Services LLP. The Trust works closely with a Partner and Senior Manager from Baker Tilly to ensure that it receives an independent, objective assurance on our systems of internal control and to evaluate and improve the effectiveness of our risk management, control and governance processes. The Audit Committee agrees an annual internal audit plan that is developed in

line with the Trust's key strategic risks and objectives, and monitors deliver against this plan at each Audit Committee meeting

4.2 Clinical Governance Committee

Membership

Professor Taunton Southwood (Chair)
Mrs. Elizabeth Chignell née Mountford
HH Frances Kirkham
Mrs Jo Chambers
Mrs Helen Shoker until 31 January 2015
Mr Garry Marsh from 16 February 2015
Mr Andrew Pearson

Purpose
The work of the Committee is primarily to:

- Provide oversight and scrutiny of all aspects of quality, patient safety, clinical outcomes, effectiveness and experience
- Assure the board that robust systems, clinical policies and processes are in place to enable the Trust to:
- Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,
- Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions

The Committee has an annual work plan that ensures it receives effective reporting from appropriate advisory groups. A note of each meeting is prepared by the Chairman and presented at the next available Trust Board.

4.3 Nominations and Remuneration Committee

Membership

Dame Yve Buckland (as Chair) and all other NEDs.

Professional advice was provided from time to time by the Trust's Director of Workforce and Organisation Development, Ms Anne Cholmondeley and financial guidance was provided by Mr Paul Athey as Director of Finance.

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 NEDs.
- 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 substantive 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. The committee will benchmark remuneration annually.

In the case of NED 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 NEDs, 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 (excluding the CEO) , the Remuneration and Nominations Committee draws up the job description and person specification, and undertakes the recruitment process and then makes a recommendation to a Committee of the Trust Board consisting of the CEO and all of the non- executive directors which may accept or reject the recommendation. The NEDs appoint and remove the Chief Executive and such an appointment requires the approval of the Council of Governors.

The Committee addressed the need to fill the post of Director of Operations during 2014/15 and used external advisors.

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

On October 29th 2015 the Board approved the replacement of, and division of responsibilities of the Nominations and Remuneration Committee with:

A Nominations Committee chaired by Dame Yve Buckland. The CEO and all other NEDs are also members. On 4th February 2015 the terms of reference were revised by the Board to give the Committee the authority to appoint or remove executive directors including the Chief Executive. In the latter case the CEO is required to withdraw.

A Remuneration Committee chaired by Mrs Elizabeth Chignell. All other NEDs are also members.

During 2014/2015 and after October 29th 2014 the Nominations Committee and Remuneration Committee each met to consider the vacancy of the post of Director of Nursing and Governance and in the case of the Remuneration Committee in addition wider matters of remuneration including pension arrangements.

4.4 Investment Committee

Membership

Mr Timothy Pile
Mr Paul Athey
Mrs Jo Chambers

The Committee did not meet during the year and was abolished by the Board on October 29th 2014

4.5 Transformation Committee

Membership

Mr Timothy Pile (Chair)
Mrs Elizabeth Chignell née Mountford
Mr Rod Anthony
Dame Yve Buckland
Mrs Jo Chambers
Mr Andrew Pearson
Mr Jonathan Lofthouse
Mrs Helen Shoker until 31 January 2015
Mr Garry Marsh from 16 February 2015
Mr Paul Athey

Purpose
The Committee was established by the Board on October 29th 2014 to be responsible for providing assurance to the Board with regards to progress on the delivery of the Trust's Transformation programme.

The Transformation Committee will use the Programme Management structure to ensure that plans are rigorous, with formal processes in place for reviewing the overall transformation strategy and responding to underperformance in the delivery of individual initiatives.

The Transformation Committee will receive monthly reports regarding progress and key risks from a number of Programme Boards (relating directly to the Trusts Strategic Plan) and will ensure that supporting strategies are appropriately aligned and mutually reinforcing.

4.6 Charitable Funds Committee

Membership

HH Frances Kirkham (Chair)

All executive directors and NEDs

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.

4.7 Attendance at meetings

Non-Executive Directors' attendance at meetings

	Trust Board	COMMITTEE						
		Audit	Clinical Governance	Remuneration and Nomination	Charitable Funds	Remuneration	Nominations	Transformation
	Number of Meetings attended							
Total number of Meetings	7	5	8	1	4	2	1	2
Dame Yve Buckland (from 1 May 2014)	4	N/A	N/A	1	0	1	0	0
Mr Timothy Pile	7	3	N/A	1	0	2	1	2
Professor Taunton Southwood	6	N/A	7		0	2	1	N/A
HH Frances Kirkham	7	N/A	7	1	4	2	1	N/A
Mrs. Elizabeth Chignell née Mountford	5	3	4	1	0	1	1	0
Mr Michael Flaxman (until 31 May 2014)	2	2	N/A	N/A	1	N/A	N/A	N/A
Mr Rod Anthony (from 1 June 2014)	4	3	N/A	1	0	2	1	2

Executive Director Meeting Attendance

	Trust Board	COMMITTEE						
		Audit	Clinical Governance	Remuneration and Nomination	Charitable Funds	Remuneration	Nominations	Transformation
	Number of Meetings attended							
Mrs Jo Chambers	7	N/A	8	1	3	N/A	N/A	2
Mr Paul Athey	7	3 Member until 29 October 2014	N/A	N/A	4	N/A	N/A	2
Mr Andrew Pearson	6	N/A	3	N/A	0	N/A	N/A	1
Mr Jonathan Lofthouse (from 1 September 2014)	4	N/A	N/A	N/A	1	N/A	N/A	1
Mrs Amanda Markall (until 31 August 2014)	3	N/A	N/A	N/A	1	N/A	N/A	N/A
Mrs Helen Shoker (until 31 January 2015)	5	N/A	4	N/A	2	N/A	N/A	N/A
Mr Garry Marsh (from 16 February 2015)	0	N/A	1	N/A	0	N/A	N/A	2

5.0 Disclosures under Schedule 7 to the Regulations

The principal activities of the Trust during the year were the provision of elective and specialist orthopaedic services.

5.1 Political donations

There were no political donations during the financial year.

5.2 Any important events since the end of the financial year affecting the NHS foundation trust

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

5.3 An indication of likely future developments at the NHS foundation trust

The Royal Orthopaedic Hospitals Birmingham has a well-developed five year strategic plan, which was published in 2014, and covers the period 2014 – 2019. Set within the strategic plan are the elements of focus which are split into two overarching initiatives and five transformational initiatives. The overarching initiatives focus on developing our people, and serving our patients:

- Creating a culture of excellence, innovation and service;
- Exceptional patient experience every step of the way.

Our transformational initiatives focus on how we improve how we do things, often from an infrastructural or application of new technology methodology:

- Safe and effective processes;
- Fully engaged patients and staff;
- Developing clinical services;
- Information for excellence;
- The knowledge leader.

This plan is currently being refreshed in the light of some significant internal and external influences, not least of all, the impact of changing tariff. However, the bulk of the strategic plan is still very much active and some of the main future developments include the introduction of:

- Electronic prescribing/pharmacy system;
- Digital dictation;
- Electronic staff record;

- Electronic discharge system;
- Referral management system;
- New patient administration system;
- New training and development suite;
- Medical workforce modelling;
- Patient pathway development.

Whilst the agenda is significant and the programme of improvement ambitious, the Trust is committed to improving the facilities and experience for the patient and by engaging staff in the transformation agenda, improving the work experience for staff across the organisation. Greater detail of the transformation programme can be found in the Trust Strategic Report.

5.4 An indication of any significant activities in the field of research and development

The last twelve months has seen the research portfolio of the trust increase with the support from the research and development team. The numbers of patients recruited into research continues to improve along with our success at acquiring research funding. We are increasing our relationships with other organisations to improve the care we deliver to our patients through ground breaking research. The appointment of a full time research grant writer this year further strengthens our research capabilities and has already delivered a prestigious research award from the European Commission in collaboration with Aston University.

R&D's contribution to corporate Strategy (2014-2019)

Research and innovation are key drivers to support the Trust's vision to become "The First Choice for Orthopaedic Care". Strategic initiative 7: ROH The Knowledge Leader, is the core initiative within the strategy that will seeks to create and integrated research, innovation, evaluation, education and teaching capability.

The corporate strategy lays down the foundations to develop an organisational structure which integrates research, innovation, clinical audit and effectiveness (outcomes) into a new department, the "ROH Knowledge Management Team". The aim of this new structure is to create an expert team to provide specialist support to colleagues across the Trust to deliver high quality research, innovation and audit projects. The new team have been integrated and co-located with Education and Teaching staff and have been housed in modern redeveloped offices within the current Research & Teaching Centre to create the new 'ROH Knowledge Hub'. Work has already commenced with the teams being integrated from January 2015 and the office suites have now been renovated.

R&D Performance

The Trust has continued to grow and expand its research portfolio and capabilities with an average of 30 new clinical research projects registered per annum with the R&D Department (Table 1).

Arthroplasty, Arthroscopy, Physiotherapy, Oncology and Histopathology are the most research active areas. The Anaesthetic Directorate has seen a notable rise in the number of research projects registered and this is due to new consultant anaesthetists being appointed with a particular interest in clinical research.

Radiology, Hand and foot and spinal departments still have huge potential to increase the amount of research that is undertaken within their specialist areas.

	2010-11	2011-12	2012-13	2013-14	2014-15	Total
Oncology	3	8	9	1	8	29
Arthroplasty	3	4	3	12	4	26
Arthroscopy		9	4	6	5	24
Other	2	3	7	6	7	25
Physio	1	1	2	6	1	11
Histopathology		4	1	3	1	9
Anaesthetics	1		1	3	3	8
Spinal		2	2	1	1	6
Hand and Foot	2		1	2		5
N/A	1	1				2
Radiology				1		1
Trust Wide				1		1
Total	13	32	30	42	30	147

Table 1 - Number of new projects registered (x) sub-specialty

Participant recruitment into clinical research studies has continued to increase year on year, with over one thousand patients recruited into studies within the last financial year, and a target set of 1250 participants to be recruited within the current reporting period.

	2010-11	2011-12	2012-13	2013-14	2014-15	Total
NIHR	92	125	837	1038	860	2952
Commercial	58	69	7	11	21	166
Other	0	19	23	20	282	344
Total	150	213	867	1069	1163	3462

Table 2 – participant recruitment by study type

NIHR adopted studies have seen the largest increase in patient recruitment figures and this can be attributed to increased collaborative projects being developed with our academic partners in addition increased funding from the National Institute for Health Research Clinical Research Network: West Midlands.

Although recruitment into commercial studies has decreased, there are five new commercial studies pending and waiting to open, which should see this figure increase for the next financial year (Table 2).

Table 3 shows recruitment by local investigator. From reviewing this data, it is clear that the majority of research undertaken within the Trust is done by a small proportion of our clinical staff, which is unfortunate, but shows that the ROH still has a lot of potential to increase the number of clinicians becoming actively involved in undertaking clinical research projects.

	2010-11	2011-12	2012-13	2013-14	2014-15	Total
Davis, ET	89	66	445	187	417	1204
Grimer, R	27	31	157	147	473	835
Moore, F		29	209			238
Snow, M	31	35	34	37	50	187
Bache, E		6		67	29	102
Siddaiah, N					55	55
Jeys, L			1	25	24	50
Revell, M		30	9			39
Gardner, A			4	16		20
Carter, S				5	14	19

Table 3 – Participant recruitment by clinician – top 10 recruiting clinicians

Research Income

The Trust has continued to increase external R&D income to fund the infrastructure costs associated with supporting the delivery of clinical research project. 72% of the research income is received from the National Institute for Health Research (NIHR) via the regional Clinical Research Network (CRN:WM) through activity based funding (ABF), research capability funding (RCF) and bids for strategic funding. The rest of the research income is received from the life sciences industries and other non-commercial income, such as charitable funding from research grants (table 4).

Funding Sources (2014/15)	**£**
NIHR funding	329,550
Other non-commercial income	24,990
Commercial income	99,709
Total	**454,249**

Table 4 – R&D financial income

Networking: CRN West Midlands

The Trust is an active member of the NIHR Clinical Research Network West Midlands (CRN: WM) and currently ranks in 13th position out of 29 member organisation in relation to participant recruitment. Although it is difficult to compare a specialist orthopaedic hospital with the large acute Trusts across the region, it should be noted that the ROH Trust has grown to become the highest recruiting specialist orthopaedic hospital in the UK relation to NIHR recruitment for 2014/15. The R&D Department works closely with CRN: WM in relation to study set-up, study delivery, networking with other member organisations and supports the provision of training and development of clinical research staff within the wider health research community. The R&D Director has been supporting the network leadership staff to develop a new role within the network; an Orthopaedic Speciality Group lead, which will link orthopaedic specialists within the West Midlands region to design and deliver high quality collaborative musculoskeletal studies.

Networking: West Midlands Academic Health Science Network (AHSN)

Representatives from our Trust have met with the leadership team of the WMAHSN regularly since its formation. Additionally, Trust staff have attended and participated in a number of regional AHSN events.

Clinical staff at the ROH have supported the WMAHSN develop and rollout a national competition. The new national Small Business Research Initiative (SBRI) Healthcare competition was launched by NHS England in partnership with the Academic Health Science Networks to find innovative new products and services. The projects were to be selected primarily on their potential value to the health service and on the improved outcomes delivered for patients. The WMAHSN led the musculoskeletal call for applications and the ROH were heavily involved in supporting this.

Mrs Jo Chambers, the CEO of the ROH is the Chair of the newly established WMAHSN Central Spoke Council and a member of the WMAHSN Board. The purpose of the Spoke Council is to help establish and maintain an inclusive partnership of key stakeholders to oversee programmes of work across the Central Spoke of the AHSN in fulfilment of pan-regional objectives. Three meetings have been held at the ROH to date, which quarterly meeting planned for the future.

Training and Development

The R&D department continues to provide research training to ROH staff including Good Clinical Practice (GCP) training, which is mandatory for all researchers. A total of 78 ROH staff have been trained in GCP, with 44 being trained during 2014/15. Additional training and courses have been provided through the NIHR Clinical Research Network (CRN) and the Birmingham Research Training Collaborative (BRTC) which are available for all staff employed within the Trust.

In an attempt to improve awareness of the Research Nurse role and to attract nurses to explore the possibility of a career in Research, the R&D department has been added to the orthopaedic pathway for the 1st year nursing students. The students spend half a day in the department attending clinics with the research nurses, learning about the role of a research nurse and the portfolio of studies at the ROH. This gives them the opportunity to see research being conducted in the Trust.

Additionally, the R&D department have also commenced a two hour session on the student nurse teaching programme. This session aims to give the participants an understanding of research and why this is important, identifies how the Trust is committed to supporting Research & Innovation, an exploration of our research portfolio and highlights what support is available from the R&D Department.

ROH R&D Investments

The Trust's R&D Department has invested in staff, systems and infrastructure during 2014/15 to improve and develop its internal resources and capabilities. Investments include a new clinical research database, which went live on 1st September 2014, a grant writer to support ROH staff to apply for external research funding, estate renovation to areas such as the Nurses Home, Pharmacy and the R&T Centre and a statistical analysis software package, which is available for ROH employees.

Full investment details that have been made during 2014/15 can be found in table 5 below.

Investment detail	Value (£)
Research Database	43,443
Grant Writer	32,749
R&T Centre Renovation	30,000
Support Staff (Pathology, Phlebotomy, Finance)	17,183
Statistical Software	10,213
Pharmacy Renovation	3,648
TOTAL	**137,236**

Table 5 – R&D Investments

Grants awarded & other income

Description	Funding source	Value (£)
Mr Edward Davis & Aston University collaboration	European Commission - Horizon 2020	183,455
Research Laboratory	ROH Charitable Funds Committee	231,700
Donation – Bequest	Charitable donation from a patient	1.3 Million

AHP & Nurse Led Research

The R&D department have created a Research Link Nurse Role across the Trust and hold bi-monthly meetings. In addition, research updates are given at the Nurse Leaders Forum. AHP (Allied Healthcare Professional) & Nurse led Research is an area that has great potential for the future and is something that the R&D Department is very keen to develop. An important first step to achieve this goal is to raise the profile; understanding and knowledge of research and the support available from the department to nurses across the Trust.

The AHP Team have continued to develop home grown studies over the last year in four key areas: sciatica treatment, functional restoration in the treatment of low back pain, bone tumour symptoms and total knee replacements. Two completed studies have been accepted for publication in peer reviewed journals, one is pending submission and out of these one has been presented at an international Conference for Back Pain Research, another has been submitted for conference presentation this year.

As a team we have grown this year with the addition of Gareth Stephens who is working as a Band 7 research physiotherapist two days a week. Gareth has contributed to an internal study led by Mr Grimer, validating EQ5D in patients with sarcoma. The abstract for this was presented at a national Sarcoma Conference last month.

We currently have two external studies which we are involved in: PROVE for osteoporotic fractures and Hip FASHION for femoroacetabular impingement. We have created and strengthened links with other centres including University of Birmingham, Oxford, Cardiff, Warwick and Keele Universities with four potential studies planned for 2015.

Future priorities for the coming year are to build on current links/ joint projects with other centres in the development of studies, to increase our portfolio of adopted studies and raise our research profile in terms of publishing, conference presentations and as a centre for physiotherapy research.

5.5 An indication of the existence of branches outside the UK

There were no branches outside the UK during the year

5.6 Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities

The Trust has a Recruitment and Selection Policy and approach which ensures fairness and equity for all people with protected characteristics, including people with a disability. Reasonable adjustments are always made for people with a disability who are shortlisted for interview to enable them to contribute of their best during the selection process

5.7 Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period

The Trust ensures as far as is practicable, the training and retention of staff who become disabled either in their role or an alternative role more suitable to their needs. This is managed within either our sickness or capability procedures.

5.8 Policies applied during the financial year for the training, career development and promotion of disabled employees

The Trust has a range of training and education policies that ensure equality of access to learning opportunities for all staff, irrespective of their background, including disability. During the year the Trust has invested significantly in the development of staff in pay bands 1 – 4 who have previously received less training and career development when compared to other staff groups.

5.9 Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees

The Trust has an established and effective approach to providing information to staff through monthly team brief, chief executive's journals, a bi-monthly newsletter and through the formal consultative forums held with trade union representatives.

5.10 Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests

During the year, the Trust has developed a new and exciting strategy for the next five years. Staff and their representatives have been actively engaged in co-producing this strategy. There have been open events for staff to attend and contribute, as well as groups of staff who have been consulted on specific details of the strategy.

5.11 Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance

Following development of the Trust's new strategy, an ambitious transformation programme has begun which seeks to improve patient care and the experience they receive at the Trust, modernise the Trust culture and improve staff experience. Staff, particularly those working directly with patients, are actively involved in leading and working on these improvement projects.

5.12 Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust

Information regarding the financial performance of the Trust, and the factors influencing this performance, is regularly shared in various forms. Performance is reported on a monthly basis at Executive Management Team, whose membership includes Executive and Senior Management, Clinical Directors and Matrons. This information is then cascaded down into local areas. In addition to this, updates are provided both through the monthly Team Brief and as part of the ROH Life magazine.

5.13 In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the NHS foundation trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity

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 22 to the accounts.

6.0 Enhanced quality governance reporting

Quality governance and quality are discussed in more detail in the quality report; this section gives a brief overview of the arrangements in place to govern service quality

6.1 How the foundation trust has had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework and a summary of action plans to improve the governance of quality

The Clinical Governance Committee reviews the quality governance framework (QGF) on a regular basis and uses it to guide its priorities. It has formed one of the key inputs to a Board workshop which covered overall governance and organisational performance and it informs the Corporate Governance Statement prepared by the Board for Monitor. The QGF is also used as an overarching framework to inform the key components of the Board Assurance Framework (BAF) and system of internal control.

The action plans to improve the governance of quality can be summarised as follows:

Strategy

Over the last 12 months the Trust has developed its five year vision and strategic plan. This process involved around 20% of all staff, in reference groups and a stakeholder strategy day in April 2014, which included patients, commissioners, partner organisations and Trust governors.

This process denoted a new inclusive model of working for the Trust, which aims to ensure that Trust plans and strategies are intrinsically linked to staff and patients and have issues of quality, transparency and governance embedded. The strategic initiatives are as follows:

- Creating a culture of excellence, innovation and service
- Exceptional patient experience every step of the way
- Safe and efficient processes
- Fully engaged patients and staff
- Information for excellence
- Developing clinical services
- ROH: The knowledge leader

All of the strategic initiatives are fundamentally based upon the quality agenda.

Since the development of the vision and strategy a comprehensive structured programme of work has been outlined to achieve the delivery of the strategy over the next five years. This work will be led by a Director of Strategy and Transformation, who was appointed in November 2014; and the establishment of a Transformation Committee (a Committee of the Trust Board) chaired by a NED, which met for the first time in January 2015. This programme management approach ensures that the Trust Board remains constantly aware of progress against the overall strategic initiatives, and has a clear line of sight to the projects and initiatives on the ground that will deliver the transformation.

Capabilities and Culture

Over the last six months, much work has been done to promote the strategy and the seven priorities to staff and patients, and we will be increasing our focus on engaging our staff in the next six months, in order to embed a sustainable culture of excellence innovation and service. Through our series of 'New Beginnings' events, we are providing every staff member with an opportunity to meet and ask questions of a member of the Executive Team, following an up-to-the-minute briefing on the Trust's progress towards its strategic goals. The events will also provide staff with opportunities to develop and further bring to life the values and behaviour framework which will underpin the development of our culture, and will be asked to help us to set priorities for action plans arising from the most recent staff survey.

Over the next year, our values and behaviour framework will be embedded into our policies and procedures, including recruitment and selection, reward and recognition, and the promotion of inclusivity.

We are developing a leadership strategy which will support the development of the right culture for the Trust, and will in turn reinforce the adoption of good discipline in the use of robust governance,

in line with our Quality Governance Framework (QGF) which the Trust commissioned from the Good Governance Institute (GGI).

Progress in developing our culture will be monitored through the BAF.

Work continues on a root and branch review of all governance systems and processes, to ensure that messages regarding quality and safety are clear and individual accountabilities are understood.

We will take the opportunities arising from an imminent reorganisation of operational teams to clearly define excellence

Capabilities

The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. Both the Board and the Council of Governors considered that there was a need to strengthen clinical governance and clinical improvement knowledge among the NEDs. A NED with improvement knowledge was recruited in June 2014 and the recruitment of an additional NED with a clinical background was initiated toward the end of 2014/2015.

Regarding executives the following appointments to key vacancies on the Executive Team have been made; in each case the governance of quality was a consideration in appointment:

- Director of Operations
- Director of Strategy & Transformation
- Interim Director of Nursing & Governance

Culture

Over the last six months much work has been done to promote the strategy and the seven priorities to staff and patients, and this work continues. The ROH programme management approach is based on the principles of engaging all our staff, from ideas to delivery, developing a 'can-do' culture where project management principles are not a mystical set of work processes but rather a simple set of processes and tools to aid and empower all staff to be able to deliver transformation in their own areas of work.

The same Programme Management Approach is now being applied in conjunction with the revised and updated BAF to assure the delivery of actions plans falling from the recent CQC visit and our own internal assessments using the QGF and work which the Trust commissioned from the CGI to ensure that all our plans are focused on quality, and aligned clearly to our strategy. An over-arching high level quality and governance actions plan is in place to ensure delivery. The Trust is in the process of a root and branch review of all its governance systems and processes, ensuring that messages regarding quality are clear; and systems are embedded and adhered to.

Processes and Structure

The Trust Board has overseen a programme of detailed actions to improve critical processes related to quality governance. This can be summarised as follows:

Processes

- Completion of a CQC Action Plan
- Review of the rolling programme of compliance of all new and existing equipment (work in progress)
- Full Medicines Management Review – resulting in the updating of policies and procedures; briefings and training. Regular compliance measurement is in place and random spot checks have been instituted.
- Review of our resuscitation equipment protocols and procedures (work in progress)
- Review of the configuration of the patients flow through clinics to improve patients' experience in the out patients department (review of pathways has taken place but this is still work in progress)
- The continued implementation of enhanced recovery programmes
- Improvement of risk management (escalation & de-escalation) (work in progress)
- Agreement and establishment of a mechanism for independent assurance and scrutiny of Trust assurance systems and processes (work in progress)
- Revised programme and processes for review of all Trust policies
- Reviewing and updating Trust systems for the recording of, and learning the lessons from all incidents. (work in progress)

Structure

The Terms of Reference of all Board committees have been reviewed; one of the purposes of the review was to make clearer the responsibilities for the governance of quality. The terms of reference and responsibilities of those groups reporting to the Clinical Governance Committee are being reviewed on a rolling basis by the CGC. In particular consideration is being given to the creation of a group covering both research and clinical outcomes and effectiveness. This group will oversee the clinical audit programme and provide assurance that the enhancements requested by the Board and CGC are implemented.

A directorate restructure was started shortly after the end of the financial year- this will enable greater clarity across the Trust for the governance of quality.

Measurement

The planned review of the Comprehensive Performance Report (CPR) will include a focus on quality information. The CPR review is intended to strengthen the link to forward planning and wider measures of quality such as best practice benchmarking.

The review of senior staff portfolios will ensure that key staff have a clearer focus around those CPR items for which they are responsible.

A stronger link will be made between the quality / outcomes data and the clinical audit programme.

6.2 Material inconsistencies (if any) between:

- the annual governance statement;
- annual and quarterly board statements required by the Risk Assessment Framework, the corporate governance statement submitted with the annual plan, the quality report, and annual report
- reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the NHS foundation trust.

There were no material inconsistencies between the above statements

7.0 Statement as to disclosure to auditors

For each individual who is a director at the time that the report is approved:

- so far as the director is aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware; and
- the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

8.0 Additional disclosures required by the FReM

8.1 Accounting policies for pensions and other retirement benefits

These are set out in Note 1.4 to the accounts and that details of senior employees' remuneration can be found within the annual report on remuneration (the third part of the remuneration report).

8.2 Details of Company Directorships and other significant interest held by Director or Governors

The Trust maintains registers of directors' and governors' interests that are opened to the public. Access to information in that register may be obtained by writing to the Company Secretary at the Royal Orthopaedic Hospital NHS Trust, Bristol Road South, Northfield, Birmingham, B31 2AP.

8.3 Sickness absence data

FTC schedules: Staff sickness absence	**2014/15**	**2013/14**
	Number	**Number**
Total days lost	13,343	12,962
Total staff years	936	914
Average working days lost (per WTE)	14	14

8.4 Cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance, (Chapter 6 of HM Treasury Managing Public Money).

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

1.0 The work of the Council of Governors 2014/15

The key role of the Council of Governors is to hold the NEDs to account for the performance of the Board. The Council of Governors is also 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 NEDs of the Trust.

On July 30th 2014, following approval by the Council of Governors and Trust Board, the Trust adopted a new constitution. This change amended the public constituencies and partner organisations. This resulted in a reduction from 25 to 18 members. Details of the changes are included in the data section of this report. The 18 representatives on the ROH 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, via the NEDs, to account and have direct responsibility for appointing the Chairman and NEDs as well as the Trust's external auditors.

There are three categories of representatives: public (which includes patients), 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 bodies. Council meetings are attended by executive directors and NEDs and in this way, the council can ask directly for supplementary information. The Council of Governors meets quarterly in public and members attend two Board meetings each year at which they are fully engaged in discussions, although any decisions taken remain the sole responsibility of the Board.

The Council of Governors elected 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 NEDs. Mr Last may be contacted through the Trust's Company Secretary, Royal Orthopaedic Hospital NHSFT, Bristol Road South, B31 2AP.

1.1 Doing its job – as a whole council

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

The Trust's one year operational plan was presented to the governors on March 24 2015. Governors fed back their comments based on their understanding of the opinion of the trust's members and the public, and for appointed governors the body they represent and were encouraged to do so subsequent to the meeting based on their continued contact with their stakeholders.

Council members attend two Board meetings each year and these focus on performance and future direction.

The council also nominates members to attend Trust advisory groups and committees as observers, so they are able to report back directly to the Council on work being undertaken. Members of the council currently attend as observers at the following groups:

- Charitable Funds Committee
- Privacy & Dignity group
- Paediatric Group
- Estates group
- PLACE assessment group
- Patient and Carer forum

Discussion are in progress regarding governor attendance at the following:

- Transformation Committee
- Clinical Governance Committee

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.

1.2 Committees

During the discussion regarding amending the Council constituencies, the Council of Governors and the Trust Board also took the decision to spend governor time engaging with existing Trust groups and committees rather than working in separate bodies which mostly duplicated work already being undertaken within the Trust. The groups currently attended by governors are set out above.

The Council has one remaining active committee, which is the Nominations and Remuneration Committee. This is supported by the Director of Workforce and Organisation Development and Company Secretary. It reviews NED remuneration based on available benchmark data and also supports the council in relation to the appointment of additional NEDs on behalf of the full council prior to making recommendations for appointment to the full council.

2.0 Constituencies

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

From 1/4/14 – 30/7/14

Public members came from identified constituencies across England and Wales and staff members from clinical and non-clinical staff groups. Stakeholder representatives are nominated by their host organisation to serve for a period of up to three years.

There were five public constituencies within public membership:

- South Birmingham (5 seats)
- Heart of Birmingham (1 seat)
- Northern & Eastern Birmingham (2 seats)
- Rest of West Midlands (4 seats)
- Rest of England & Wales (1 seat)

There were two constituencies within staff membership:

- Clinical (2 seats)
- Non-clinical (1 seat)

All election boundaries for public members (including patients) were coterminous with either PCT or local authority boundaries. Public membership eligibility was 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 and staff members, a number of key organisations that work closely with the Trust appointed representatives for the Council of Governors.

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

From 31/07/14 – 31/3/15

Public members come from a smaller number of identified constituencies across England and Wales and staff members from clinical and non-clinical staff groups. Stakeholder representatives are nominated by their host organisation to serve for a three year period with an option to re-nominate at the end of the period.

There are two public constituencies within public membership:

- Birmingham & Solihull (5 seats)
- Rest of England & Wales (4 seats)

There are two constituencies within staff membership:

- Clinical (2 seats)
- Non-clinical (2 seats)

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

3.0 Elections

There was one set of elections results to report during 2014/15

As the constitution was amended on 30 July 2014, an election was called to fill seats in the following constituencies:

- Birmingham & Solihull **2 seats**
- Rest of England and Wales **1 seat**
- Staff non-clinical **1 seat**

3.1 Results

Elections to our Council of Governors for vacancies arising in 2014/15 have been overseen by the Electoral Reform Society.

Public: Birmingham & Solihull November 2014

Number of eligible voters	**3783**
Total number of votes cast	**623**
Turnout	**16.5%**
Number of votes found to be invalid	**11**
Blank or spoilt No declaration form	**11**
Total number of valid votes to be counted	**612**

Result (two to elect):

The percentage return rate for elections this year is slightly lower in some groups than is usual, but still within the realms of typical returns for Foundation Trust's. Elections are run by external providers that have full understanding of the regulations and the Trust has continued to work with these providers to look at options that may encourage more members to vote.

The election was conducted using the single transferable vote electoral system.

The following candidates were elected (in order of election):

ARNOTT, Sue
THOMAS, Anthony

Public: Rest of England and Wales November 2014

Number of eligible voters	**1923**
Total number of votes cast	**373**
Turnout	**19.4%**
Number of votes found to be invalid	**3**
Blank or spoilt No declaration form	**3**
Total number of valid votes to be counted	**370**

Result (one to elect):

The election was conducted using the single transferable vote electoral system.

The following candidate was elected:

LAST, Alan Thomas

Staff: Non-Clinical November 2014

Uncontested Election

BRAHAM, Alison

4.0 Elected Members serving during the year 2014/15 meeting attendance

South Birmingham (5 seats) (from 1 April 2014 – 31 July 2014)

1. BETTERIDGE, Marion – appointed for 3 years until July 2015
(attended 2 out of 2 council meetings)

2. MARTIN, Dia – appointed for 3 years until July 2015
(attended 2 out of 2 council meetings)

3. ROOKES, Jean – appointed for 3 years until April 2016
(attended 2 out of 2 council meetings)

4. ARNOLD, Peter – appointed for 3 years until July 2015
Removed in June 2014 for non-attendance

5. VACANT SEAT (elections paused until new council in place)

Heart of Birmingham (1 seat) (from 1 April 2014 – 31 July 2014)

1. VACANT SEAT (elections paused until new council in place)

Rest of the West Midlands (4 seats)) (from 1 April 2014 – 31 July 2014)

1. SCOTT, Yvonne - appointed on re-election for 3 years (third term) until July 2015
(attended 1 out of 2 council meetings)

2. NOON, Stella – appointed on re-election for 3 years (third term) until April 2016
(attended 2 out of 2 council meetings)

3. VACANT SEAT (elections paused until new council in place)

4. VACANT SEAT (elections paused until new council in place)

East and North Birmingham (2 seats) (from 1 April 2014 – 31 July 2014)

1. VACANT SEAT (elections paused until new council in place)

2. VACANT SEAT (elections paused until new council in place)

Rest of England (1 seat) (from 1 April 2014 – 31 July 2014)

1. TALBOYS, Robert – elected on re-election for 3 years (second term) until April 2016.
(attended 2 out of 2 meetings)

Clinical Staff Representatives (from 1 April 2014 – 31 July 2014)

1. HUGHES, Karen – elected for 3 years until end July 2015
(attended 1 out of 2 council meetings)

2. TREACY, Ronan – elected for 3 years until end July 2016
(attended 1 out of 2 council meetings)

Non-Clinical Staff Representatives (from 1 April 2014 – 31 July 2014)

1. LOCOCO, Susan – elected for 3 years until July 2016
(attended 0 out of 2 council meetings)

Birmingham & Solihull (5 seats) (from 1 August 2014 – 31 March 2015)

1. BETTERIDGE, Marion – elected for 3 years until end July 2015
(attended 5 out of 5 council meetings)

2. MARTIN, Dia – elected for 3 years until end July 2015
(attended 4 out of 5 council meetings)

3. ROOKES, Jean – elected for 3 years until end April 2016
(attended 4 out of 5 council meetings)

4. ARNOTT, Sue – elected for 3 years until November 2017
(attended 3 out of 3 meetings)

5. THOMAS, Anthony – elected for 3 years until November 2017
(attended 2 out of 3 meetings)

Rest of England and Wales (4 seats) (from 1 August 2014 – 31 March 2015)

1. SCOTT, Yvonne - elected on re-election for 3 years (third term) until July 2015
(attended 5 out of 5 council meetings)

2. LAST Alan - elected on re-election for 3 years (third term) until November 2017
(attended 3 out of 3 council meetings)

3. NOON, Stella – elected on re-election for 3 years (third term) until April 2016
(attended 5 out of 5 council meetings)

4. TALBOYS, Robert – elected on re-election for 3 years (second term) until April 2016.
(attended 4 out of 5 meetings)

Clinical Staff Representatives (from 1 August 2014 – 31 March 2015)

1. HUGHES, Karen – elected for 3 years until end July 2015
(attended 4 out of 5 council meetings)

2. TREACY, Ronan – elected for 3 years until end July 2016
(attended 2 out of 5 council meetings)

Non-Clinical Staff Representatives (from 1 August 2014 – 31 March 2015)

1. LOCOCO, Susan – elected for 3 years until July 2016
(attended 4 out of 5 council meetings)

2. BRAHAM, Alison – elected for 3 years until November 2017
(attended 2 out of 3 council meetings)

Partner Nominees (from 1 April 2014 – 31 July 2014)

The following organisations make nominations to the Council of Governors and the following individuals held posts during the above period:

South Birmingham PCT - no nominee in year

Heart of Birmingham PCT - no nominee in year

Birmingham City Council - no nominee in year

University of Birmingham

Andrew Clarke (attended 1 out of 2 council meetings)

Birmingham City University

Marion Thompson (attended 1 out of 2 council meetings)

Bournville Village Trust

Paul Sabapathy (attended 0 out of 2 council meetings)

Patient Support Groups

Sue Arnott (attended 1 out of 2 council meetings)

Member of Parliament

Richard Burden MP (attended 1 out of 2 council meetings)

Birmingham Council of Faiths

Parwez Hussain Removed June 2014 for non-attendance

Partner Nominees (from 1 August 2014 – 31 March 2015)

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

Andrew Clarke (attended 2 out of 5 council meetings)

Birmingham City University

Marion Thompson (attended 3 out of 5 council meetings)

Bournville Village Trust

Paul Sabapathy (attended 1 out of 5 council meetings)

Member of Parliament

Richard Burden MP (attended 0 out of 5 council meetings)

5.0 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.

6.0 Engaging Our Membership

The focus of membership activity has continued to be creating regular and one-off opportunities for members to engage directly with the Trust, rather than on growth of numbers.

The Trust has continued to look at offering more opportunities for engagement from home that members can become involved with, as well as maintaining existing opportunities on site. Examples include:

- Invitation to members to take part in the Trust PLACE assessments
- Invitation to members to become involved in specific work improvement schemes such as Outpatient Experience and the building of the Admission and Day Case Unit
- Focus Groups for Research and Development opportunities, continuing from the initial expression of interests
- Assist in ensuring that protected characteristics are considered in provision of services and policies
- Increase in the use of the virtual patient and carers' forum for proof-reading patient information and papers to ensure readability.
- Asking for member feedback on current provisions e.g. Look and ease of use of Trust external website

Members continue to:

- Be involved in the Simulated Patient Programme
- Help conduct patient surveys and the Friends and Family Test 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 4000

6.1 Membership size and movements

Public constituency	**2014 – 15**	**2015 – 16 (estimated)**
At year start (April 1)	5813	5,713
New members	57	200
Members leaving	139	150
At year end (March 31)	5,713	5,781
Staff constituency		
At year start (April 1)	948	987
New members	190	157**
Members leaving	160	157*
At year end (31 March)	978	987

**Based on projected leavers at 15.88% raw turnover ** being replaced in year*

The year-end figure for 2014/15 differs from the year start figure for 2015/16. This is due to the assignment status of people on the unpaid element of maternity leave, who are not included in the figures at year end, but are included at the start of the year.

6.2 Analysis of current membership

At the end of 2014/15 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	5	307 258
17-21	83	102 089
22+	5,330	897 586
Not stated	313	

Public constituency	Number of members	Eligible membership
Ethnicity		
White	3962	805 880
Mixed	114	52 009
Asian or Asian British	417	299 201
Black or Black British	282	99 599
Other	78	23 030
Not Stated/Do not wish to state	858	

Public constituency	Number of members	Eligible membership
Socio-economic Category		
AB	1,418	74 277
C1	1,605	112 334
C2	1,212	65 459
DE	1,375	121 879
Data not available	121	
Gender		
Male	2,187	643 582
Female	3,458	663 351
Unspecified	86	

D. Remuneration Report

1.0 Annual statement on remuneration

During the year the committee made decisions concerning executive pay in relation to 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 and took the decision to award an annual uplift of salary to executive directors and committed to considering a revised reward strategy for executive directors during 2015-16 to include variable payments in recognition of individual contribution.

During the year the committee made decisions in relation to the remuneration of two existing posts and one new role, prior to recruitment to these roles. In relation to the Director of Operations post, the committee decided to increase remuneration for this post, in recognition of the need to recruit an Operations Director, with extensive experience within this portfolio and as an Board member. In relation to the Director of Nursing and Governance post, following receipt of a report from the Good Governance Institute, the Committee agreed for responsibility for matters of corporate governance to be assigned to the Company Secretary, enabling the Director of Nursing and Clinical Governance to focus on matters relating to patient care and clinical governance. Furthermore in considering the remuneration for this role, following the resignation of the previous postholder, the committee decided to increase remuneration in recognition of the market rate for suitably experienced candidates.

Following a review of executive portfolios, the vacant Deputy Chief Executive post was removed with the funding reinvested into a Director of Strategy and Transformation post to ensure that the Board had the capacity and skills in place to lead the transformation programme required to deliver the Trust's strategy. The Remuneration Committee determined the appropriate pay for this post and an appointment was made during the year. Details of the specific pay decisions are contained later in this report.

2.0 Senior managers' remuneration policy

2.1 Future policy table: Executive Directors

	Salary and fees	Taxable Benefits	Annual Performance - related bonuses	Long-term performance-related bonuses	Pension -related benefits	Other Remuneration
Description	Basic pay for Executive role	Expenses incurred in the course of their duties such as public transport, mileage and subsistence as determined by Trust policy	N/A	N/A	NHS Pension Scheme membership	Basic pay for consultant role (Medical Director only)
How that component supports the short and long-term strategic objectives of the foundation trust;	To ensure the Trust is well-led and all short and long term objectives are met, the salary for senior managers must be competitive in order to recruit and retain talented individuals	To ensure senior managers are appropriately compensated for those journeys they have undertaken on behalf of the Trust. The policy for senior managers is the same as that applying to other staff.	N/A	N/A	This enables the Trust to recruit sufficient talent at executive director level and accords with custom and practice in the rest of the NHS.	This is essential to ensure a medically qualified person can occupy the role of Medical Director

an explanation of how that component operates	Executive Director Salaries are determined by the Remuneration Committee of the Trust Board, informed by benchmark salary derived from established national NHS pay surveys. Executive directors are appointed on a permanent basis under a contract of service at an agreed salary	Trust Expenses Policy applies to Senior Managers. Taxable benefits incurred fell within the scope of this policy. Levels of benefits reflect national terms and conditions for other staff groups to ensure consistency	N/A	N/A	This is determined in accordance with NHS Pension Scheme Benefits. No additional payments are made	As determined by national terms and condition of employment
the maximum that could be paid in respect of that component	Fixed salary determined by Remuneration Committee	N/A	N/A	N/A	As determined by NHS Pension Scheme Entitlements	As determined by national terms and condition of employment
where applicable, a description of the framework used to assess performance	N/A	N/A	N/A	N/A	N/A	N/A

Provisions for the recovery of sums paid to directors exist where overpayments have been made in error or annual leave taken in excess of entitlement.

Accompanying notes

- There were no new components of the remuneration package,
- There were no changes made to existing components of the remuneration package other than the pay award referred to above;
- The policy on remuneration for other employees is to utilise national terms and conditions of employment, with local policies relating to pay progression. The approach for senior managers is currently as determined above.

2.2 Future policy table: Non- Executive Directors

	Fee payable	**any additional fees payable for any other duties to the foundation trust**	**such other items that are considered to be remuneration in nature**
Description	Fee for the Chair , Committee Chairs and other NEDs	N/A	Expenses incurred in the course of their duties such as public transport, mileage and subsistence as determined by Trust Policy.
How that component supports the short and long-term strategic objectives of the foundation trust;	To ensure the Trust is well-led and all short and long term needs met, the fee for NEDs must be competitive in order to recruit and retain talented individuals	N/A	To ensure NEDs are appropriately compensated for those journeys they have undertaken on behalf of the Trust. The policy for NED expenses is the same as that applying to staff.
an explanation of how that component operates	The chair and non-executive members are entitled 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. The level of remuneration is determined by the Governors with due regard to the remuneration paid in other Foundation Trusts	N/A	Mileage and subsistence allowances for NEDs are set by the Council of Governors.
the maximum that could be paid in respect of that component	The rate of remuneration payable to the Chairman of the Trust is £35,000 pa for up to 2 days a week. The Chair of the Audit Committee, Chair of Clinical Governance	N/A	N/A

	Committee and the Senior Independent Director are remunerated at a rate of £14,000 pa. The current rate of remuneration payable to other non-executives is £11,000 pa for approximately 3 days a month.		
where applicable, a description of the framework used to assess performance	Performance of NEDs is assessed by the Chairman annually, and for the Chairman, by the Lead Governor and Senior Independent Director	N/A	N/A

2.3 Service contracts obligations

There were no obligations on the Trust which:

- were contained in all senior managers' service contracts or;
- were contained in the service contracts of any one or more existing senior managers (not including any obligations in the preceding disclosure); and/or
- the Trust proposes would be contained in senior managers' service contracts to be entered into
- and which could give rise to, or impact on, remuneration payments or payments for loss of office but which are not disclosed elsewhere in the remuneration report.

2.4 Policy on payment for loss of office

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 directors and NEDs, 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 contractual notice period or other statutory entitlements, to be made on termination of employment.

2.5 Statement of consideration of employment conditions elsewhere in the foundation trust

The pay and conditions of employees were taken into account when setting the remuneration approach for senior managers; by ensuring consistency in determination of non-pay taxable benefits to ensure no favourable treatment for Executive Directors.

The staff governors contribute to the determination of non-executive pay, alongside other governors, however they have no further responsibility to consult more widely to ensure their views reflect those of the wider staff and community and do not have any involvement in the determination of executives remuneration

In determining pay for executive directors, the remuneration levels for other NHS Trust's is reviewed, utilising published and recognised remuneration reports.

3.0 Annual report on remuneration

3.1 Service contracts

Name and title	Date of their service contract	Unexpired term	Details of notice period
Mr Timothy Pile Non-Executive Director	15 January 2013	Until 14 Jan 2016	Note 1
Dame Yve Buckland Chairman and Non-Executive Director	1 May 2014	Until 31 April 2017	Note 1
Mrs Jo Chambers Chief Executive Officer	1 December 2013	n/a	6 months
Mr Paul Athey Director of Finance	1 June 2013	n/a	6 months
Mr Andrew Pearson Medical Director	11 March 2013	n/a	6 months
Mrs Amanda Markall Director of Operations	1 April 2012 to 31 August 2014	n/a	6 months
Mr Jonathan Lofthouse Interim and substantive Director of Operations	1 September 2014 as interim, substantive from 20 October 2014	n/a	6 months
Mrs Helen Shoker Interim and substantive Director of Nursing and Governance	1 October 2013 as interim, substantive from 1 April 2014 to 31 January 2015	n/a	6 months
Mr Garry Marsh Interim Director of Nursing and Governance	16 February 2015	n/a	1 month

HH Frances Kirkham Non-Executive Director	11 February 2014	Until 10 February 2017	Note 1
Professor Taunton Southwood Non-Executive Director	1st February 2014	Until 31 January 2017	Note 1
Mrs Elizabeth Chignell nee Mountford Non-Executive Director	1 January 2013	Until 31 December 2015	Note 1
Mr Michael Flaxman Interim Non-Executive Director	1 March 2014 to 31 May 2014	n/a	Note 1
Mr Rod Anthony Non-Executive Director	1 June 2014	Until 31 May 2017	Note 1

Note 1:

Non-Executive Directors notice periods are as follows:

- NEDs may resign from office by giving one month's notice in writing to the Trust Secretary.
- NEDs may be removed from office with or without notice by a resolution of the Council of Governors with the approval of three-quarters of the members of the Council of Governors.

3.2 Remuneration committee

The Directors Report provides the following details in respect of the remuneration committee:

Details of the membership of the remuneration committee. This means the names of the chair and members of the remuneration committee should be disclosed (Code of Governance A.1.2).

The number of meetings and individuals' attendance at each should also be disclosed (Code of Governance A.1.2).

Anne Cholmondeley, Director of Workforce and Organisational Development provided advice to the committee in considering their responsibilities and decisions. She had no conflicts of interest in relation to this role because her own terms and conditions of employment were governed by Agenda for Change and were therefore outside the remit of the remuneration committee.

3.3 Disclosures required by Health and Social Care Act

The Trust believes that all relevant disclosures are detailed elsewhere in the report.

3.4 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 2015, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2015	9
Of which…	
No. that have existed for less than one year at time of reporting	9
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 2014 and 31 March 2015, 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 2014 and 31 March 2015,	11
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	10
No. for whom assurance has been requested	10
Of which…	
No. for whom assurance has been received	8
No. for whom assurance has not been received	2
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 2014 and 31 March 2015

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.	14

The off-payroll engagements are in relation to Mr J. Lofthouse and Mr. M. Flaxman.

Mr. M. Flaxman was contracted as a NED 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 NEDs on the Board. His contract lasted three months, and was replaced by the substantive engagement of Mr Rod Anthony as NED director and chair of audit committee.

Mr. J. Lofthouse was contracted as Interim Operations Director between 11 August 2014 and 20 October 2014 following the departure of Mrs. A. Markall while substantive recruitment took place. Mr. Lofthouse was subsequently appointed as the Trust's substantive Director of Operations as of 20 October 2014.

Off-payroll engagements Trust policy

The Trust is required as part of this report to disclose its policy in relation to the engagement of individuals via off-payroll arrangements. At present the Trust does not have a specific policy in relation to the circumstances in which off-payroll engagements would be utilised, however these would always be procured via the Trust's normal procurement procedures with value for money being considered. The Trust does have a policy in relation to the management of these arrangements once these are in place. The Trust monitors engagements which are more than £220 per day and are expected to last at least six months. Individuals which fall into this category are required to provide assurance to the Trust that the income they receive is properly accounted for in relation to tax.

Contracts for these individuals include a clause which states that this information must be provided when requested by the Trust, failure to do so could result in the contract being terminated. Where information is not provided the Trust notifies HMRC.

To date no contracts have been ended or notified to HMRC due to the failure to provide the required assurance to the Trust.

3.5 Remuneration subject to audit (*This element of the annual report has been audited)

2014-15

Name and Title	2014-15 (12 months to 31st March 2015)					
	Salary and fees	**Taxable Benefits**	**Annual Performance - related bonuses**	**Long-term performance-related bonuses**	**Pension - related benefits**	**Other Remuneration**
	(bands of £5,000) £000	**Rounded to the nearest £100**	**(bands of £5,000) £000**	**(bands of £5,000) £000**	**(bands of £2,500) £000**	**(bands of £5,000) £000**
Mr Timothy Pile – Non-Executive Director (from 1 January 2013) & Acting Chairman (from 1 February 2014 to 30 April 2014)	15-20	0	0	0	0	0
Dame Yve Buckland – Chairperson (from 1 May 2014)	30-35	0	0	0	0	0
Mrs Jo Chambers – Chief Executive	145-150	300	0	0	120-122.5	0
Mr. Paul Athey – Director of Finance	95-100	0	0	0	47.5-50	0
Mr. Andrew Pearson – Medical Director	20-25	100	0	0	27.5-30	120-125
Mrs. Amanda Markall – Director of Operations (from 1 April 2012 to 31 August 2014)	35-40	0	0	0	Note 4	0

Mr Jonathan Lofthouse – Interim and substantive Director of Operations (from 1 September 2014), (Substantive from 20 October 2014) **Note 1**	105-110	0	0	0	Note 4	0
Mrs. Helen Shoker – Interim and Substantive Director of Nursing and Governance (interim from 1 October 2013) (Substantive from 1 April 2014 to 31 January 2015)	110-115 Note 5	0	0	0	Note 4	0
Mr. Garry Marsh – Interim Director of Nursing and Governance (from 16 February 2015) **Note 2**	10-15	0	0	0	0	0
HH Frances Kirkham – Non-Executive Director	10-15	0	0	0	0	0
Professor Taunton Southwood – Non-Executive Director	10-15	0	0	0	0	0
Mrs. Elizabeth Chignell née Mountford – Non-Executive Director	10-15	0	0	0	0	0
Mr Michael Flaxman – Interim Non-Executive Director and Audit Committee Chair (from 1 March 2014 to 31 May 2014) **Note 3**	0-5	0	0	0	0	0
Mr. Rod Anthony – Non-Executive Director and Audit Committee Chair (from 1 June 2014)	10-15	0	0	0	0	0

*This element of the annual report has been audited.

Notes

Mr Jonathan Lofthouse joined the Trust on an interim basis on 11 August 2014 via a contract with Gatenby Sanderson while a substantive replacement for Mrs. Amanda Markall was sought. Mr. Lofthouse took up the substantive post from 20 October 2014 and was subsequently transferred onto the Trust's payroll.

Mr. Garry Marsh is currently seconded to the Trust from United Lincolnshire Hospitals NHS Trust as Interim Director of Nursing and Governance following the departure of Mrs. Helen Shoker. The contract started on 16 February 2015. Mr. Marsh is paid by United Lincolnshire Hospitals NHS Trust who then recharge the costs to the Trust.

Mr Michael Flaxman was contracted as a NED from 1 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 NEDs on the Board. His contract lasted 3 months, and was replaced by the substantive engagement of Mr. Rod Anthony as NED and Chair of Audit Committee.

Pension-related benefits 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 or 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.

The salary and fees figure provided for Mrs. Helen Shoker includes an amount paid to her in the year solely in lieu of notice.

2013-14

Name and Title	2013-14 (12 months to 31st March 2014)					
	Salary and fees	**Taxable Benefits**	**Annual Performance -related bonuses**	**Long-term performance-related bonuses**	**Pension - related benefits**	**Other Remuneration**
	(bands of £5,000) £000	**Rounded to the nearest £100**	**(bands of £5,000) £000**	**(bands of £5,000) £000**	**(bands of £2,500) £000**	**(bands of £5,000) £000**
Mr Timothy Pile - Non Executive Director (from 1 January 2013) & Acting Chairman (from 1 February 2014)	15-20	0	0	0	0	0
Mr Bryan Jackson - Non Executive Director and Chairman (from 1 April 2013 to 1 February 2014)	30-35	300	0	0	0	0
Mr. Chris Monk – Non Executive Director (from 15 November 2012 to 1st June 2013) and Acting Chairman (to 30 March 2013)	5-10	0	0	0	0	0
Mrs Jo Chambers – Chief Executive (from 1 December 2013)	50-55	0	0	0	Note 10	0
Mr. Graham Bragg - Director of Strategic and Business Development (from 13 September 2012 to 1 December 2013) and Acting Chief Executive (to 30	130-135	300	0	0	Note 10	0

November 2013)						
Mr. Donal O'Donoghue – Chief Executive (to 1 July 2013) note 6	120-125	0	0	0	Note 10	0
Mrs. Helen Shoker – Interim and Substantive Director of Nursing and Governance (from 1 October 2013) (Substantive from 1 April 2014) note 9	40-45	0	0	0	5-7.5	0
Mrs. Lindsey Webb – Director of Nursing and Governance, and Deputy Chief Executive (to 7 November 2013)	55-60	0	0	0	Note 10	0
Mr Andrew Pearson – Medical Director (from 11 March 2013)	20-25	0	0	0	Note 10	115-120
Mrs. Amanda Markall – Director of Operations (from 1 April 2012)	95-100	0	0	0	25-27.5	0
Mr. Paul Athey – Director of Finance (from 1 June 2013)	80-85	0	0	0	Note 10	0
Mr. Paul Taylor – Interim Director of Finance (from 3 December 2012 to 30 June 2013) note 7	35-40	0	0	0	0	0
Mr. Robert Millinship - Non Executive Director (to 6 October 2013)	5-10	200	0	0	0	0

HH Frances Kirkham – Non Executive Director	10-15	0	0	0	0	0
Professor Taunton Southwood – Non Executive Director	10-15	0	0	0	0	0
Mrs. Elizabeth Chignell née Mountford– Non Executive Director (from 1 January 2013)	10-15	0	0	0	0	0
Mr. Andrew Meehan – Non Executive Director and Audit Committee Chair (from 1 January 2013 to 1st February 2014)	10-15	200	0	0	0	0
Mr Michael Flaxman – Non Executive Director and Audit Committee Chair (from 1 March 2014) note 8	0-5	0	0	0	0	0

*This element of the annual report has been audited.

Notes

6. In 2012/13, Mr. Donal O'Donoghue was on long term sick leave, resulting in Mr. Graham Bragg performing the role of Acting Chief Executive with Mrs. Lindsey Webb as the Deputy Chief Executive. In 2013/14, Mr. 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.

7. Mr. Paul 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.

8. Mr Michael Flaxman commenced his post on 1st March 2014. He was remunerated through contract arrangements with In Form Solutions Ltd.

9. Mrs. Helen 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.

10. Pension-related benefits 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.

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 2015 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase/ (decrease) in Cash Equivalent Transfer Value £000	Employer's Contribution to Stakeholder Pension To nearest £100
Mrs Jo Chambers – Chief Executive (from 1 December 2013)	20-22.5	200-205	950	816	124	0
Mrs. Helen Shoker – Interim and Substantive Director of Nursing and Governance (from 1 October 2013) (Substantive from 1 April 2014 to 31 January 2015) note 1	80-82.5	80-85	322	0	322	0
Mr. Garry Marsh – Interim Director of Nursing and Governance (from 16 February 2015) note 2	0	0	0	0	0	1600
Mr. Andrew Pearson – Medical Director (from 11 March 2013) note 3	2.5-5	155-160	459	426	27	0

Mrs. Amanda Markall – Director of Operations (from 1 April 2012 to 31 August 2014)	0-2.5	115-120	487	447	14	0
Mr Jonathan Lofthouse – Interim and substantive Director of Operations (from 1 September 2014), (Substantive from 20 October 2014) note 4	0-2.5	0-5	7	0	7	0
Mr. Paul Athey – Director of Finance (from 1 June 2013)	7.5-10	75-80	238	203	33	0

*This element of the annual report has been audited

Note

Mrs. Helen Shoker did not hold a substantive executive position prior to 1 April 2014 and so no comparative numbers have been provided in this report.

Mr. Garry Marsh is currently on secondment with the Trust in the role of Interim Director of Nursing & Governance. Therefore it is not possible to calculate Mr. Marsh's pension benefits. For the purpose of this report the pension contributions made to date during this secondment have been shown in the 'Employer's contribution to stakeholder pension' column.

The Trust was notified that the pension figures provided by Greenbury for inclusion in the 2013/14 pension benefit table were incorrect and were overstated. Due to this the figures were restated for the 2014/15 calculation.

The figures shown for Mr Jonathan Lofthouse are in relation to contributions made into the NHS England Pension scheme only. Mr. Lofthouse has previously made contributions into the NHS Scotland pension scheme and these contributions had not been transferred as at the year end.

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.

3.6 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 2014/15 was £145-150k (2013/14: £175-180k). This was 4.9 times (2013/14: 5.5 times) the median remuneration of the workforce, which was £31k (2013/14: £32k).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 2014/15, one employee (2013/14: 0) received remuneration in excess of the highest-paid director. Annualised remuneration ranged from £2k to £183k (2013/14: £3k to £173k), 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 agency staff costs within the year calculation. 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.

3.7 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;

	2014-15	**2013-14**
Number of Directors in office	14	18
Number of Directors with expense claims	6	7
Financial value of expense claims made by Directors (£00)	10.06	56.11
Number of Governors in office	25	15
Number of Governors with expense claims	1	2
Financial value of expense claims made by Governors (£00)	4.61	3.48

Mrs Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust

26 May 2015

E. Code of Governance and FT Reporting Manual Disclosure requirements

The Royal Orthopaedic Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Board considers that the Trust has applied the Code of Governance in all respects except as listed at the end of this section where an explanation is given of the reasons for the departure and how the alternative arrangements continue to the reflect the main principles of the Code of Governance.

Code of Governance reference	Summary of requirement	Reference in Annual Report/ Response
A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Summary statement included in the Directors report paragraph 1.0 and 4.1
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration* committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Included in the Directors report paragraphs 2.1 and 4
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Included in the Governors' Report paragraph 4

n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Included in the Governors' Report paragraph 4

*This requirement is also contained in paragraph 7.46 as part of the remuneration report requirements. The disclosure relating to the remuneration committee should only be made once

B.1.1	The board of directors should identify in the annual report each non- executive director it considers to be independent, with reasons where necessary.	All of the NEDs are considered to be independent – see statement in Director's report paragraph 3.3
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Directors report section 2 and statement in Directors report paragraph 3.5
n/a	The annual report should include a brief description of the length of appointments of the NEDs, and how they may be terminated	See Directors report paragraph 2.1 and 2.2
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See Directors report paragraph 4.3
n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or NED.	See Directors report paragraph 4.3
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	See Directors report paragraph 2.1

B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Included in the Governors' report paragraph 1.0
n/a	If, during the financial year, the governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	This power was not exercised during 2014/2015
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	See Directors report paragraph 3.5
B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	See Directors report paragraph 3.5
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and	See Directors report paragraph 3.2 and Annual Governance

	provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 7.90	Statement paragraph 4.3
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See Directors report paragraph 3.2
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	See Directors report paragraph 4.1
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	The council of governors did accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor.
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the	Included in Director's report paragraph 4.1

	value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	

D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a NED elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	No executive directors were released to serve elsewhere.
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the NEDs, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Included in Directors report paragraph 3.4
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Included in the Governors' Report paragraph 6.1 and 6.2
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Included in Directors report paragraph 3.4

n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Included in the Governors' Report
n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 7.33 as directors' report requirement.	Alternative disclosure included in Directors report paragraph 3.3

Comply or explain requirements

The Trust believes that it complies with all of the requirements of the code of governance in the "comply or explain" category except as detailed below

Code of Governance reference	Summary of requirement	Explanation in where the trust has departed from the Code of Governance, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code of Governance
B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and NEDs.	The Trust Board has a nominations committee for executive directors only, For NED appointments the Council of Governors' Nominations and Remuneration committee plays an equivalent role; this arrangement avoids the need for governors to be members of two committees. Both committees ensure that there is a formal, rigorous and transparent procedure for the appointment of new directors to the board and that Directors of the Trust meet the "fit and proper" test requirements. The Trust Chairman chairs both Council and Board Committees, and ensures that the requirements of a unitary Board are met.
B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	Largely compliant but some work in progress: The Chair led a reflection and assessment of the workings of the Council in May –June 2014 with the governors. A number of changes have been made to the conduct of Council meetings as a result and further networking and training opportunities have been identified for Council members. A communications strategy aimed at the public describing how Council members have discharged their responsibilities is being developed.

E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Largely compliant but some work in progress: The governors have reflected upon which local community forums and stakeholders need to be represented on the Council and Patients and Carers Forum. There has been a review of the overlap between the Council and the Patients and Carers Forum and arrangements have been simplified. The Board will clarify these arrangements on the website once they have been reviewed and assessed for effectiveness.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Quality Account and Report 2014–2015

The Royal Orthopaedic Hospital NHS Foundation Trust

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Quality Account and Report 2014/15

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 2014/15, 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 2015/16 we will strive to be an organisation which:

- Delivers exceptional patient experience and world class outcomes.
- Develops services to meet changing needs, through partnership where appropriate.
- Is at the cutting edge of knowledge, education, research and innovation.
- With safe, efficient processes that are patient centred.
- Is delivered by highly motivated, skilled and inspiring colleagues.

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.

Our Values

The aim of the Trust's values is to create a culture of excellent patient care by ensuring we all:

- Respect and listen to everyone

- Have compassion for all

- Work together and deliver excellence

- Have pride in and contribute fully to patient care

- Be open, honest and challenge ourselves to deliver the best

- Learn, innovate and improve to continually develop orthopaedic care

The Board has set this new set of values recently, following widespread consultation with staff, governors, members and external stakeholders. These values reflect the changing external environment whilst building on the more traditional values of care, safety and service. They recognise that, with some loss of public trust in the NHS (i.e. post the Francis Report), openness and transparency need to be very explicit values. They are underpinned by a view that, for the NHS to survive, it has to change radically and at a far greater pace than the past. We need to build in urgency for improvement in everything we do. These values are aligned to the NHS constitution and values.

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 structures.

The Clinical Governance Committee reviews the quality governance framework (QGF) on a regular basis and uses it to guide its priorities. It has formed one of the key inputs to a Board workshop undertaken during this year which covered overall governance and organisational performance and it informs the Corporate Governance Statement prepared by the Board for Monitor.

The Quality Governance Framework is also used as an overarching framework to inform the key components of the Board Assurance Framework and systems of internal control.

The action plans to improve the governance of quality can be summarised as follows:

Strategy

Since the development of the Vision and Strategy in April 2014 a comprehensive structured programme of work has been outlined to achieve the delivery of the strategy over the next five years. This work will be led by a Director of Strategy and Transformation, who was appointed in November 2014; and the establishment of a Transformation Committee (a Committee of the Trust Board) Chaired by a NED, which met for the first time in January 2015. This programme management approach ensures that the Trust Board remains constantly aware of progress against the overall strategic initiatives, and has a clear line of sight to the projects and initiatives on the ground that will deliver the transformation.

Capabilities and Culture

Over the last six months, much work has been done to promote the strategy and the seven priorities to staff and patients. We will be continuing our focus on engaging our staff in the next six months in order to embed a sustainable culture of excellence innovation and service.

A series of 'New Beginnings' events are planned, providing every staff member with an opportunity to meet and ask questions of a member of the executive team, following an up-to-the-minute briefing on the Trust's progress towards its strategic goals. The events will also provide staff with opportunities to develop and further bring to life the values and behaviour framework which will underpin the development of our culture, and will be asked to help us to set priorities for action plans arising from the most recent staff survey.

Over the next year, our values and behaviour framework will be embedded into our policies and procedures, including recruitment and selection, reward and recognition, and the promotion of inclusivity.

We are developing a Leadership Strategy which will support the development of the right culture for the Trust, and will in turn reinforce the adoption of good discipline in the use of robust governance, in line with our Quality Governance Framework (QGF) which the Trust commissioned from the Good Governance Institute (GGI).

Progress in developing our culture will be monitored through the Board Assurance Framework (BAF).

Work continues on a root and branch review of all governance systems and processes, to ensure that messages regarding quality and safety are clear and individual accountabilities are understood.

Board Capabilities

The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. Both the Board and the Council of Governors considered that there was a need to further strengthen clinical governance and clinical improvement knowledge among the non-executive directors. A NED with improvement knowledge was recruited in June 2014 and the recruitment of an additional non-executive director with a clinical background was initiated toward the end of 2014/2015.

Regarding executives the following appointments to key vacancies on the Executive Team have been made; in each case the governance of quality was a consideration in appointment:

- Director of Operations
- Director of Strategy & Transformation
- Interim Director of Nursing & Governance

Culture

Over the last six months much work has been done to promote the Strategy and the seven priorities to staff and patients, and this work continues. The ROH programme management approach is based on the principles of engaging all our staff, from ideas to delivery, developing a 'can-do' culture where project management principles are not a mystical set of work processes but rather a simple set of processes and tools to aid and empower all staff to be able to deliver transformation in their own areas of work.

The same programme management approach is now being applied in conjunction with the revised and updated BAF to assure the delivery of actions plans falling from the recent CQC visit and our own internal assessments using the QGF and work which the Trust commissioned from the GGI to ensure that all our plans are focused on quality, and aligned clearly to our strategy. An over-arching high level quality and governance actions plan is in place to ensure delivery.

The Trust is in the process of a root and branch review of all its governance systems and processes, ensuring that messages regarding quality are clear; and systems are embedded and adhered to.

Processes and Structure

The Trust Board has overseen a programme of detailed actions to improve critical processes related to quality governance. This can be summarised as follows:

Processes

- Completion of a CQC action plan
- Review of the rolling programme of compliance of all new and existing equipment (work in progress)

- Full Medicines Management Review – resulting in the updating of policies and procedures; briefings and training. Regular compliance measurement is in place and random spot checks have been instituted.

- Review of our resuscitation equipment protocols and procedures (work in progress)

- Review of the configuration of the patients flow through clinics to improve patients' experience in the out patients department (review of pathways has taken place but this is still work in progress)

- Implementation of new Clinical Audit programme (linked to the Trusts Quality Agenda and delivery of the strategic initiatives) (work in progress)

- The continued implementation of enhanced recovery programmes

- Improvement of Risk Management (escalation & de-escalation) (work in progress)

- Agreement and establishment of a mechanism for independent assurance and scrutiny of Trust assurance systems and processes (work in progress)

- Revised programme and processes for review of all Trust policies

- Reviewing and updating Trust systems for the recording of, and learning the lessons from all incidents. (work in progress)

Structure

The Terms of Reference of all Board Committees have been reviewed; one of the purposes of the review was to make clearer the responsibilities for the governance of quality. The terms of reference and responsibilities of those groups reporting to the Clinical Governance Committee (CGC) are being reviewed on a rolling basis by the CGC. In particular consideration is being given to the creation of a group covering both research and clinical outcomes and effectiveness. This group will oversee the clinical audit programme and provided assurance that the enhancements requested by the Board and CGC are implemented.

A directorate restructure was started at the end of the financial year- this will enable greater clarity across the Trust for the governance of quality.

Measurement

There is a planned review of the Comprehensive Performance Report (CPR) will include a focus on quality information. The CPR review is intended to strengthen the link to forward planning and wider measures of quality such as best practice benchmarking

The review of senior staff portfolios will ensure that key staff have a clearer focus around those CPR items for which they are responsible

1.3 Visibility of the Executive Team

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

As part of the Chief Executive's commitment to communication to all staff throughout the organisation Team Brief has been implemented this involves a briefing from the Chief Executive to all heads of department on key matters that affect the trust. This briefing is then disseminated throughout the organisation both electronically and in briefings at local department level led by senior leads. A Chief Executive Blog has also been commenced.

The Chair is regularly seen on independent walkabout throughout the organisation, visiting wards and departments throughout the trust and casting an independent eye on the care we provide our patients on a daily basis.

During the year, the Director of Nursing and Governance has also held monthly drop in sessions for members of the nursing team and all staff within the organisation, they were implemented to give staff an opportunity to raise concerns about quality and patient safety issues.

The Deputy Director of Nursing and Governance has also undertaken regular Quality Assurance Visits throughout the clinical in-patient wards. These walk-abouts consist of a patient story, clinical observation, discussion with staff, as well as reviews of medical notes and documentation.

Work has commenced on further enhancing the current quality assurance visits to extend its membership to include executive directors, NEDs, patient representation and matron attendance. The assurance visits will be based on the CQC Key Lines of enquiry and the five key domains of Safe, Effective, Caring, Responsive and Well-led.

The Clinical Programme Board (CPB) has developed further through the year to better enable transformational change. The Clinical Board has moved to be replaced by the Transformation Board. The primary function of the Transformation Board is to monitor and support work streams designed to enable the trust to meet its key strategic goals. The Transformation Board is changing and evolving and is an opportunity for front line staff to really engage in transformational change and the positive effects it has on its service and is service users.

Trust Business and Learning Days have continued throughout the year wherever possible, this is to enable the whole organisation to have time to focus on business and educational priorities. These days are regarded by staff working within the organisation as really valuable and there is a commitment in the coming year to maintaining the opportunities the day brings, although it is likely they will be changing in format to further support the business of delivering healthcare to our patients.

1.4 Chief Executive's Statement of Quality

Our vision is to be the first choice for orthopaedic care and providing safe, quality care is our highest priority at the ROH. This has been a longstanding vision, based on a commitment to excellence and a focus on single specialty care.

This Quality Account aims to provide you with a true and accurate reflection of our performance over the past year and is accurate to the best of my knowledge.

As a Trust we have faced a challenging year in many aspects and these will be highlighted in some detail throughout the report. As a Trust we take pride in being open about the challenges we face and we will continue to focus on raising quality standards for our patients ensuring they remain at the heart of every decision we make.

Under the CQC's new regime of the Chief Inspector of Hospitals, we have been rated overall as "Requires Improvement" although we were pleased that many areas were rated as "good", and that we achieved the "good" rating in the "caring" domain across all specialities. We were pleased to be recognised by the inspection team for the caring and compassionate approach of our staff and for the open and transparent way in which this Trust operates. The CQC did identify two key areas of underperformance where we were rated as inadequate these being within our Critical Care Unit and Outpatients Department. The Trust has been focused on improving the performance in these areas over the last six months with a comprehensive plan of work in each area of non-compliance devised and overseen by the Board.

Much work has been undertaken on reviewing and improving the Trust's internal governance processes and mechanisms of assurance and some of this work is detailed within the accounts. Good governance is the cornerstone of safer patient care and we remain committed to the work we have commenced during this year. We have sought expert knowledge in our endeavours for self-improvement from external agencies such as the GGI to further support this work.

Over the last 12 months the Trust has developed its five year vision and strategic plan. This process involved around 20% of all staff, in reference groups and a stakeholder strategy day in April 2014, which included patients, commissioners, partner organisations and Trust governors.

This process denoted a new inclusive model of working for the Trust, which aims to ensure that Trust plans and strategies are intrinsically linked to staff and patients and have issues of quality, transparency and governance embedded. The strategic initiatives are as follows:

1. Creating a culture of excellence, innovation and service

2. Exceptional patient experience every step of the way

3. Safe and efficient processes

4. Fully engaged patients and staff

5. Information for excellence

6. Developing clinical services

7. ROH: The knowledge leader

All of the strategic initiatives are fundamentally based upon the quality agenda and have the patient at the heart of every decision.

We continue to invest in services across the Trust, with work undertaken on the paediatric ward to improve the environment for our youngest and most vulnerable patient group as well as funding into our radiography services. A significant investment has also been made into our IT systems with a comprehensive IT strategy developed to ensure better and more efficient ways of working

We are proud of our nursing initiatives which contribute to the daily care our patients receive including a continuing reduction in the incidents of hospital acquired pressure ulcers.

In the coming year, we are keen to further embed much of the work that has been commenced during 2014/2015. We recognise we still have areas of improvement and remain committed to focusing our efforts on the achievement of these. Key areas remain to be;

Establishing and embedding good governance principles throughout the organisation both at corporate and local level.

Supporting and developing clinical leadership within the organisation, embedding the trust values to foster a culture of excellence in patient care.

Completion of work required as part of the CQC inspection to assure safe and effective care for our patients.

Improving incident reporting so that we can be confident as a Trust of learning from when things have not gone as we anticipated.

Improving pre-operative starving times for our patients to support them adequately for their surgical procedure.

We would like to acknowledge the hard work and commitment of our staff in their efforts to provide high quality and patient centred care. We look forward to 2015/2016, working in partnership with our key stakeholders and the challenges the new year will bring.

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.

- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.

- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.

- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate

Mrs. Jo Chambers, Chief Executive

Dame Yve Buckland, Chair

2.0 Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement

The following table show how we have performed against the quality improvement priorities for 2014/15 with further information available in part 3, this includes any data performance for 2013/2014 pertaining to these specific priorities. Unless otherwise stated information in section two have been taken from internal trust sources.

Table 2 – Progress against quality improvement priorities for 2014/15

PRIORITIES	RATIONALE	MEASURING, MONITORING AND REPORTING
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 **Achievement Status** Not achieved. Data indicates that there has been a 32% decrease in medicines reporting. Further information available in Section 3.0 of the report.
More than 95% of patients will be assessed for risk of Venous Thrombolytic Event (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 **Achievement Status** Achieved. Over 95% of patients have been assessed for VTE on admission. Further detailed analysis available throughout the report and in Section 3.0 of the report.

To ensure actions from Serious Incidents Requiring Investigation's (SIRI's) are demonstrated in clinical practice	Developmental step following 2013/14 Quality Improvement Priorities 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 **Achievement Status** Not achieved – whilst spot audits would indicate better compliance in completion of red and SIRI Incident plans, further focus in required to improve the culture of learning and sharing throughout the organisation. Further detailed analysis available in Section 3.0 of the report.
EFFECTIVENESS		
To be compliant with National Joint Registry (NJR) 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 **Achievement Status** Not achieved – There has been inconsistent compliance indicated in monthly NJR data. Further detailed analysis available throughout the report and in Section 3.0 of the report.
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 **Achievement Status** Not achieved – There has been inconsistent compliance in the earlier part of the year, whilst this has significantly improved - monthly

		monitoring indicates compliance of between 97 and 99%. Further detailed analysis available in Section 3.0 of the report.
To increase results for Q40 of the CQC National Patient Survey, Do you think hospital staff did everything to control your pain?	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 Committee and Executive Management Team to Trust Board **Achievement Status** Achieved – survey results indicate increase to 8.5 Further detailed analysis available in Section 3.0 of the report.
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 **Achievement Status** Not Achieved – survey results indicate static results remain the same. Further detailed analysis available in Section 3.0 of the report.
To ensure the patient journey through the organisation for	Aligned to the new 2014/15 CQUIN scheme following patient journeys	CQUIN scheme reporting to Executive Management Team and Clinical Governance Committee to

surgical interventions is considered with areas of best practice shared and opportunities for development addressed	Trust Board patient stories	Trust Board **Achievement Status** Achieved. All CQUIN Milestones achieved. Further detailed analysis available in Section 3.0 of the report.
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	**Achievement Status** Not Achieved Further detailed analysis available in Section 3.0 of the report.

2.1 Quality Improvement Priorities for 2015/16

The table below identifies the improvement priorities for 2015/16, the rationale for selection and how we propose measuring, monitoring and reporting. The priorities have been considered by staff, patients and stakeholders. This was undertaken via a number of means including discussion at professional staff forums including Leadership Forum and Matrons Forum to other multi-professional committees such as the Quality Committee and open discussion with our partner commissioners.

We believe the priorities are based on providing an excellent quality of orthopaedic care.

PRIORITIES	RATIONALE	MEASURING, MONITORING AND REPORTING
SAFETY		
To improve medicine safety awareness through incident reporting of harm/potential harm	Incident reporting and learning from incidents remains a priority for the trust and as such this improvement priority has been taken forward into 2015/2016	Enhanced data collection Patient Quality Report Reporting to Executive Management Team, Clinical Governance Committee to Trust Board
Staff Survey – Raising	The trust is focused on improving patient safety. To enable this staff	Reporting to Quality Committee.

concerns	must feel able to raise concerns and feel assured that these concerns will be acted upon appropriately.	Exception reporting to Clinical Governance Committee.
To improve standards of incident investigation	To ensure learning from incidents is embedded high standards of investigation are required. Many current investigators have had minimal training.	Training to be arranged by the Trust. Monitoring of attendance at training by all members of the multi-disciplinary team. Reporting to Quality Committee Exception Reporting to Clinical Governance Committee
EFFECTIVENESS		
To be compliant with National Joint Registry standards of consent and reporting	The trust strategy focuses on the best clinical outcomes for all patients. Therefore as this has not been achieved consistently for this year it shall be rolled into 2015/2016.	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	The Trust takes intra-operative safety very seriously and as such will continue to focus continued work on embedding the changes required to meet compliance.	Current method with increased scrutiny and robust reporting to Executive Management Team and Clinical Governance Committee to Trust Board
To ensure robust, regular and well attended Quality Assurance Visits	The Trust is raising the profile of the current Quality assurance visits to maximise engagement and ensure the process is robust and meaningful.	Fortnightly/monthly documented Quality Assurance Visits. Directorate and Central reporting of action plans. Reporting through the Patient Quality Report to Executive Management Team and Clinical Governance Committee.
EXPERIENCE		
To reduce the length of time patients are	The Trust takes nutrition of its patient population very seriously	Bi-annual starvation Audits

starved before surgery to less than 10 hours	and notes the importance to both safety and experience of reducing starvation times.	Matron Care Quality Rounds Nutritional monthly audits Protected mealtime audits Reporting to Executive Management Team and Clinical Governance Committee to Trust Board.
To reduce the length of time patients whilst in attendance their outpatient appointment – patients will wait no longer than 60 minutes.	CQC Inspection highlights outpatient wait times as unacceptable and this contributed to the inadequate rating in efficiency for OPD.	Reports to Transformation Board on OPD work streams Local Audit Exceptions reporting to EMT.
To ensure that patients wait no longer than 60 minutes when deemed clinically well enough for transfer from the Recovery Unit to Wards/HDU/ADCU	CQC Inspection highlighted poor patient flow throughout the Hospital including patients waiting for long lengths of time in the Recovery Unit.	Local Audit Report to Quality Committee and Clinical Governance Committee.

2.2 Statements of assurance from the Trust Board

1 During 2014/2015 The Royal Orthopaedic Hospital NHS Foundation Trust provided four NHS services (trauma and orthopaedic, neurosurgery, pain management and general medicine).

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

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

- The Board receives assurance on the Quality of Care through the Patient Quality Report, and the BAF, and through the oversight of the Clinical Governance Committee (CGC). The CGC in turn receives more detailed reports from subgroups covering particular aspects of quality, for example drugs and therapeutics. There is a process of escalation of risk related to quality throughout the Trust; further work is being carried out to strengthen its operation.

- Quality information is scrutinized by advisory groups before submission to the CGC and ultimately to the Board. Work is ongoing to develop enhanced approaches to data reporting to enable greater and more informed scrutiny; in addition work is being carried out to develop further the capabilities of groups supporting the CGC in relation to quality information.

- The governance of clinical outcomes data is being reviewed; the role of clinical audit in providing assurance regarding quality and outcomes data is also being strengthened.

- Assurance is obtained routinely on compliance with CQC registration requirements through directors and senior managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards. After the last CQC inspection, the Trust produced an action plan which includes strengthened internal controls, systems and responsibilities for quality. This was particularly true in relation to the management of controlled drugs, where an external review by KPMG was commissioned to provide further assurance and additional ways to enhance the Trust's internal control system and culture of leadership to ensure quality.

- Quality rounds are undertaken by the senior 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 have been undertaken within nursing and the Chair regularly walks the site meeting staff and patients within the organisation.

- The Clinical Governance Committee continues its review of the quality governance framework on a quarterly basis. This process is being matured to allow for more robust organisational review.

- Patient stories have been 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. The forthcoming plan is to ensure these stories are heard on a more regular basis by the Board. Patient stories continue to be an item at the Nurse Leaders Forum.

1.2 The income generated by the NHS services review in 2014/15 represents 99.2% of the total income generated from the provision of NHS services by The Royal Orthopaedic Hospital NHS Foundation Trust for 2014/15.

2.0 Participation in Clinical Audit

During April 2014 – March 2015 3 national clinical audits and one national confidential enquiry covered relevant health services that The Royal Orthopaedic Hospital provides.

2.1 During that period The Royal Orthopaedic Hospital NHS Foundation Trust participated in three national clinical audits (100%) and one national confidential enquiry (100%) of the national clinical audits and confidential enquiries of which it was eligible to participate in.

2.2/2.3 The national clinical audits and the national confidential enquiries (identified in section 2) that The Royal Orthopaedic Hospital NHS Foundation Trust was eligible to participate in and actually participated in during April 2014 – March 2015 are as follows:

1. National Joint Registry
2. Elective Surgery (National PROMs Programme)
3. National Cardiac Arrest Audit (NCAA)
4. Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Sepsis

2.4 The national clinical audits and national confidential enquiries (identified in section 2.2) that The Royal Orthopaedic Hospital NHS Foundation Trust participated in, and for which data collection was completed during April 2014 – March 2015, 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	91% (internal fig Apr 14-Feb 15) 109% (actual fig July 13-June 14).
PROMS	Yes	94.2% (actual fig Apr 13-Mar 14). 97.2% (internal fig May-August 14)
Cardiac Arrest	Yes	100% eligible cases submitted.
NCEPOD Sepsis	Yes	Organisational survey only – completed as per terms of audit.

2.5/2.6 The reports of four national clinical audits that were reviewed by the provider in April 2014-March 2015 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 continues to attain high levels this year. NJR data is 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 2013/14 the Trust is above the

national average in all hips though not all knees. The 2014/15 trend data is not yet available due to the six-month follow-up period.

The NJR process is undergoing a review and there will be changes to the way consent is collected and compliance is monitored, which will help increase the compliance figures.

The Trust is planning to improve the processes around collecting national audit data by using innovative IT solutions to increase efficiency.

2.7/2.8 The reports of 48 local clinical audits that were reviewed by the provider in April 2014-March 2015 and The Royal Orthopaedic Hospital Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit Detail	Committee Reviewed/Monitored	Description of Actions Taken
SSI surveillance	EMT	Significant reductions in SSI have been reported over the past 5 years, with a reduction of 65% in both primary Hips and Knees. Many interventions have been made that have had an effect on the SSI rate, the most recent being Aquacel surgical dressings which have been very effective and are well liked by clinicians and patients. There have been zero incidences of blisters where Aquacell was the only dressing in use; this is a considerable improvement for patients. Work is currently ongoing to ensure funding for Aquacel is available to all areas. An appointment has been successfully made to expand the surveillance for all arthroplasty patients to 1 year post operatively and this commenced in September 2014. Full analysis, including by consultant data, will be undertaken at the end of March 2015 to provide a full position.
Safety Thermometer	EMT	It was noted that in November there was a fall in compliance for safety thermometer, which was specifically related to pressure ulcers. We have seen a significant rise in patients transferred into the trust with pressure ulcers in place. In these circumstances, a letter is written to the transferring trust and the CCG also informed of all pressure ulcers grade 3 and above.

Infection Control indicators	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 were introduced from April 2014.
Falls risk assessment Quality Indicators	EMT	All patients are now receiving hospital falls and falls prevention information pre-operatively. The first 4 ultra-low beds were delivered into the trust during October. These beds support the care given to confused or agitated patients. The Throne Project review for a small number of pilot wards has been completed and ward leaders are invited to discuss the findings and plans to take actions forward. Ward 1 is now piloting the use of the "Tuft Box". This is a distraction device used to support the care given to confused or agitated patients. A falls grab bag is now in place on Ward 2 as a pilot this will support the immediate care needs of patients who have experienced a fall.
Are caudal epidural injections with sciatic stretch as effective as caudal epidural injections alone for sciatica.	Surgical Audit	Recommendations made included: • The summary scoring sheets need to have full date (including year) documented. • ODI scores should be routinely documented as a footnote at least in relevant clinic letter. • Retrospectively data collection needs to be expanded to increase the numbers in this audit. • Prospectively a database should be set up on a network drive and collected in clinics.

		• Re-audit in 6 months
Notes audits	Health records group	The first of a new cycle of a mandatory audit. Aim to improve patient record This will evolve with the IM&T development Overall good state of notes Significant improvement in compliance in comparison to previous audit conducted in March 2012. To standardise data collection for next audit cycles.
Outcome after PEEK plate for 4 corner fusion	Small Joints	Audit showed PEEK plates to be safe and effective implant for 4 corner fusion.
Neurological observations following Spinal Surgery		Recommendations: Continue protocol Commend nursing staff for documenting neuro observations Re-audit in 2-3 years
How well is information transmitted to GPs?		Comment: A proportion of the notes without an electronic document were from Ward 7, which used the old paper forms. Overall, the results show that GPs are not always being informed of our findings and recommendations, and in particular they are often not transmitted via the electronic document, or when the information is only in one category. While not the object of this audit, there seemed to be remarkably little medical information e.g. on complications, on the electronic letters, and complications of one sort or another are the major reason for which a physician's opinion is sought. Apart from the importance of communication with GPs, as electronic records come in, the discharge summary will become increasingly important as the accessible, definitive record of an admission. We may be said to be delegating our medical responsibilities to inform GPs inappropriately to

		nursing staff.
Audit of imaging during and after spinal surgery		Recommendations: Erect whole spine films to assess coronal and sagittal balance Post-op radiographs if patient is symptomatic Re-audit
Audit on prescribing of perioperative analgesia in patients undergoing TKR and THR at the ROH and adherence to local prescribing standards and enhanced recovery after surgery (ERAS) protocols		Recommendations Presentation of audit results at the next Trust Clinical Audit meeting to increase awareness amongst prescribers and highlight that ERAS protocols are not being adhered to Clear guidance is needed on ERAS protocols and trust wide dissemination of these to increase awareness and compliance i.e. posters, prescribing flashcards, presentations at junior doctors induction sessions Potential Cost Improvement Programme if oxycontin M/R is switched to generic morphine sulphate M/R

3.0 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 relevant health services provided or sub-contracted by The Royal Orthopaedic Hospital NHS Trust in April 2014-March 2015 that were recruited during that period to participate in research approved by a research ethics committee was 1035.

The Royal Orthopaedic Hospital NHS Foundation Trust was involved in setting up and conducting 74 clinical research studies in orthopaedics during 2014/15. 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 was 58 clinical staff participating in research approved by a Research Ethics Committee at The Royal Orthopaedic Hospital NHS Foundation Trust during 2014/15. These staff participated in research covering seven sub –specialties.

Mr Ed Davis, Research and Development Director, has been awarded a grant from the European Commission to undertake a collaborative project with Aston University looking at the wireless monitoring of inpatients vital signs. The trust is engaged in two commercial research trials which are due to commence in 2015, one of these is testing a new pain killer for children undergoing major surgery. The other is a new innovative therapy for treating avascular necrosis (AVN) which was recently the leading health article in the mail online.

The departments AHP Research Team (Physiotherapists) have been very active during 2014/2015 and also have two external studies open; PROVE for osteoporotic fractures and Hip FASHION for femoroacetabular impingement. The team have continued to create and strengthen links with other centres including University of Birmingham, Oxford, Cardiff, Warwick and Keele Universities with four potential studies planned for the next year.

4.0/4.2 Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of The Royal Orthopaedic Hospital NHS Foundation Trust's income in 2014-15 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.

The total amount of income conditional upon achieving quality improvement and innovation goals in 2014-15 was £1.561 million.

The payment made to the Trust was £1.536 million, an achievement of 98.4% of the total potential value.

Further details of the agreed goals for 2015-16 are available on request from the Trust's Head of Commissioning, Gareth Hyland, (gareth.hyland@nhs.net.com)

5.0 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.

5.1 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 2014/2015.

7.0/7.1 Care Quality Commission Reviews

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

The Royal Orthopaedic Hospital NHS Foundation Trust opted to participate in a CQC inspection in June 2014 as one of a number of pilot inspections during 2014. The inspection was undertaken as part of the new CQC hospital inspection approach and took place over three days with an additional inspection taking place out of hours

The Royal Orthopaedic Hospital NHS Foundation Trust's CQC report was published on 16th October 2014. The Trust was allocated an overall rating of 'Requires Improvement' and individual ratings for each of the CQC inspection domains can be seen in the grid below;

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Requires improvement	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Children & young people	Good	Outstanding	Good	Good	Good	Good
Outpatients	Requires improvement	Inspected but not rated[1]	Good	Inadequate	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Alongside the key performance measures the Trust received five legally enforceable compliance actions from the CQC. These were as follows:

Regulation	**How the regulation was not being met**
The registered person must, so far as reasonably practicable, make suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users.	Lack of a Chaperone Policy. Whilst the Trust has a Privacy and Dignity policy with a section referring to chaperone support this was not well known to staff or discussed widely with the CQC. A specific chaperone policy is to be developed and chaperones made available to support patients' privacy and dignity.
People who use services were not protected from the risks associated with the unsafe management of medicines because controlled drugs were not checked in accordance with legislation. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines	The Controlled Drug cupboard was left open and unattended within the High Dependency Unit.
The registered person must ensure that patient records which may be in paper or electronic form are kept securely. Regulation 20 (2)(a) HSCA 2008 (Regulated Activities) Regulations 2010.	Within the Outpatients Department Confidential patient information and records were found unsupervised in unrestricted public areas of the outpatients department.
People who use services were not protected from the use of unsafe equipment as electrical	Equipment was found for which there was no visible evidence of having been properly checked

safety checks were not routinely undertaken. Regulation 16 (1)(a) HSCA 2008 (Regulated Activities) Regulations.	and maintained in accordance with electrical safety requirements.
The provider did not have systems in place to monitor the quality of services in OPD. Regulation 10(1)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision	During the inspection the CQC found that appointments were not always organised for clinics and led to lengthy waiting times for patients, this had a detrimental effect on the experience of the patient/carer in the outpatients department. The Inspection team found an inconsistent view of the oversight and management of the quality of the services within Outpatients

- In addition to the legally enforceable compliance actions the Trust are required to undertake additional actions following the CQC inspection. These are as follows;

Area for Action	**Action Required**
Checking of Resuscitation Equipment	Resuscitation equipment is routinely checked in accordance with the trust's procedures and records of the checks are kept in outpatients
Patient flow through the hospital	Discharge arrangements to facilitate early identification and availability of beds for patients admitted on the day of surgery are improved.
Lack of an embedded enhanced recovery programme for patients	The implementation of Enhanced Recovery Programmes to reduce patient length of stay in hospital and promote greater patient involvement in their care

- The Trust is working in partnership with the CQC to act upon the findings of the inspection and raise performance in all of the key domains inclusive of the legally enforceable actions. An overarching action plan has been developed with attention to the areas of under achievement. Specific focus has been applied to the "inadequate" domains in safety and effectiveness. This action plan is reviewed at a number of Committees, including Sub Committees of the Board and the Board.

8.0/8.1 NHS Number and General Medical Practice Code Validity

The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 2014/2015 to the Secondary Uses Service for inclusion in the 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:
    - 99.66% for admitted patient care
    - 99.87% for outpatient care
- Which included the patient's valid General Medical Practice Code was
    - 98.40% for admitted patient care
    - 99.99% for outpatient care

The percentage of records in the published data:

In Patients April 2014 to February 2015

Total with NHS_Number	Total patients
9511	9543

Percentage **99.66**

Out Patients April 2014 to February 2015

Total with NHS_Number	Total patients
113856	114009

Percentage **99.87**

IP

all populated

212	default codes
13895	total records
13673	number of valid codes
98.40	percentage

OP

all populated

185	default codes
0	not populated
98934	total records
99.99	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.

9.0 Information Governance Assessment Report

The Royal Orthopaedic Hospital Foundation Trust Information Governance Assessment Report overall score for 2014/2015 was 74% Satisfactory and was graded green.

10.0 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**
Primary diagnosis	6.0
Primary procedure	4.5
Overall error rate	6.0

This performance would place the Trust better than average, and was 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.

11.0 The Royal Orthopaedic Hospital NHS Foundation Trust will be taking the following actions to improve data quality; As the Trust has performed extremely highly in this indicator the Trust will continue to pursue the actions that have resulted in such high standards of data quality whilst continuing to monitor and challenge its own standards internally.

2.3 Reporting against core standards

Unless otherwise stated Data sourced from Corporate Performance Report or Patient Quality Report.

12.0 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).

18.0 The trusts reported outcome measures scores for hip replacement surgery and knee replacement surgery during

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. Patients complete a questionnaire before the operation and six months after the operation.

The EQ5D Index asks patients five questions regarding their general health (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression).

The Oxford Hip/Knee Score comprise of 12 questions relating to the patient's experience of pain, ease of joint movement and ease of undertaking normal domestic activities such as walking or climbing stairs.

The adjusted average health gain is used for comparison between providers and the England average; (this is adjusted for case-mix - age, sex, co-morbidity etc.).

This data is the latest available for the period April 2013 – March 2014.

The percentage of cases submitted is 94.2% (Apr 13-Mar 14).

Adjusted Average Health Gain

Procedure Type	Measure	England Average	England Highest	England Lowest	ROH	Position
Hip Replacement Primary	EQ-5D Index	0.436	0.545	0.342	0.479	Significantly above national average (99.8% control limit)
Hip Replacement Primary	Oxford Hip Score	21.340	24.444	17.634	23.165	Significantly above national average (99.8% control limit)
Hip Replacement Revision	EQ-5D Index	0.255	0.365	0.154	0.296	Above Average
Hip Replacement Revision	Oxford Hip Score	12.096	16.839	8.164	13.304	Above Average
Knee Replacement Primary	EQ-5D Index	0.323	0.416	0.215	0.331	Above Average
Knee Replacement Primary	Oxford Knee Score	16.248	19.762	12.049	16.982	Above Average
Knee Replacement Revision	EQ-5D Index	0.245	0.29	0.10	0.10	Significantly below national average (99.8% control limit)
Knee Replacement Revision	Oxford Knee Score	11.348	15.326	6.984	7.749	Significantly below national average (95% control limit)

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons: the Trust is not yet in a position to give an analysis of these reasons but intends to investigate further

and to improve the specific PROMS indicators and so the quality of its services – The Clinical Outcomes and Effectiveness Committee that reviews outcome data such as PROMS is currently under review by the Medical Director with reporting to the Clinical Governance Committee. This includes its terms of reference, committee membership and Chair. The improved functioning of the committee will ensure closer scrutiny of data as it is received with recommendations and monitored actions put into place to effect real change. The focus for the Trust will be knee replacement revision.

19.0 Patients readmitted to a hospital within 28 days of being discharged

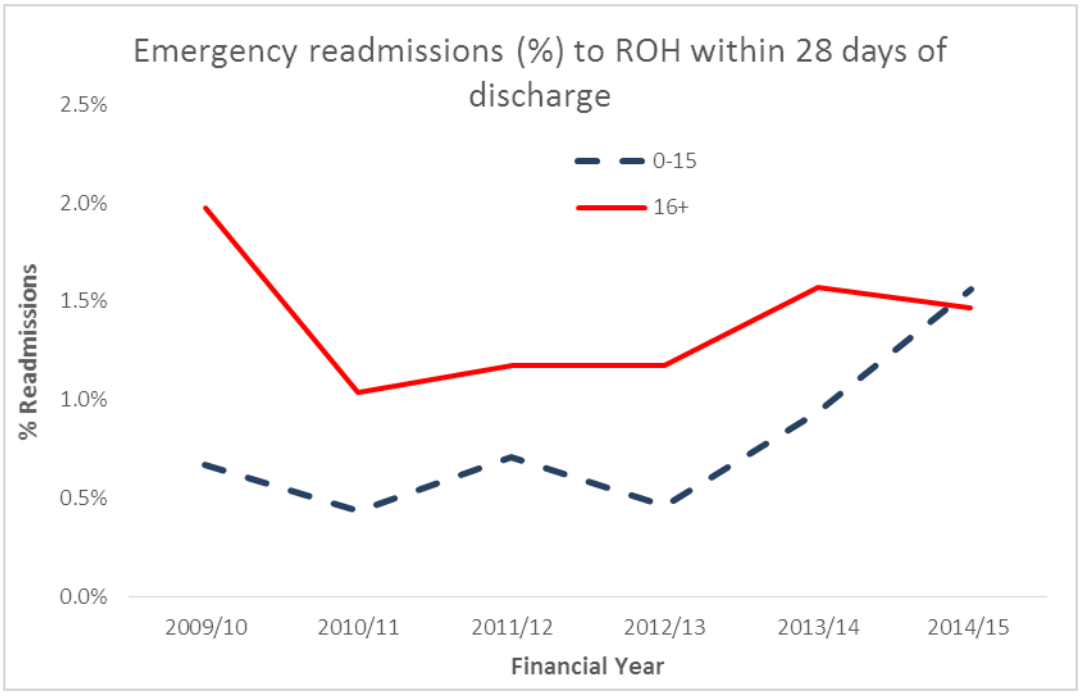
The percentage of patients aged:

i. 0 to 15 and

ii. 16 or over

Who are readmitted to a hospital which forms part of the trust within 28 days of being discharged during the reporting period.

Results

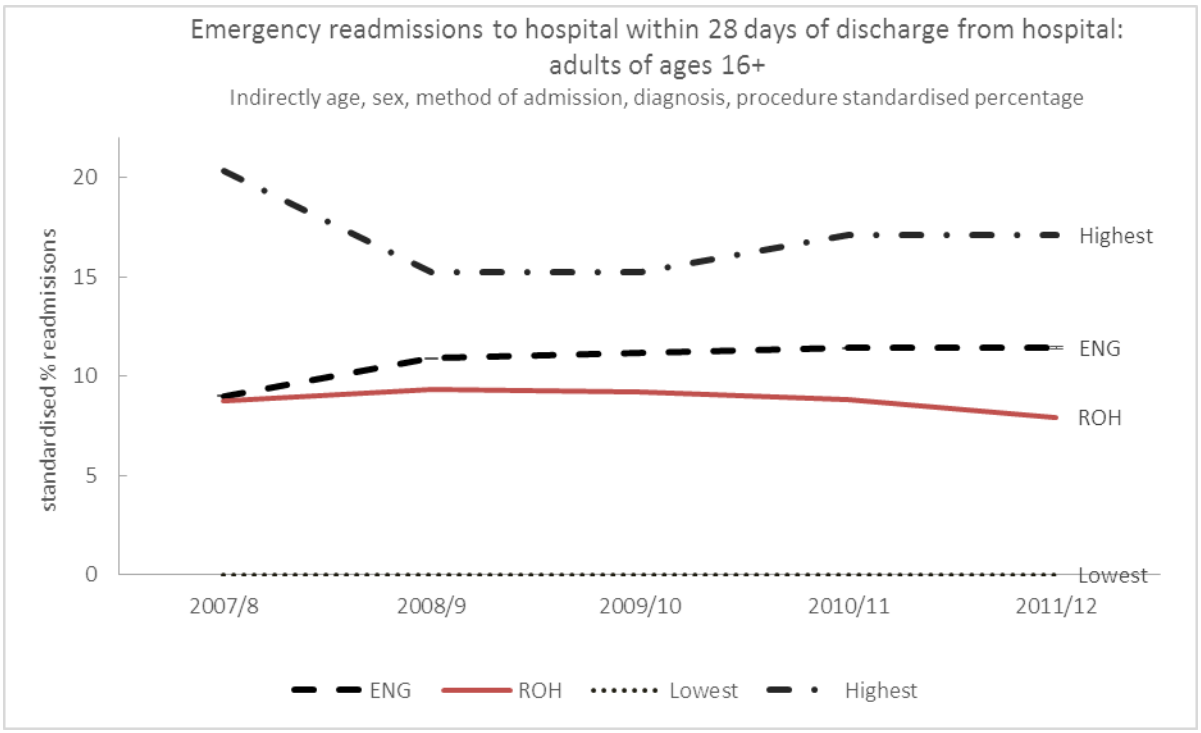


Number of Emergency Readmissions to ROH within 28 days of discharge						
	2009/10	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
0-15	4	3	5	3	6	9
16+	111	62	69	65	86	74

The 28 day readmissions as defined by Monitor for the Quality Accounts is a local indicator and therefore cannot be benchmarked or compared to a national average.

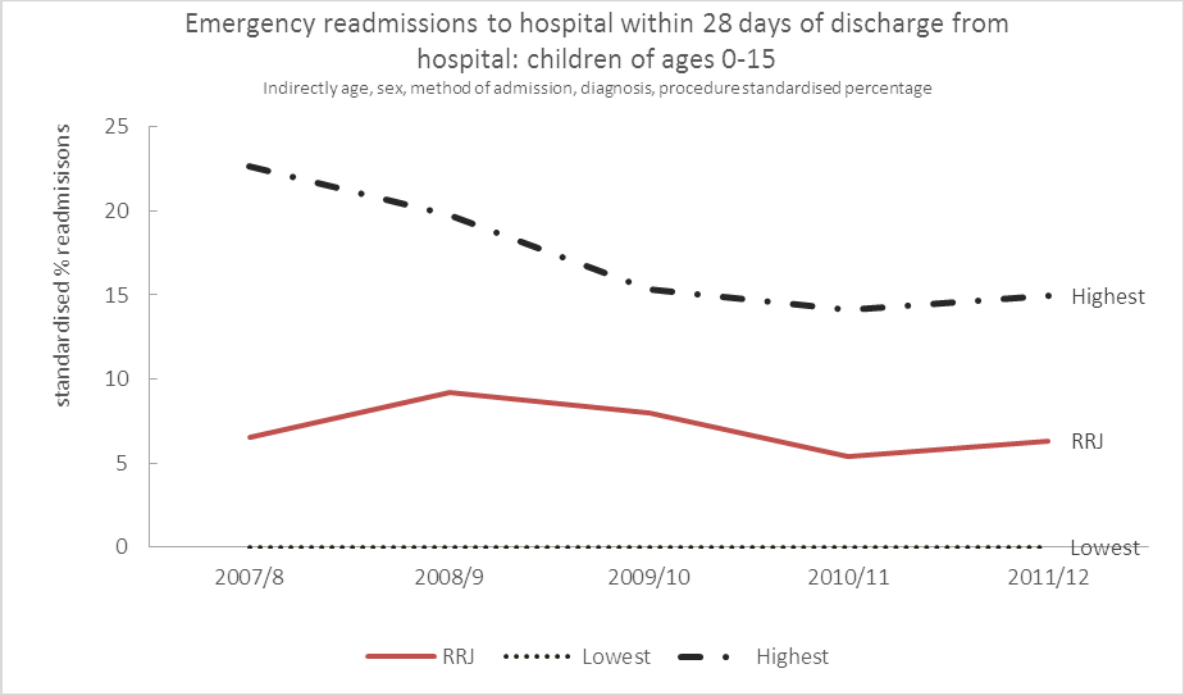
However a further readmissions indicator identified in the quality accounts data dictionary is able to be benchmarked nationally. This is produced by the Health & Social Care Information Centre and has national data -the latest available is 2011/2.For the purposes of the Quality Accounts this has been included, there is no England value available for readmissions for patients aged 0-15.

Emergency readmissions to hospital within 28 days of discharge from hospital: adults aged 16+



It is noted that for the Royal Orthopaedic Hospital Foundation Trust standardised emergency readmissions figure for adults aged 16+ is significantly better than the England average. The latest period this data is available for is 2011/12.

Emergency readmissions to hospital within 28 days of discharge from hospital: children aged 0-15 (In the chart below RRJ is the code for the ROH)



It is noted that for the Royal Orthopaedic Hospital Foundation Trust, standardised emergency readmissions figure for children aged 0-15 is within the expected range of the England average. The England average figure is not available on the published data. The latest period this data is available for is 2011/12.

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons: the Trust is not yet in a position to give an analysis of these reasons but is currently reviewing its data including the area, specialism and reason behind readmission. The Trust does not consider the data presented in the chart as giving rise to material concerns but nonetheless is committed to striving to understand and improve its performance in this area to be the best it can be.

The Royal Orthopaedic Hospital intends to take the following actions to improve the specific readmission indicators and so the quality of its services – Dependant on the data analysis further focused actions will be taken to reduce readmissions if and where possible.

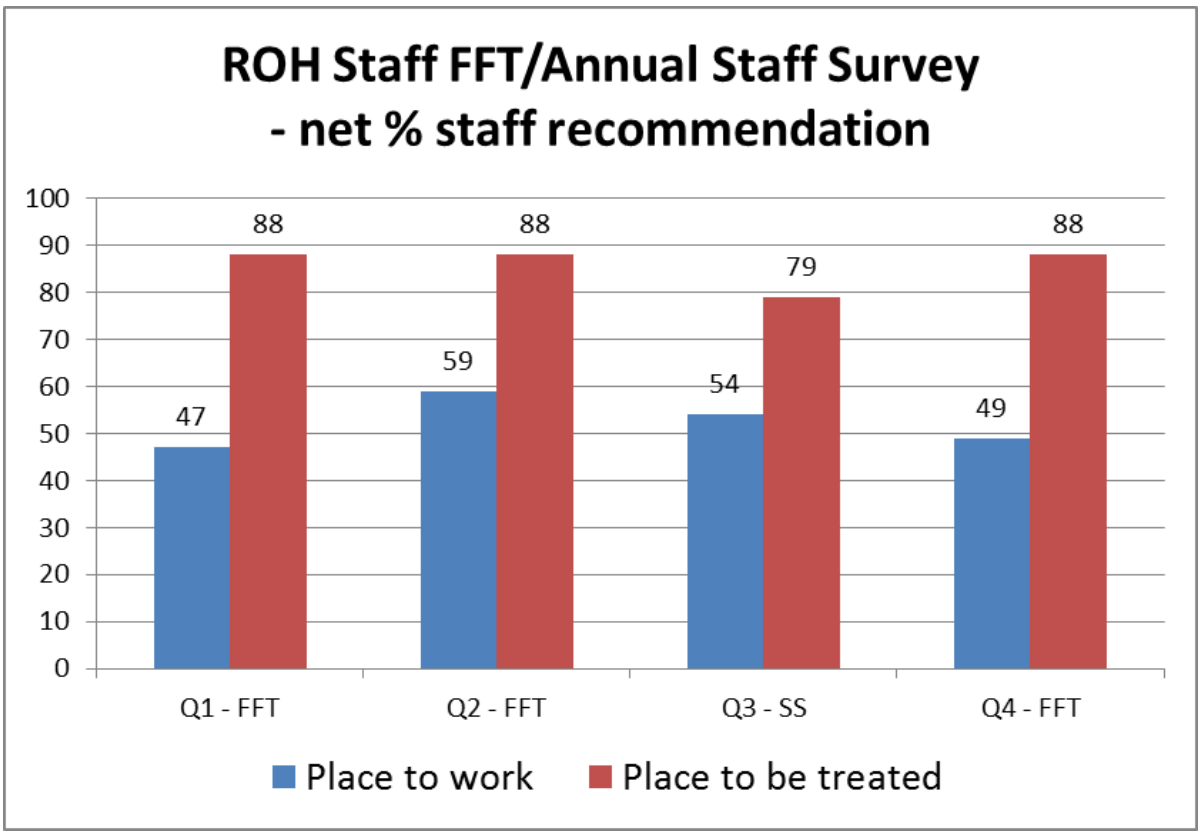
21.0 The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

The Staff Friends and Family Test (Staff FFT) is a survey which runs quarterly, except for Q3 (Oct-Dec) which is the period in which the Annual Staff Survey is conducted.

The survey/test comprises two questions on the likelihood of the responding staff member recommending the Trust as a place to work, and as a place to be treated.

The results indicate that over the four quarters; 47-59% of staff would recommend the Trust as a place to work with 79 – 88% of staff recommending the Trust as a place to be treated.

The results are shown below.



The graph includes the unweighted Staff Survey results in Q3, to provide a comparison between the two methodologies and to support trend analysis. Scores are calculated by subtracting 'unlikely to recommend' scores from 'likely to recommend' scores.

The response rate for the Staff FFT has been relatively low (24%), and the Annual Survey response rate was 52%. Work is underway to increase participation rates in both quarterly & annual surveys.

Recent analyses of long term trends, comparing ROH results with other acute specialist Trusts, indicate that we have consistently scored lower than our sector average in these questions.

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons; the Trust has been undergoing a significant amount of change over the last 12 months including a new leadership team with new focus. Such change may be attributable to staff feeling less confident at this stage as they are adjusting to different ways of working.

The Royal Orthopaedic Hospital intends to take the following actions to improve the specific Friends and Family indicators and so the quality of its services - The Trust has embarked upon an extended engagement/consultation exercise with all of the Trust staff to understand underlying causes, and will develop action plans based on the findings.

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

The following tables indicate the numbers of patients assessed for risk of Venous Thrombo-Embolism at the Royal Orthopaedic Hospital.

Monthly

Month	No Assessed	No Admitted	%
Apr 14	923	938	98.4
May 14	971	987	98.4
June 14	933	964	96.8
July 14	967	999	96.8
August 14	890	909	97.9
Sept 14	1103	1134	97.3
Oct 14	1061	1116	95.1
Nov 14	1074	1102	97.5
Dec 14	1010	1016	99.4
Jan 15	926	940	98.5
Feb 15	1040	1053	98.8
March 15	1138	1149	99.0

Quarterly

Quarter	No Assessed	No Admitted	%
Qtr 1	2827	2889	97.9
Qtr 2	2960	3042	97.3
Qtr 3	3145	3234	97.3
Qtr 4	3104	3142	98.8

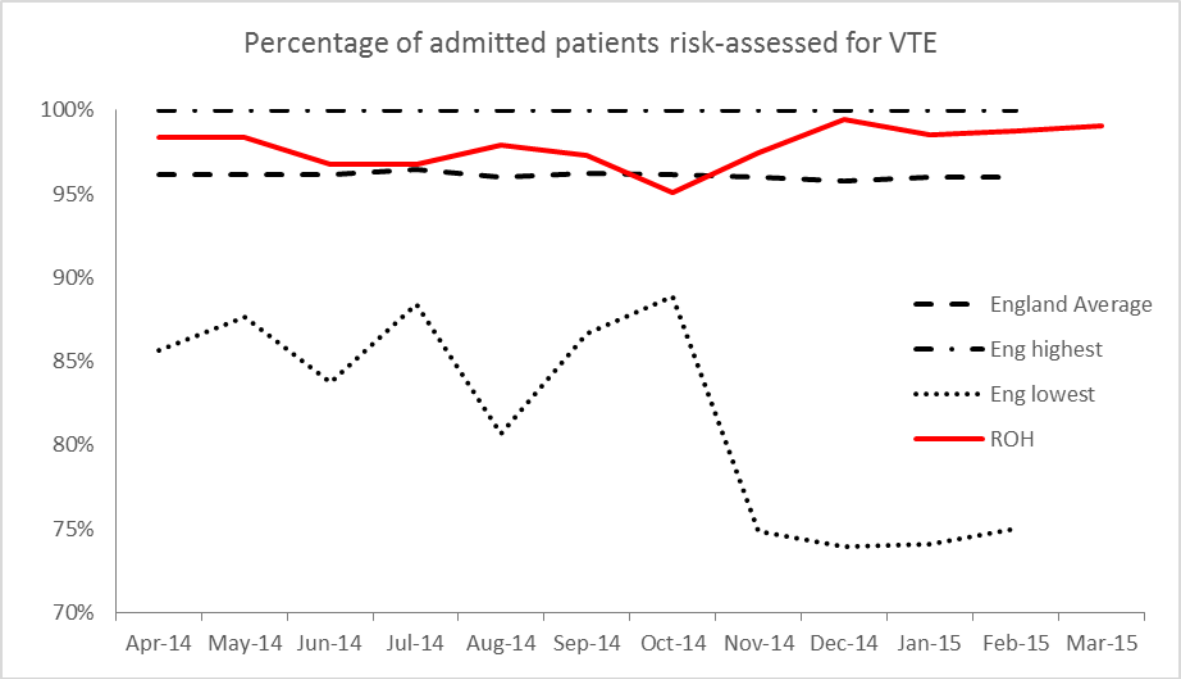
Annual

Year	No Assessed	No Admitted	%
2014/15	12036	12307	97.8

Additional Performance Data - Percentage of admitted patients risk-assessed for VTE

All data displayed in this section is obtained from HSIP.

The graph below indicates the performance of the Trust in comparison to the national picture, including highest, lowest and average compliance percentages.



It is noted on review of the data that the Royal Orthopaedic Hospital Foundation Trust findings indicate our percentage of patients risk assessed for VTE is above the England average and has been above the 95% target throughout 2014/15. At the time of reporting national data for comparison is only available up to February 2015.

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons; the Ttrust has maintained focus and support on the areas previously identified as failing the required target. New local systems have been put into place and embedded well yielding good compliance against the required target and most importantly ensuring patient safety.

The Royal Orthopaedic Hospital intends to take the following actions to improve the specific VTE indicators and so the quality of its services – As VTE initial assessment has proven to be highly successful this year due to the numerous actions taken by the Trust and the Trust VTE Leads. Further focus for the coming year will be prevention of VTE. A number of actions are underway to

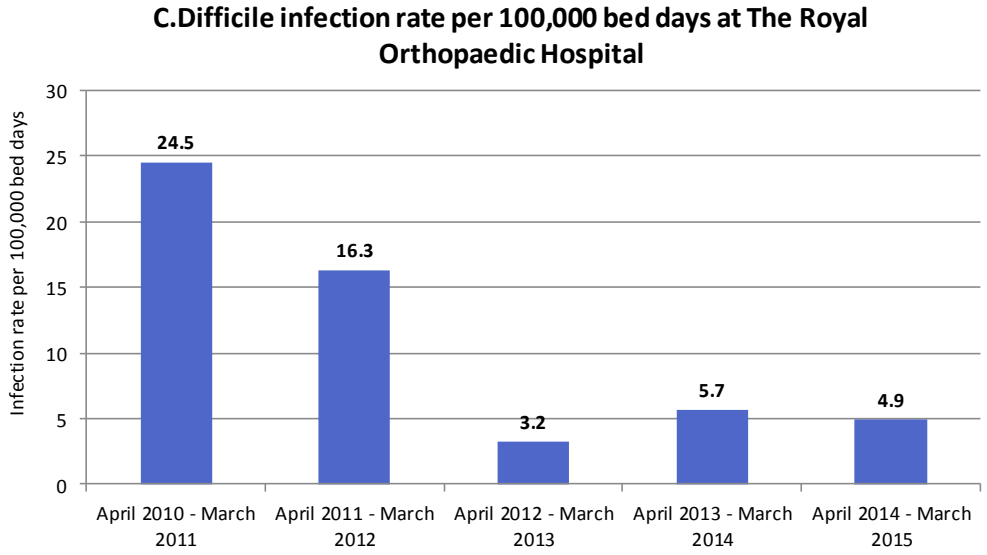
commence this vital piece of work including a review of the Trusts VTE's over the year, identifying any key themes or areas for action. This work is being reviewed by the VTE Committee and overseen by the Clinical Governance Committee.

24.0 Rate of *Clostridium difficile* infection

All data displayed in this section is obtained through the HCAI data capture system managed by Public Health England (PHE)

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**	**April 2014 - March 2015**
The Royal Orthopaedic Hospital	**24.5**	**16.3**	**3.2**	**5.7**	**4.9**
All England Rate	**29.6**	**21.8**	**17.3**	**14.7**	Data has not yet been published
Lowest England Rate	0	0	0	0	
Highest England Rate	71.8	51.7	30.8	37.1	



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 zero avoidable cases of *Clostridium difficile* being reported this year. Two unavoidable cases have occurred, both were fully investigated and avoidability was agreed with the lead commissioners, who deemed both cases as unavoidable. Both were complex

bone infection patients who were referred to the Trust's Bone Infection Unit for specialist treatment of their infected joints; both patients required targeted antimicrobial therapy in order to treat their infections. A balance of risk is required as both *Clostridium difficile* and deep infection can pose a risk to the patient's life. Both patients were treated and recovered from their *Clostridium difficile* infection.

The rate of *Clostridium difficile* infection is lower than the national rate and has remained so since 2011. Unfortunately data for other West Midlands trusts is not yet available to enable benchmarking.

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

25.0 Patient Safety incidents with severe harm/death

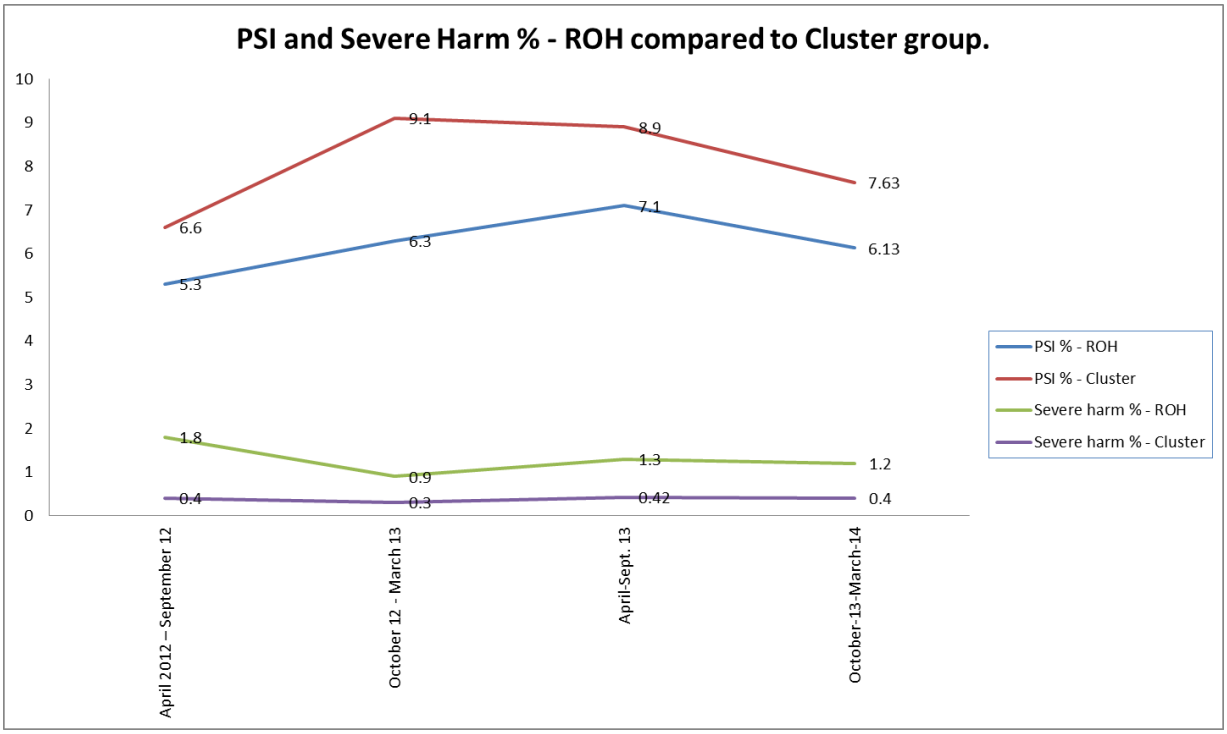
The Royal Orthopaedic Hospital NHS Trust considers that this data is as described for the following reasons:

- The Trust transfers details of all patient safety incidents onto the National Reporting and Learning Service (NRLS) database on a monthly basis.

- The patient safety incident data outlined below is extracted from the most recent report produced by the NRLS report.

The National Reporting and Learning Service (NRLS) was established in 2003 and enables patient safety incident (PSI) 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 Trusts as this may not be comparable. The next NRLS report will cover April-September 2014



All Patient Safety Incidents	April 2012 to Sept2012	October 2012 to March 2013	April 2013 - Sept 2013	October 2013 – March 2014	April 2014 to September 2014
The Royal Orthopaedic Hospital No. of patient safety incidents	381	456	474	409	515 (per 1000 bed days)
The Royal Orthopaedic Hospital rate (per 100 admissions)	5.3	6.3	7.1	6.13	35.92 (per 1000 bed days)
Average Cluster Rate (per 100 admissions)	6.6	9.1	8.9	7.63	
Lowest Cluster Rate (per 100 admissions)	1.37	3.8	3.69	4.72	
Highest Cluster Rate (per 100 admissions)	24.88	31	27.88	32.88	

Severe Harm Incidents	**April 2012 – Sept 2012**	**October 2012 - March 2013**	**April 2013 - Sept 2013**	**October 2013 – March 2014**	**April 2014 to September 2014**
The Royal Orthopaedic Hospital no. of severe harm incidents	7	4	6	5	1
The Royal Orthopaedic Hospital rate (percentage of all PSI)	1.8	0.9	1.3	1.2	0.2%
Average Cluster Rate (percentage of all PSI)	0.4	0.3	0.42	0.4	
Lowest Cluster Rate (percentage of all PSI)	0	0	0	0	
Highest Cluster Rate (percentage of all PSI)	1.8	1.8	2.3	3.6	

During the period of review, there are a number of incidents highlighted as involving severe harm. These incidents included 'deterioration in clinical condition', 'post-op fracture', 'delay in diagnosis' and 'inadequate nursing care'.

A review of incident trends and types of incident has been undertaken to ascertain whether any key themes have come through for the period of 2014/2015.

Patient deterioration

It has been identified that there were a small cluster of incidents related to deteriorating patient condition, whereby there was a delay in the patient undergoing review and receiving the specialist HDU care that was required for them. The Trust has taken a number of actions to address this;

- Areas where apparent trends for patient deterioration were identified have had internal reviews undertaken by the directorate matron, supported by the Deputy Director of Nursing and Governance. The review included looking at incident type, area and timing of the incident.

- Staffing and skill mix was reviewed in this area with upskilling and additional numbers put on shifts where deemed clinically appropriate.

- Additional training has been arranged by the matron for the areas to include MEWs (clinical observation) training, fluid balance training, and identification of the sick or deteriorating patient.

- An action plan was developed between the unit matron and ward manager to support engagement and active monitoring.

- The Trust has signed up to the Deteriorating Patient CQUIN for 2015/2016 to further support internal learning and improve processes for the deteriorating patient.

Never events

During the period of 2014/2015 the Trust also reported two incidents that constituted "Never Events" under the NHS England Never Events Framework 2014. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Both never events were wrong site surgery and involved spinal surgeries.

Although two were reported within the period of April 2014 to March 2015, one of the Never Events occurred in 2013 and was identified through a formal complaint.

The Trust takes incidents of this nature very seriously and following identification of the second never event has commissioned an external review. This is currently underway. Immediate actions taken by the Trust include increased peri-operative radiology to support senior decision making in correct positioning techniques for surgery.

The Royal Orthopaedic Hospital considers that this data is as described for the following reasons; reviews of the data indicate a need for support and teaching for clinicians and AHPs on how to appropriately report incidents including "near miss" events. Staff also need to feel safe to raise incidents and raise concerns and the trust recognises the importance of this and is committed to ensuring it fosters an environment where an open, honest culture can flourish.

The Royal Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of services

- Incidents graded as 'severe harm' are reviewed by the Governance Team and the Clinical Governance Committee. This also supports the Trust in ensuring compliance with Duty of Candour for 'severe harm' incidents.

- Mandatory and bespoke incident reporting training to staff training to ensure accurate grading of incidents.

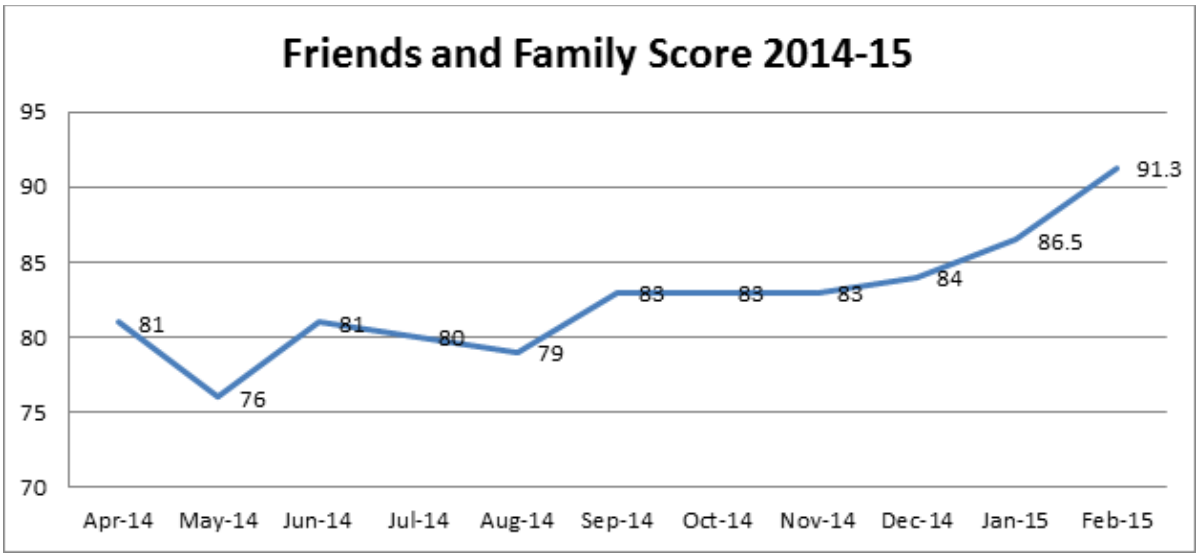
- Regular review of figures submitted to the NRLS to ensure all patient safety data has been submitted.

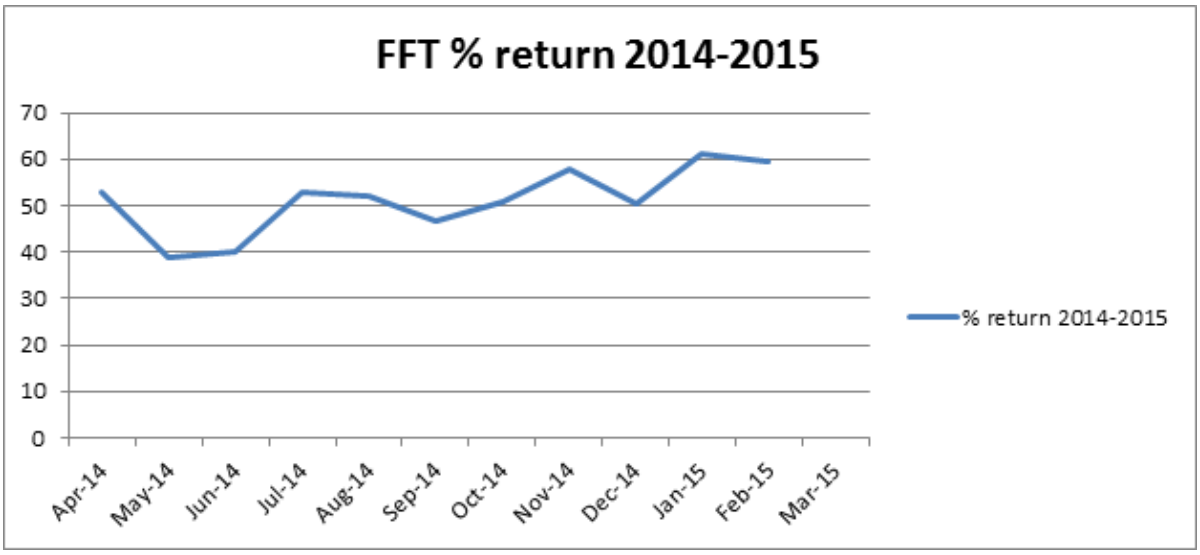
- The rollout of two Patient Safety Culture surveys to staff in order to identify areas where the culture of safety (such as incident reporting) could be improved within the Trust.

- "New Beginning" Workshops are being rolled out across the organisation to increase staff engagement and ensure their views and concerns are listened to and acted upon.

In Addition - 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 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.

3.0 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 focus for 2014/15 has been to continue to embed our culture of continual quality improvement within the 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.

Despite the financial and activity challenges faced in 2014/15 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 2015/16.

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.

Transformation Committee

As highlighted, over the last 12 months the Trust has developed, in partnership with its key stakeholders its five year vision and strategic plan.

The strategic plan identifies seven key initiatives, these being:

1. Creating a culture of excellence, innovation and service

2. Exceptional patient experience every step of the way

3. Safe and efficient processes

4. Fully engaged patients and staff

5. Information for excellence

6. Developing clinical services

7. ROH: The knowledge leader

The programme of work required to deliver the strategy has been agreed by the Board. This work is led by the Director of Strategy and Transformation and is supported by the Transformation Committee

The Committee maintains oversight of the key risks to delivery of the Trust's Strategy and feeds back to the Trust Board where appropriate. It regularly reviews and tracks the progress of key deliverables within the Trust's Strategic Plan – via routine monitoring reports presented by seven programme boards. It supports the programme boards in understanding the impact of delays and underperformance in individual initiatives on the wider programme to ensure that risks are mitigated, interdependencies are managed and to help identify solutions where appropriate.

Quality underpins each of the initiatives, with quality impact assessments undertaken for each scheme.

Building for the Future

The spring of 2014 saw the re-opening of the paediatric ward following an extensive refurbishment, the works included the creation of more single occupancy bedrooms, improved bathroom and toilet provisions and a new reception facility. The works have modernised the outdated facilities and also provided much needed play space for our younger patients.

Throughout 2014 the Trust have been investing in the replacement of our Radiology diagnostic equipment, a new computer tomography scanner and Fluoroscopy machine have been installed together with a new DR x-ray machine. The Trust has also created a facility to enable a mobile MRI scanner to visit site, this is helping to meet the clinical demand on the service.

In the winter of 2014 we replaced the passenger lift which provides access to our Therapy Services Department; the lift has been built to modern standards and is DDA compliant.

In early 2015 the Trust created new education/training facilities, the Learning and Development training facilities offer greater flexibility in the delivery of the learning agenda.

Putting Patients First

The Board continues to be strongly committed to prioritise patients and their care, ensuring they are at the heart of every decision we take.

This ethos is supported with the new trust values that have been developed by the Board including widespread consultation with staff, governors, members and external stakeholders.

The aim of the Trust's values is to create a culture of excellent patient care by ensuring we all:

- Respect and listen to everyone
- Have compassion for all
- Work together and deliver excellence
- Have pride in and contribute fully to patient care
- Be open, honest and challenge ourselves to deliver the best
- Learn, innovate and improve to continually develop orthopaedic care

PALS and Complaints, Patient Experience and Patient Information support the Trust to understand what matters most to our patients and what we need to learn to improve the care we deliver.

The management of complaints was reviewed by the CQC during our inspection in June 2014 and no concerns were noted, with personable contact and agreement of timescales with complainants noted as areas of good practice. Complaints staff are reported as particularly helpful and professional by both patients and staff and many complainants reported that they would feel confident in complaining again if they felt the need to do so. The department has undertaken considerable work throughout the year to improve its internal processes for complaint handling. This includes work to devolve complaints handling to the directorate teams to embed local ownership and ensure that changes that are required are embedded at local level.

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.

3.1 Quality Improvement Priorities

We set a range of priorities for 2014/15 that were agreed by the Board and staff, patient and public stakeholders as important areas to focus on. These have changed from the previous priorities in 2013/2014. The change in priorities is primarily because of key successes in many of the priority areas identified previously such as pressure areas, surgical site infection and food. The Trust has therefore moved its focus to new areas that require determined focus. The following is information on how we have performed against those priorities including where possible data from 2013/2014 to support analysis and performance scrutiny.

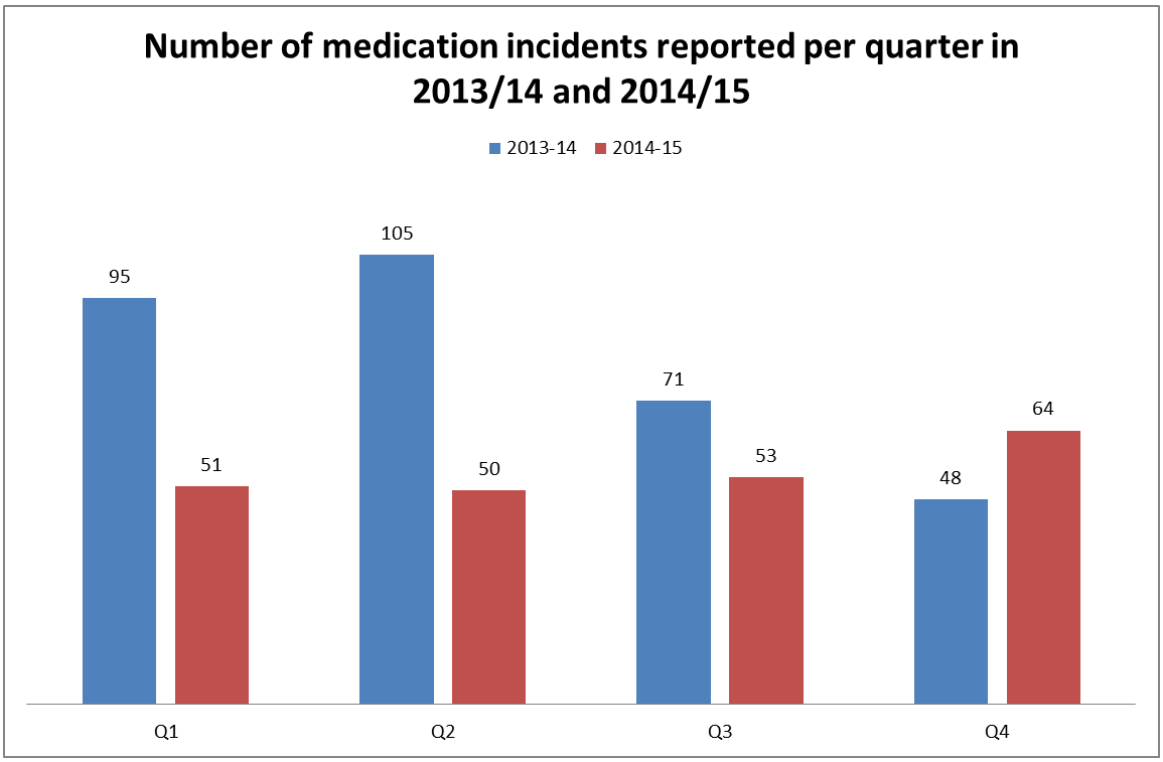
Data sourced from Corporate Performance Report or Patient Quality Report.

Patient Safety

Medicines Safety

The reporting of medicines incidents was identified as an improvement priority for 2014/2015. Incident reporting is important as it helps us a trust to identify key areas of risk for our patients and therefore implement measures to reduce that risk. These measures can be varied and may involve staff training and development or implementing new processes/ways of working to reduce risk.

The table below indicates the numbers of medicines related incidents that were reported this year 2014/2015 and throughout last year 2013/2014.



What can be seen is that in Q1 through to Q3 incident reporting was comparatively lower this year than in the previous year. This increases in Q4 indicating an improvement in incident reporting for this final quarter.

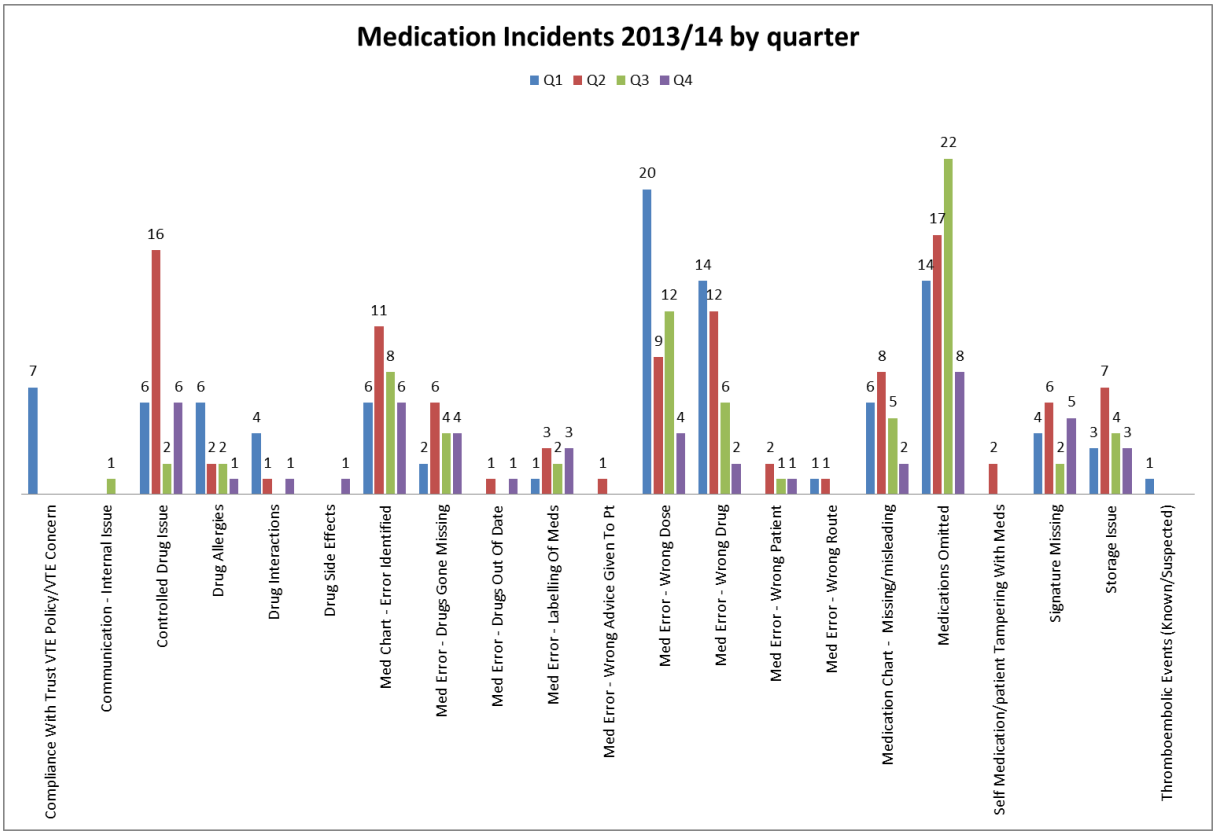
The total number of medicine incidents reported in 2013/2014 was 319

The total number of medicine incidents reported in 2014/2015 was 218

This represents a 32% decrease in overall reporting in comparison to the previous year.

The graphs below indicate the types of medication incidents reported within the trust both in 2013/2014 and in 2014/2015.

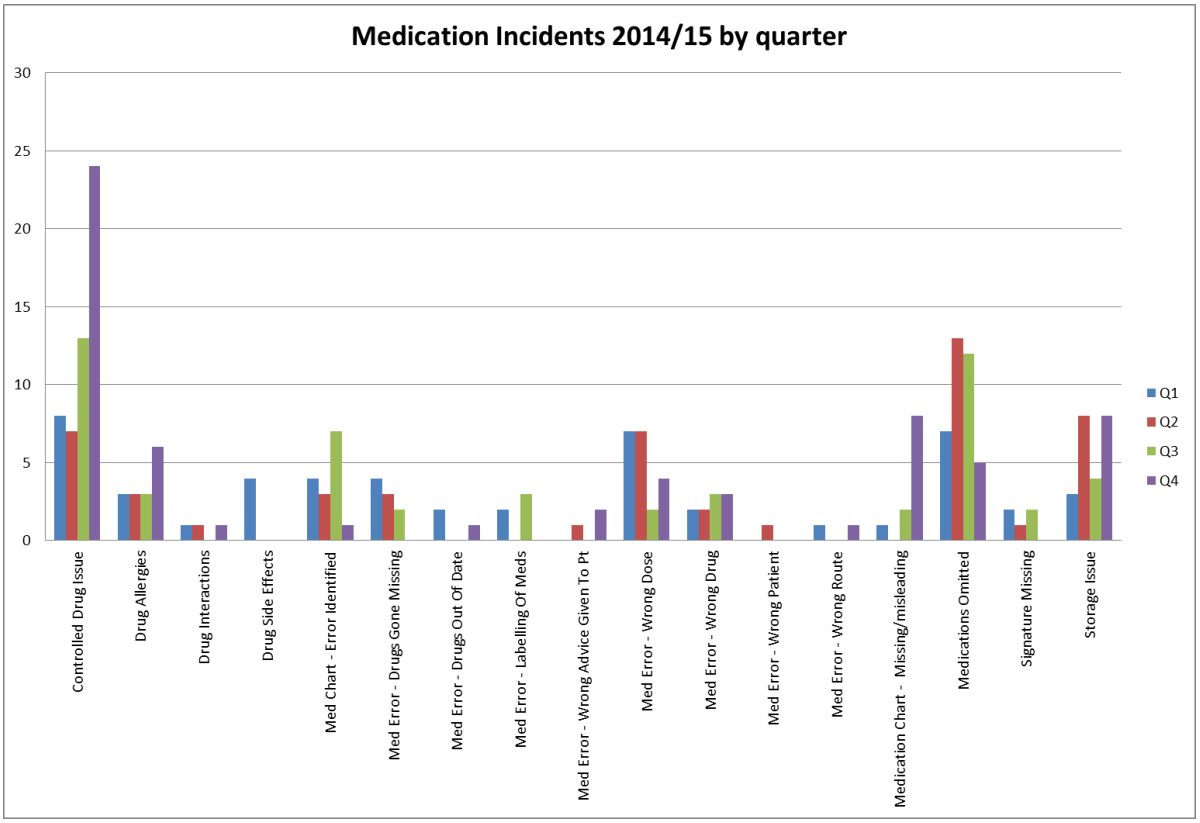
Medication Incident 2013/2014



The top three incident categories for 2014/2015 are noted as;

- Medications omitted
- Medication error – wrong dose
- Medication error –wrong drug

Medication incidents 2014/2015



The top three incident categories for 2014/2015 are noted as;

- Controlled drug issues
- Medications omitted
- Storage issues

Overall Summary

Overall, there were higher reporting levels for medication incidents during 13/14 compared to 14/15 (as identified, 319 medication incidents in 2013/2014 compared to 218 medication incidents in 2014/2015).

High levels of reporting are a key element to patient safety as it can provide greater opportunities for learning. It is encouraging to see that approximately 10% of near miss medication incidents were reported in both periods. The reporting of near miss incidents reflects a proactive approach to the prevention of actual medication incidents. Near miss incidents can also support the identification of weak spots and vulnerabilities, and prevent more serious incidents from occurring.

In terms of patient harm, in 2013/2014 2 incidents (0.5% of all medication incidents) resulted in severe harm to the patient. There were no instances of severe harm medication incidents during 2014/15.

Approximately 90% of medication incidents during both periods (13/14 and 14/15) resulted in either no harm or low harm to patients.

Particular areas of note in relation to increases and decreases in medication incident reporting include:

- Increase in 'controlled drug issues' (5% of all medication incidents in 13/14 compared to 11% in 14/15)

- Decrease in 'medication wrong dose' (14% of all medication incidents in 13/14 compared to 9% in 14/15)

The Trust has commissioned and completed an external review of the governance processes surrounding controlled drug administration and documentation. This has resulted in a number of key recommendations which have been formally agreed and incorporated into a detailed action plan. The progress against the action plan is reviewed by the Trust Board.

Actions we have taken

Numerous actions have been undertaken by the trust throughout the year to encourage the reporting of medicines incidents and to support good medicines practice. These include;

- The Trust Medicines Policy has been updated; further work is being undertaken on the policy with an anticipated completion date of end of June.

- Standard Operating Procedures have been developed to further support and inform clinical practice – specifically in relation to controlled drugs practice.

- Additional focused teaching and support in clinical areas provided by the Clinical Nurse Tutor and the Pharmacy Department.

- Strengthening of pharmacy processes and leadership.

- Governance meetings with directorate leads to review local governance processes, including reporting of incidents and management of risk

- Sign up to the Patient Safety Culture CQUIN

- Encouraging debate and discussion around the importance of incident reporting at staff and professional forums on a regular basis

- Better utilisations of round table events following serious incidents to fully engage all staff involved in incidents, providing a multi-disciplinary approach, and promote learning.

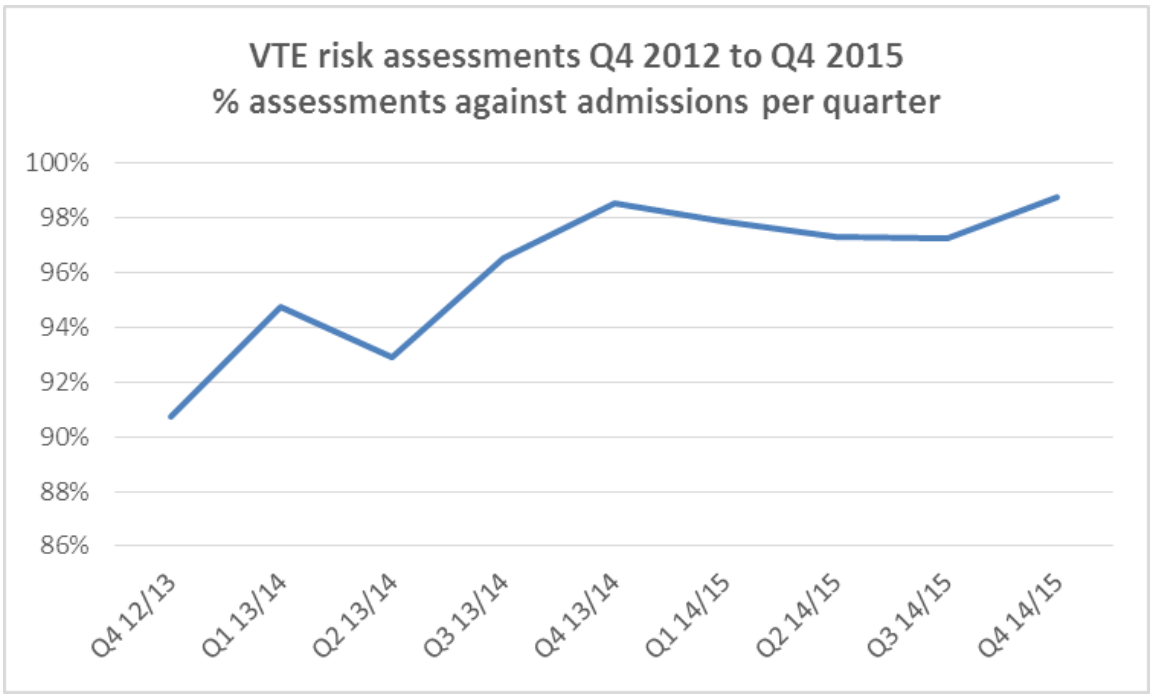
Venous Thrombolic Event (VTE) Risk Assessment

Patient safety remains a priority for the Trust and building on the work from the previous year we identified VTE Risk Assessment as an improvement priority for 2014/2015. The importance of

undertaking these assessments on all patients undergoing surgery is significant as it supports active identification of those patients that may be at more risk of getting a blood clot. This enables the Trust to take the necessary precautions to minimise risk to patients supporting safer surgery and better outcomes for patients.

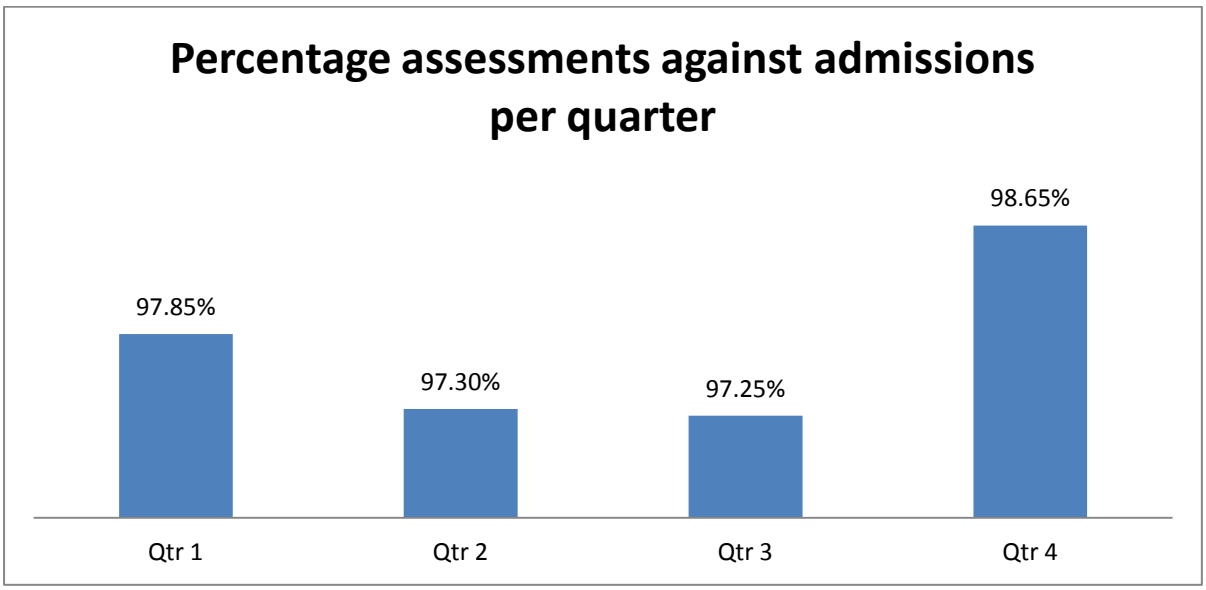
From Unify2 VTE risk assessment return published at:
http://www.england.nhs.uk/statistics/statistical-work-areas/vte/

The graph below indicates the numbers of patients who were appropriately assessed for risk of VTE both in the reporting periods of 2013/2014 and for 2014/2015.



In April 2013 the national minimum requirement for VTE assessment increased from 90-95% compliance monthly. This was initially a significant challenge as the Trust continues to rely on a paper based data collection system at ward level. Including the risk assessment form within the new Trust prescription chart improved completion compliance and made collecting data easier. 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.

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period 2014/2015.



Actions we have taken

- **Requirement: 95% of adult inpatients undergo VTE risk assessment on admission.**

Our percentage of patients risk assessed for VTE has continued to increase. The set target has been consistently exceeded month on month. Adding the risk assessment form to the adult prescription chart has raised the profile of the risk assessment form and the requirement for completion on admission and the data collection systems, which are paper based, have now embedded well as business as usual.

- **Requirement: 90% of patients receive pharmacological thromboprophylaxis in line with Trust guidance**

The percentage of patients receiving pharmacological thromboprophylaxis has consistently far exceeded the required target. There is evidence that all surgeons are now prescribing appropriate prophylaxis and in the majority of cases where deviations due to clinical conditions are required, this is being documented. Further work is taking place around prescribing in Oncology where bleeding v thrombosis risk factors exist. This work is being overseen and supported by the VTE Committee within the Trust.

- **Requirement: 100% of reported hospital acquired VTE's (within 90 days of admission) have a RCA completed**

Root Cause Analysis (RCA's) have been completed on 100% of reported hospital acquired VTE's. Work has been ongoing throughout the year to increase knowledge amongst clinical staff of the requirement to report in a timely manner. Medical staff from Oncology and Spinal Unit have engaged well in the process of carrying out RCA's and this is currently being progressed with the Arthroplasty Directorate. Those deemed avoidable relates in virtually all cases to documentation. Printed prescriptions for pharmacological and mechanical prophylaxis are now

part of adult prescription charts. The need for accurate documentation continues to be enforced through existing training programmes. Learning for individual staff, areas or directorates are part of action plans.

A further piece of work is planned for 2015/2016 to review in further detail our "avoidable" VTE's and evaluate how well lessons are being learnt organisational wide. This is being led by the VTE Committee and is being progressed by specific Directorate Leads. It is planned that the detailed review be shared widely at Surgical/Anaesthetic Audit and at Clinical Governance Committee, a subcommittee of the Trust Board.

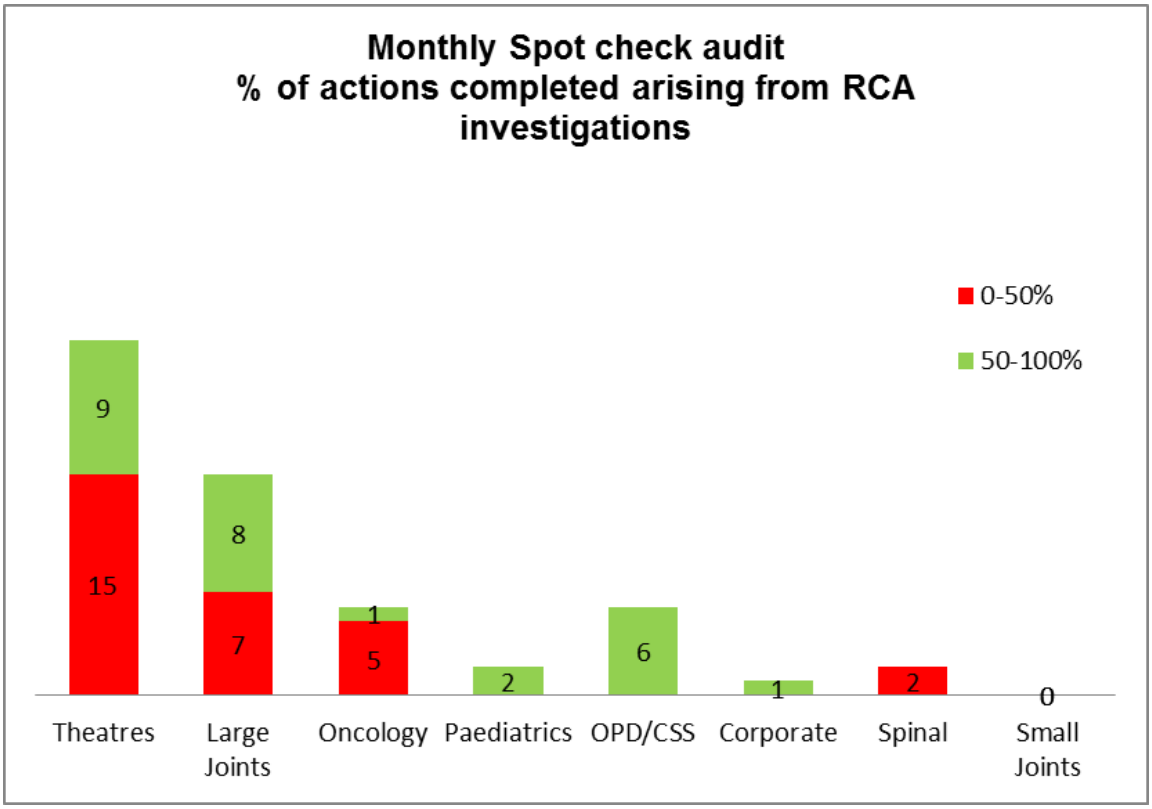
Learning from Serious Incidents

The aim of this quality improvement priority is to ensure that actions arising from serious incident investigations and lessons learned are demonstrated in clinical practice.

Each month a spot-check audit of action plans (arising from Serious Incident investigation reports) is undertaken by the Governance Department. Up to three action plans covering at least two directorates are audited. Where it is identified that actions have not been completed, a re-audit takes place during the next quarter. This is a new initiative designed to support governance overview of serious incident reviews and was not in place during 2013/2014. The figures discussed below therefore are only for the period 2014/2015.

A total of 56 action plans were audited and approximately 50% of these action plans had actions requiring completion at the end of March 2015.

The table below outlines the results of the spot-check audits over the period April 2014 to March 2015.



The data suggests we have further work to do in closing action plans arising from serious incidents. Closure of these actions are important for the Trust to ensure that lessons are learnt thoroughly throughout directorates and throughout the Trust, safeguarding patients safety and promoting an open learning culture.

In addition to this the Governance Department has implemented a new system of working by which all open serious incident action plans are collated and sent back out to directorate and incident leads on a quarterly basis using the ULYSEES System. This new process has been started at the commencement of the new year. It is designed to be supportive to directorates and to provide greater scrutiny and challenge to the vital closure of these incidents.

Currently overview of serious incidents by committees such as Executive Management Team and Clinical Governance Committee is achieved through the Patient Quality report. Moving forwards into the new year this process is to be enhanced further with a separate report being provided to these committees detailing the serious incidents currently under investigation and the leads responsible for completing the investigations.

In 2014/2015, the trust reported 47 Serious Incidents externally. 88% of these were submitted within the required contractual time frames of 45 days. 12% required additional extensions to allow for further investigation. The Trust is committed to completing incident investigation in a timely manner and it is anticipated that greater scrutiny of serious incidents at committee level will ensure that delays to investigations are minimised and opportunities for learning optimised.

Actions we have taken

The following are some of the actions the Trust has been taking throughout 2014/2015;

Throughout the year Governance has been meeting with directorate leads reviewing local governance systems including how risk is managed and escalated and how incidents are shared and learning is embedded. These meetings are not restricted to once only meetings and Governance remain committed to supporting change at local level.

A review of the presentation given to Surgical/Anaesthetic Audit has taken place to best provide the data and learning from serious incidents. Governance has found this a challenging but well engaged forum for discussion and debate of clinical incidents.

There are a number of ways the Trust encourages cross organisational learning from serious incidents and these are as follows;

- As described, presentation at Surgical/Anaesthetic Audit. This forum includes consultants, anaesthetists, and senior nurse leads

- Patient Quality Report – further work is being undertaken on this to improve its effectiveness in the early part of 2015/2016

Learning from incidents has become more focused in varying cross organisation committees including Clinical Directors Meetings, Executive Management Team Meetings and Quality Committee.

Clinical Effectiveness

Compliance with National Joint Registry Standards of Consent and Reporting

The National Joint Registry (NJR) for England, Wales and Northern Ireland collects information on joint replacement surgery and monitors the performance of joint replacement implants. It was set up in 2002 by the Department of Health.

The NJR currently collects data on all hip, knee, ankle, elbow and shoulder joint replacements across the NHS and independent healthcare sector.

A wide range of implants can be used in the joint replacement operations that are carried out across England, Wales and Northern Ireland. The registry helps to monitor the performance of these implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic industry.

In 2008 (1 April), the management of the NJR was transferred from the Department of Health to the Healthcare Quality Improvement Partnership (HQIP), a consortium comprising the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices.

The ROH vision is to be the first choice for orthopaedics, producing world class outcomes for our patients. Our ambition is to be in the top decile for clinical outcomes. With this focused intent, the Trust put forward NJR as a Quality Improvement Priority for 2014/2015.

The following narrative and graphs indicate data for 2013/2014as well as 2014/2015.

NJR Consent Compliance - 2013/2014

For the period January to December 2013 with an end submission date of 28th February 2014: 2237 forms were submitted and include hip, knee, shoulder, ankle, elbow replacements and revisions.

It is to be noted that the Trust was well above the 90% (overall) compliance rate overall during 2013.

The provisional NJR consent progress for January to December 2013 was 88%. NJR consent relates specifically to patients giving consent to their personal data being recorded on the NJR database.

Specific areas to note

- The consent compliance for 2013 was slightly under expected levels but this did not affect the Best Practice Tariff which came into place in 2014/15. To achieve this tariff organisations are expected to have achieved over 75% consent compliance.

- CQC inspection of specialist orthopaedic organisations will have increased scrutiny of NJR and the actions and improvements made as a result of the findings.

End of year summary 2013/2014

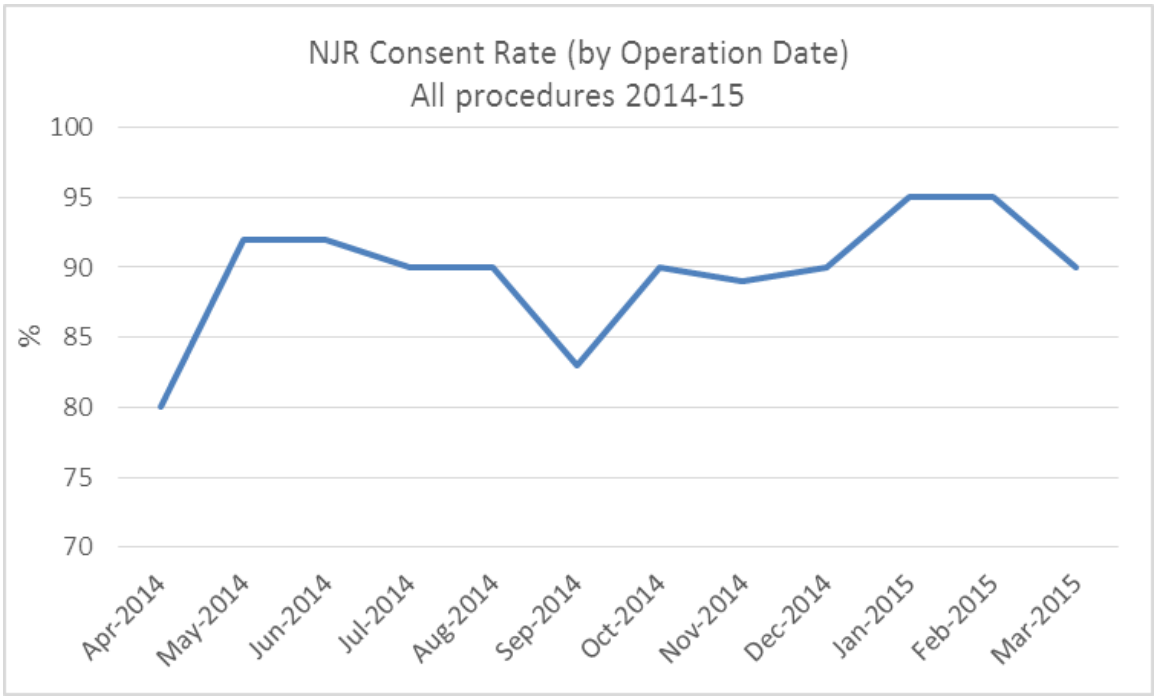
- Compliance with the NJR mandatory national audit was met through significant focus. Continued work to improve internal processes was identified as being required and that robust reporting and escalation of results and concerns are shared in a timely manner.

NJR Consent Compliance April 2014-March 2015

Consent Rate is measured as the percentage of cases submitted to the NJR with patient consent confirmed. This is rated as Red if lower than 80%, Amber between 80-95% and Green if 95% or more.

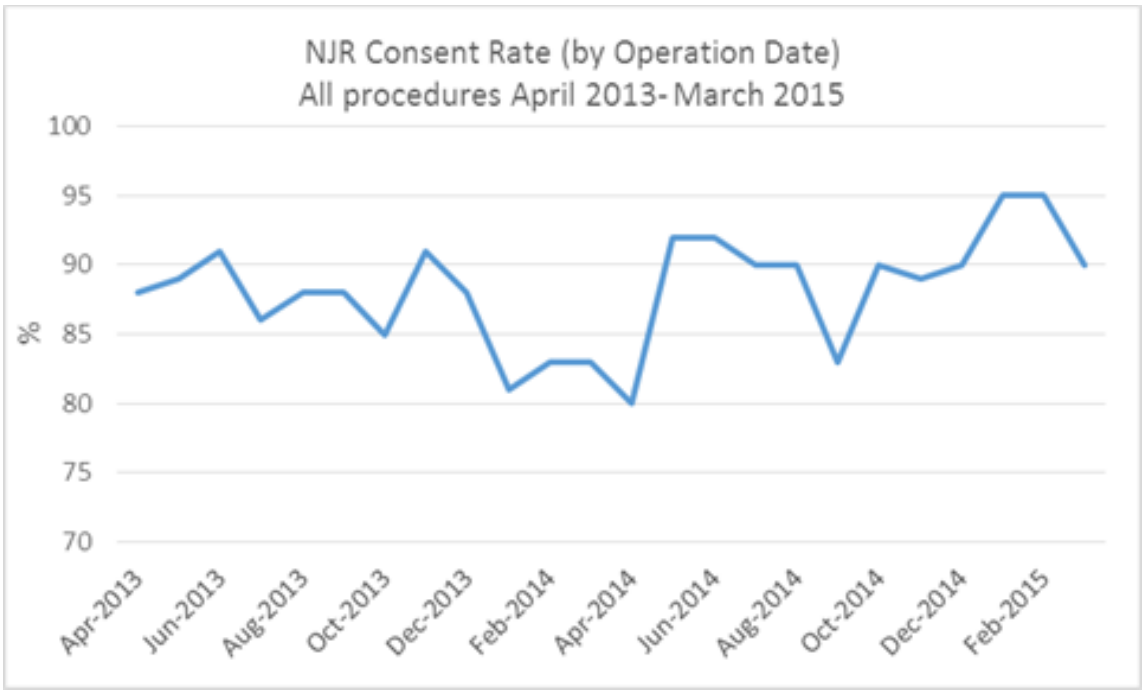
For the period April 2014- March 2015 the trust is rated Amber.

As shown below there has been an overall trend towards improvement throughout the year in recording of consent.



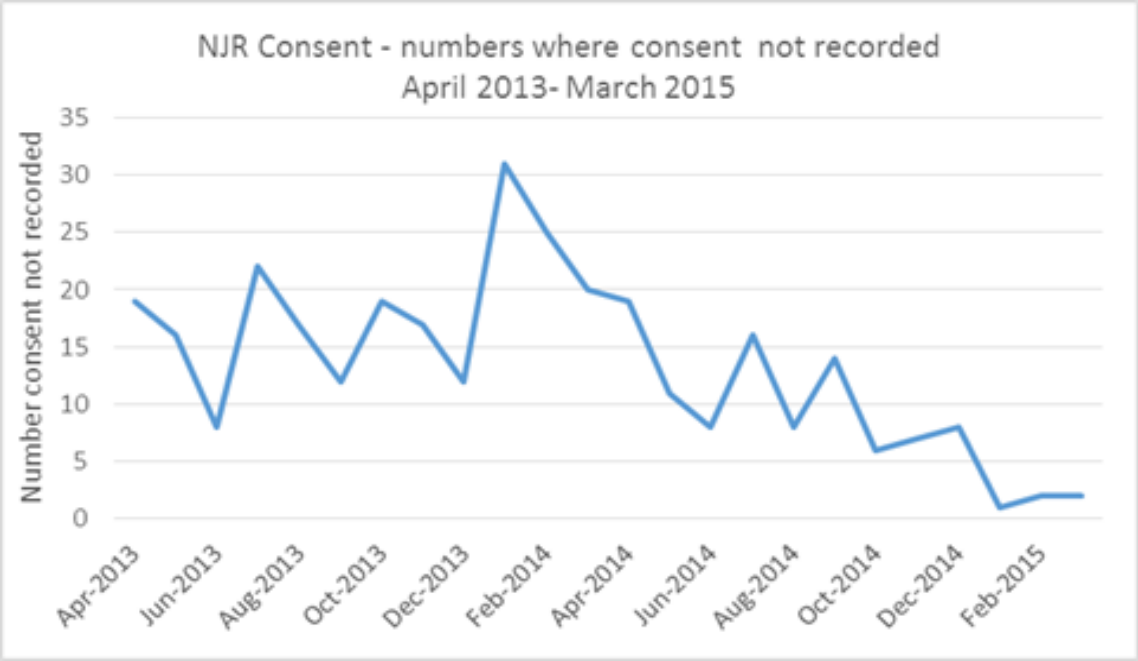
The following graphs indicate the trend of **consent compliance throughout 2013 through to 2015**.

The first graph shows what percentages of procedures have NJR Consent taken in readiness for the surgery taking place. The graph indicates an overall improvement since October 2014.



If a consent form cannot be identified within the notes at peri-operative stage, patients may still be contacted post-operatively to request consent for their details to be logged on the NJR database.

The second graph indicates the percentages of procedures where no NJR Consent was gained. It is pleasing to see the trend has generally continued to fall from February 2014. This would indicate that the Trusts processes for capturing consent are improving compliance.



Actions we have taken

Improvements have been made to the processes involved in recording consent with a view to ensuring a higher consent compliance figure. This includes work within the preoperative assessment environment to support nursing staff in ensuring that informed consent is obtained.

Increased scrutiny of consent processes throughout the year has taken place with monitoring of our successes and areas for development.

Exception reporting has commenced to identify patients who have not consented at their pre-operative assessment to enable any patients missed to be consented on admission.

Compliance progress 2014

For the period January to December 2014 2393 forms were submitted including hip, knee, shoulder, ankle, elbow replacements and revisions. Based on the number of NJR forms submitted, the Trust is above the 90% (overall) compliance rate for 2014. The Trust is also above the target for January-March 2015 period.

Notable achievements of 2014/15

The trust has met the compliance and consent rates required for the best practice tariff for hips & knees. The backlog of forms for data entry has been cleared and the process for consenting patients at POAC has been modified which is showing improvement from previous performance.

The NJR process is being scrutinised by the Knowledge Management Team with a view to ensuring a higher overall compliance and consent compliance figure. Self Service exception reports are being developed by Informatics to identify patients not consented at POAC to enable any patients missed to be consented at admission.

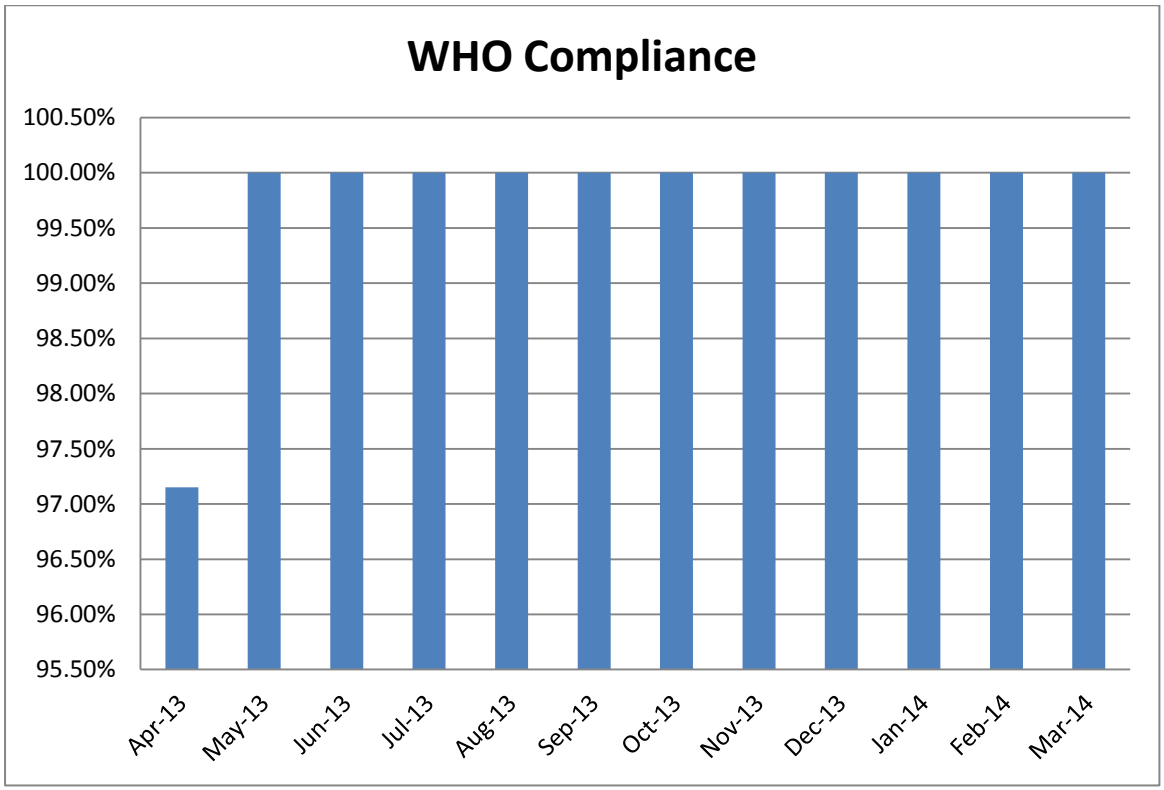
Compliance with the World Health Organisation (WHO) Safety Checklist

The WHO Surgical Safety Checklist was created by an international group of experts gathered by the WHO with the goal of improving the safety of patients undergoing surgical procedures around the globe. Input from anaesthesiologists, nurses, surgeons, patient safety experts, patients, and other professionals were used in the development of this tool.

The aim of this checklist is to reinforce accepted safety practices and foster better communication and teamwork between clinical disciplines. The checklist is intended as a tool for use by clinicians interested in improving the safety of their operations and reducing unnecessary surgical deaths and complications.

The table below indicates the percentage of patients within the Trust who had a WHO Checklist completed in its entirety during their operative procedure both in 2013/2014 and 2014/2015. The data extracted is taken from patients who undergo a surgical procedure and covers the WHO Safety Checklists within the Theatre/Recovery Department only.

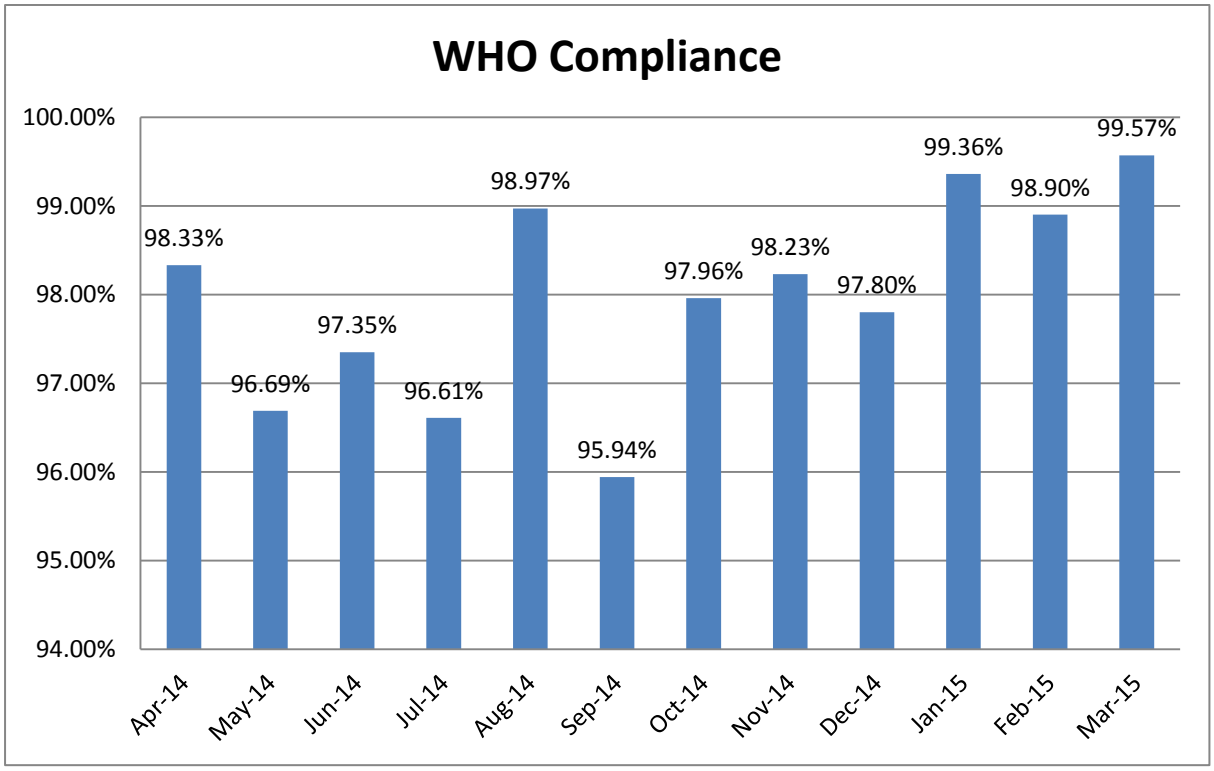
WHO Checklist Compliance 2013/2014



The compliance percentage for this year is noted to be excellent with 100% achievement noted on almost all months. Following a review of this data the Trust adapted its audit methodology in order

to gain greater assurance and clarity on what the compliance statistics were telling us as an organisation.

As a result of the change of methodology and more detailed collation of data the Trust noted a decrease in performance overall. This can be seen in the second graph below. The new methodology was implemented in April 2014.



The Trust has worked closely with our commissioning partners to ensure the safety of our patients and monitoring arrangements are in place with a compliance target of 99% of patients to have had a checklist completed in full agreed in April 2014. New audit processes bought in noted that we have fallen below the safety targets agreed with our Commissioners.

The Trust has been focused and committed to making change happen and ensure the peri-operative safety of our patients. A review of the targets was taken late in the year working in partnership with our Commissioners and new safety targets of 98% were set for November whilst key work undertaken was embedded through to February with 99% agreed for March. It can be seen with the exception of December these safety targets have continued to be met.

Actions we have taken

The Theatre Department, supported by the Executive Team, have taken the following actions to improve their compliance with WHO Safety Checklist;

- Interim Theatre manager presented data and WHO Safety Information to the medical staff at Clinical Audit

- Regular training updates with theatre staff at audit meetings to support staff in the key working principles of the WHO Checklist

- Weekly reports collaborated for both the Trust and external stakeholders for scrutiny and action.

- Route of escalation identified and formalised if persistent non-compliance was observed within theatre teams and/or their leading surgeon

- Nursing Agencies were written to and informed of the expected standards from individual professionals working as temporary staff within the Trust.

- A WHO Safety Working Party has been commenced with a cross section of the multi-disciplinary team active members of the group.

Improved Results for Q39 of the CQC National Patient Survey - Control of Patients' Pain Improved Results for Q23 of the CQC National Patient Survey - Support for Patients Nutritional Intake

The importance of understanding how patients view the services that we provide cannot be underestimated. At the ROH, we use a number of internal and external measures which allow us to identify potential issues and areas of good practice that can be shared.

We monitor and report on external feedback such as Patient Opinion, NHS Choices, National Surveys, Facebook and Twitter. This feedback is compared monthly with internal feedback mechanisms such as Friends and Family scores, a real time Patient Satisfaction survey that mirrors key questions from the National Survey, Patient and Carer Forum, Complaints and PALS.

The Trust strategy identifies its commitment to delivering exceptional patient experience and world class outcomes. A review was therefore undertaken of some of the key themes coming through the patient surveys and to focus on these as Quality Improvement Priorities. Two areas were noted within the CQC National Patient Survey, these being;

- Patients' pain needed to be better controlled

- Patients needed more support with their nutritional intake.

A review of the data collected from patients throughout the year shows improvement or static performance in both of these areas based on last year's performance but that we still have further work to do and actions to take to bring us in line with the national average

EFFECTIVENESS	
To increase results for Q40 of the CQC National Patient Survey, Do you think hospital staff did everything to control your pain?	Target - The 2013 survey results are 8.1, a decrease from 9.0 in 2012. Best national performance is 9.3

	Achievement 2014/2015 -The 2014 survey results are 8.5, an increase from 8.1 in 2013. Best national performance is 9.3
EXPERIENCE	
To increase the results for Q23 CQC National Patient Survey, Did you get enough help from staff to eat your meals?	Target - The 2013 survey results are 7.9, an increase from 7.2 in 2012. Best national performance is 9.4 **Achievement 2014/2015** - The 2014 survey results are 7.9, the same as last year. Best national performance is 9.4

Actions we have taken

- Identification of areas requiring focus by the Patient Experience Team to the Matrons
- Improvement in the quality of monthly updated information given to Matrons on Patient Experience Data
- Improved scrutiny of data at local level including performance meetings
- Improved scrutiny at Committee level – Quality Committee.

Patient Experience

The first Core Indicator for review and discussion in the area of patient experience has been identified above in respect to supporting patients to eat their meals. The survey results indicate that we have remained unchanged from 2013/2014. Nutrition is a key emphasis for 2015/2016 and ensuring patients are properly supported and assisted with foods will form part of the focused work moving ahead.

Sharing the Patient's Journey through the Organisation

This was a new initiative for the Trust and therefore no performance data is available in this area previous to 2014/2015.

In its commitment to delivering exceptional patient experience, the Trust signed up to a local CQUIN Scheme in 2014/2015 with our partner commissioners, which reviews 10 patients' journeys through their hospital stay. This is from their initial assessment at the Pre-Operative Assessment Clinic, through to admission, their theatre journey, and their in-patient stay on the wards.

To ensure the Trust covered its patient population it reviewed at least two journeys from the following patient groups;

- A child
- An adolescent
- An older adult
- A working adult.

Following completion of the journeys, areas for improvement were identified and actions put together to bring about the necessary changes required to improve patient's journeys through the hospital.

The patient journeys are shared at ward level including good and outstanding practice. Lessons learnt and areas of development are also shared to ensure staff engagement in the process of learning and to gain their ideas on how to improve the patient experience.

Wider organisational learning is gained through the patient journeys being shared at the Nurse Leaders Forum where membership consists of all of the senior nursing leads within the Trust. Further organisational learning is achieved through the sharing of patient journeys at Quality Committee. Membership of the Committee includes executive attendance as well as departmental leads/deputy.

In some reviews multiple areas have been identified where change is required to improve the patient experience. In these journeys, cross reference and sharing between departments is ensured to better promote engagement and understanding.

The following were the key findings identified within the patient journeys;

- Excellent care provision was identified throughout the patient journeys. Of note were; generally high standards of documentation, clear and concise risk assessment processes, and patients reporting they would recommend the hospital to family and friends.
- Several areas of review in all of the patient groups drew similar conclusions that involved organisational wide change. Of note these were; fasting times of patients pre-operatively, lack of physiotherapy support over weekends and the requirement for better consent processes.
- Whilst local actions could be implemented to make rapid changes for our patients, the organisational wide issues require further time to fully change processes and ensure they are embedded.
- Ward/department staff have engaged well with the project and effected real changes that have made a real difference to our patients.

The Vulnerable Patient Journey CQUIN has facilitated a number of changes to working processes and documentation, all of which will improve the patients experience and support the delivery of high quality, safe care. Identified below are some of the key processes/documents that have been embedded;

- Implementation of the new paediatric drug charts with additional adjustments made to ensure the documentation of height and weight.

- A new 72 hour call pre-operatively has been implemented within the paediatric directorate to ensure information is disseminated particularly in relation to pre-operative fasting requirements before bringing children into hospital. This is to minimize the length of time children fast before they come into hospital.

- Implementation of the "What's New" board on the paediatric ward to support staff awareness of new documentation requirements, new legislation requirements, and other changes within the organisation – updated by link nurses and senior ward staff. Consideration is being given to rolling this out trust wide as a concept in improving communication across the organisation.

- A patient friendly chart has been designed and implemented to encourage paediatric patients to be self-empowered and document their fluid intake. Consideration is being given to rolling this out trust wide as a concept in improving fluid balance management across the organisation

- A new Consent Information Leaflet has been designed and implemented on "Parental Responsibility", to provide information to patients and their families on this specific area of the consent process

- In line with the above a Consent Flow Chart has been designed and implemented to help inform health care professionals in this specialist field.

- The Vulnerable Patient Journey findings within paediatrics have been implemented into the new integrated care pathway document. This has been designed and is currently pending Trust approval.

- A new LMP Leaflet has been designed and implemented to support and inform decision making when preparing paediatrics for surgery. (Appendix 4)

A key achievement remains the engagement of staff in this project, not only at senior level but across all staff groups and across all areas of the Trust.

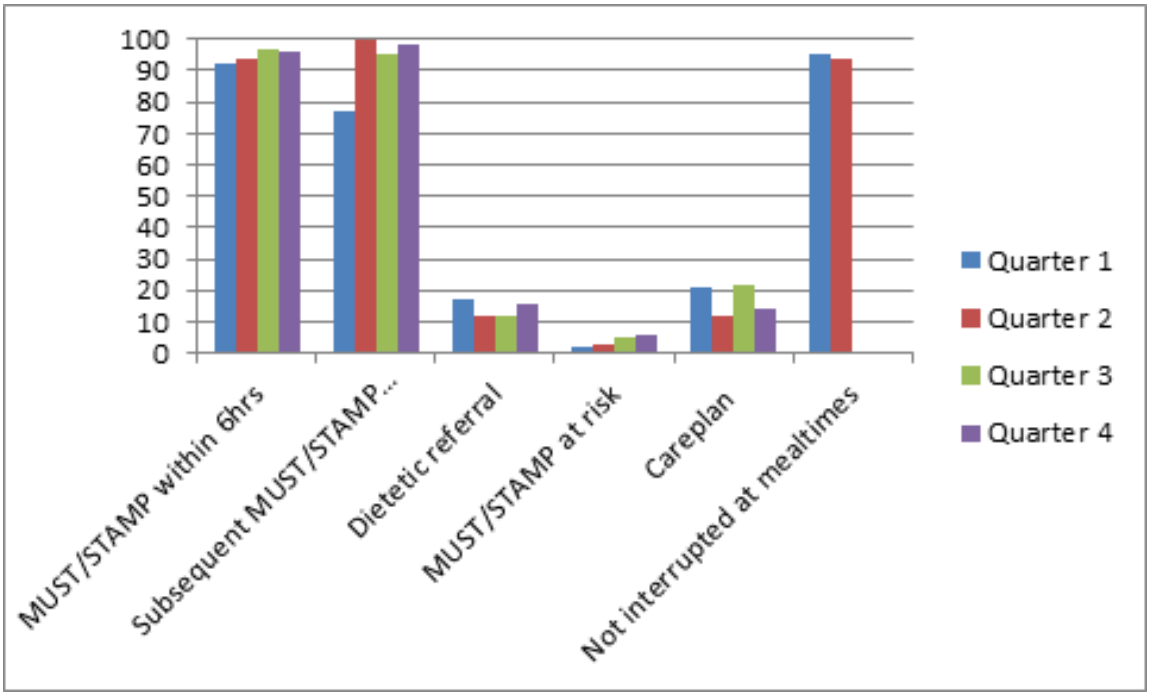
The Trust continues to work on key themes arising from the CQUIN and a sustainability plan has been implemented for use during 2015/2016, alongside a planned themed review by Commissioners to review the changes and progress made over the next 6 to 12 months.

Nutrition – Improving Pre-Operative Fasting Times for Patients

Nutrition is taken very seriously within the Trust, and it is recognised that it is the cornerstone of ensuring the best outcome for our patients. Ensuring the best nutrition for our patients is wide ranging from assessing them for risk of malnutrition and pre-disposition to pressure ulcers/skin damage, to ensuring they are not starved for too long prior to their surgery, to ensuring appropriate support is given to patients to eat healthy, nutritious food.

The graph below demonstrates the overall results for the year 2014/2015. A review of the results over the last three quarters demonstrates averages of 95% of patients were assessed for MUST/STAMP, a nutrition risk assessment tool, within six hours of admission.

The percentage of patients who needed a subsequent assessment rose from 77% in Quarter 1 to an average of 98% in Q2, 3&4. This is evidence of the good practice of staff in appropriately assessing the risks posed to patients following their surgical procedure.



Registered Nurses, Health Care Assistants (HCA's), and Student Nurses attend training on the clinical skills days offered every month. The risk and potential consequences of poor nutrition and hydration are taught on this day including when and how to complete the MUST Tool and the importance of this. To enhance this knowledge further each ward has a nutritional folder and includes competencies which trained nutritional link nurses will facilitate.

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

Fasting Patients Pre-operatively

The importance of minimising harm through appropriate lengths of fasting pre-operatively has been highlighted as a quality improvement priority for this year.

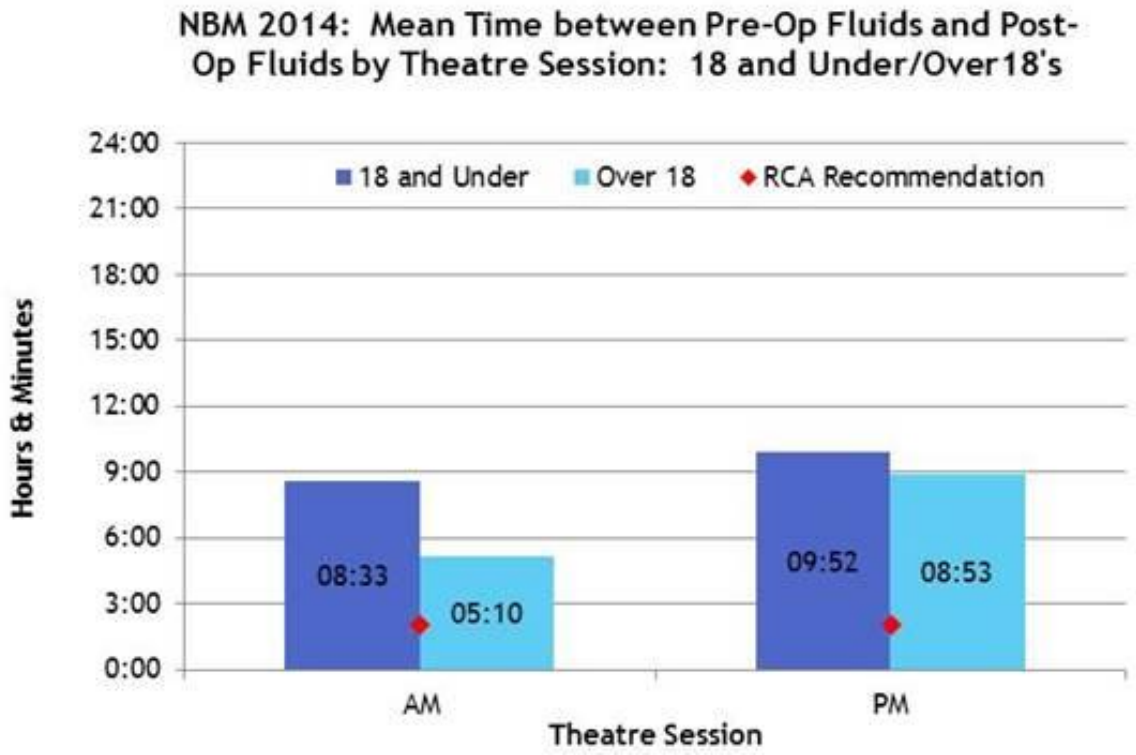
The following data shows the results of a trust wide audit undertaken on pre-operative fasting. These results indicate performance during 2013/2014 and 2014/2015.

Audit Data 2013/2014

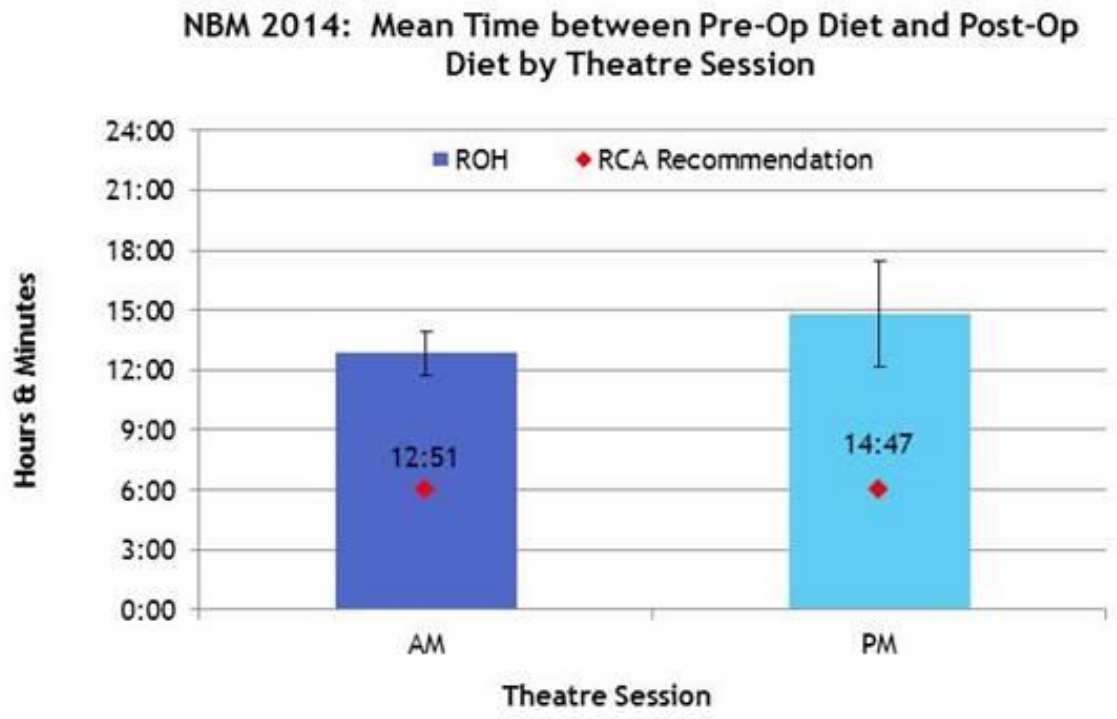
- There were a total of 106 Nil by Mouth (NBM) forms submitted as part of the audit in March 2014.

Mean starvation times are documented as;

- Fluids: 7.17hrs (Unchanged from previous years audit findings)
- Diet: 13.4 hrs. (Unchanged from previous years audit findings)



During the 2013/2014 audit there was a significant difference noted between patients who were fasted for fluids based on whether they were listed for a morning or afternoon theatre session.



Audit findings also indicated that patients who were 18 and under had a longer fasting time for fluids compared to over 18's for both morning and afternoon theatre sessions.

Audit results from 2013/2014 were presented to Surgical/Anaesthetic Audit to demonstrate a breakdown of clinical directorates and also the position of the patient on theatre list.

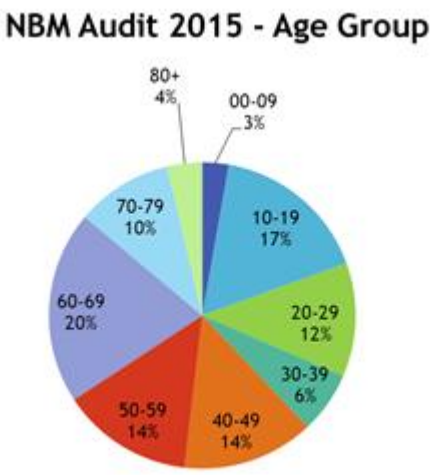
Audit data 2014/2015

Introduction

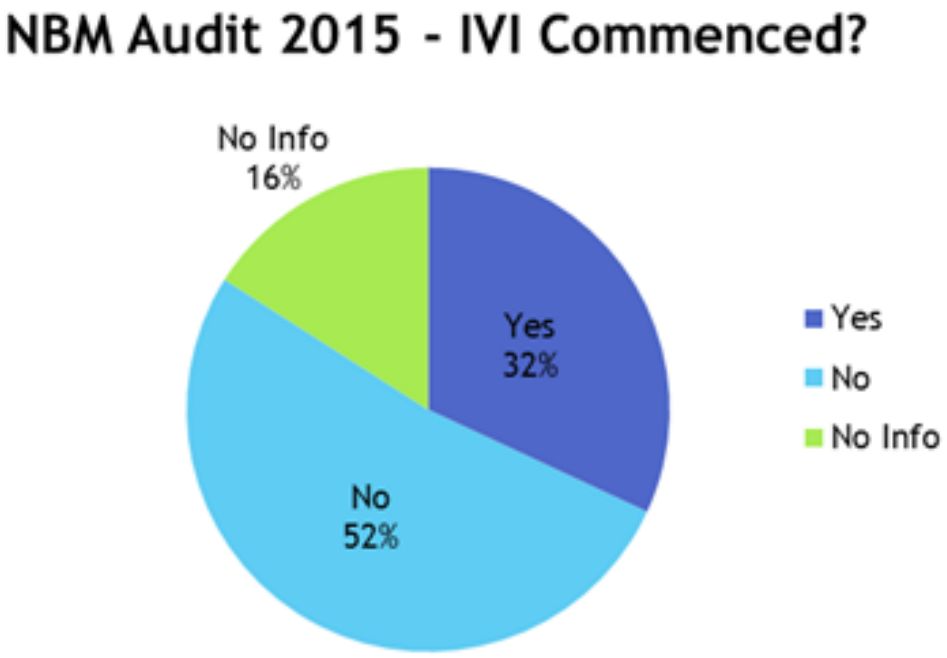
There were a total of 119 Nil by Mouth (NBM) forms submitted as part of this year's audit.

Demographics

The mean age of patients was 45 years, with a median age of 49 years and a range of 5 to 85 years.



10 Year Age Group	No.
00-09	3
10-19	18
20-29	13
30-39	7
40-49	15
50-59	15
60-69	22
70-79	11
80+	4
Total	**108**



In 2015, over a third of patients were commenced on IVI, this is an improvement to 2014 where around a quarter (23%) of all patients were commenced on IVI.

Overall, paediatric patients had a greater mean fasting time for fluids of 11hrs and 7 minutes when compared to patients who were over 18 who had a mean fasting time of 9 hours and 29 minutes.

Discussion and recommendations

The Royal College of Anesthetists and AAGBI safety guidelines Jan 2010 recommend:

- fasting 2 hours clear fluids
- 6hrs for solid food

Patient's satisfaction:

- Prolonged fasting can lead to complaint of
- Headaches
- Nausea
- Generally feeling unwell
- Verbal complaints

The results of completing yearly audit since 2010 resulted in initial improvements but this has not improved for fluid fasting in the last 12months but there has been some limited improvement seen for patients who are fasted, although the length of time patients are waiting is well over twice the recommended time period for fasting.

	Dec'10	**Feb'11**	**Feb'12**	**Feb'13**	**Mar 14**	**Feb 15**
Fluid Mean	10.3hrs	8.43hrs	7.3hrs	7.17hrs	7.17	7.12hrs
Diet Mean	13.4hrs	13.4hrs	13.9hrs	13.53hrs	13.36	12.07hrs

Therefore, an improvement in fasting times would result in:

- Increased patients' satisfaction
- Reduced post-operative complications
- Reduced infection risk
- Improved wound healing
- Reduced pressure ulcer risk
- Reduced length of stay

As clinical evidence in the enhanced recovery programmes have demonstrated Enhanced Recovery Partnership Programme DoH March 2010

Further Actions

It is important as an organisation we improve further on pre-operative fasting times, therefore, actions to be taken forward include:

- Continue to provide education to patients, relatives and all staff regarding recommended fasting times.
- Minimise the changes to theatre lists to help to facilitate these recommended fasting times.
- Review advice given regarding fluid fasting - currently this is two hours from admission for staggered admissions; consider changing this to one hour. As the process of admission and preparation takes over an hour.
- Consider including the fast and fluid times on the theatre list so all staff are aware.
- ADCU to use the communication board to include actual fast time for anesthetists, for the ward based patients this can be included on bed signage already in place.
- To review the admission process to ADCU and anaesthetic review to help with the prescription of fluids.
- Upon the WHO check list completion for each patient, the theatre staff and anaesthetist could then establish the fluid and fast times at this stage and changes are to be communicated to wards.
- In the absence of disorders of gastric emptying or diabetes, preoperative administration of carbohydrate rich beverages 2-3 hours before induction of anaesthesia may improve patient well-being and facilitate recovery from surgery. It should be considered in the routine preoperative preparation for elective surgery.
- This is the recommendation of British Consensus Guidelines on Intravenous Fluid Therapy for Adult Surgical Patients GIFTASUP:
- “Carbohydrate rich drinks given preoperatively may help improve patient outcomes. As surgical stress in the presence of fasting worsens the metabolic state, this causes insulin resistance and may delay recovery. A systematic review was undertaken to analyse the effect of preoperative carbohydrate loading on insulin resistance, gastric emptying, gastric acidity, patient wellbeing, immunity and nutrition following surgery. The findings indicated administration of oral carbohydrate drinks before surgery is probably safe and may have a positive influence on a wide range of perioperative markers of clinical outcome.”
- Further studies are required to determine its cost effectiveness, Bilku DK, Dennison AR, Hall TC, Metcalfe MS, Garcea G. Role of preoperative carbohydrate loading: a systematic review, 2014 <http://www.ncbi.nlm.nih.gov/pubmed/24417824>

Actions we have taken so far

The Trust has taken the following actions to improve the nutritional care we provide our patients including the length of time patients are fasted prior to surgery;

- Mandatory training sessions have been implemented once a month for both clinical and non-clinical staff to also cover fasting guidance and recent audit results.
- Patients who are identified at Pre-operative Assessment as being nutritionally "at risk" have a Ward Referral form completed; this is incorporated in the patient's notes for admission and uploaded on PAS.
- A new Corporate Lead for Nutrition has been implemented within the Nursing Team.
- Work has commenced on implementing a hydration assessment for patients commencing in ADCU ensuring patients can remain well hydrated prior to their surgery.
- A nutritional strategy ensuring adherence to best practice guidelines is being written with a roll out plan for 2015/2016.
- Risks pertaining to nutrition and pre-operative fasting have been escalated through the risk management structure and are now under the scrutiny of the Trust Board.

3.2 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. Specifically, these indicate the performance against the relevant indicators and performance thresholds as set out in Appendix A of the Risk Assessment Framework.

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 2014/15 this has remained a challenge as with last year in spinal deformity surgery. 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.

During the year, and in conjunction with colleagues in the Specialist Commissioning Group, we offered patients the choice of being treated at another centre, this being the Cromwell Hospital, that offers facilities able to manage this type of complex surgery.

The table below shows our track record against these targets.

National target	08/9	09/10	10/11	11/12	12/13	13/14	14/15	Target
MRSA	Achieved 2 cases	Achieved – 0 cases	Achieved – 0 cases	Achieved – 0 cases	Achieved – 0 cases	Achieved – 0 cases	Achieved 0 cases	0
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 unavoidable	Achieved 0 Avoidable cases	0 Avoidable Cases
31 day subsequent treatment all cancers	NA	Achieved – 100%	Achieved – 100%	Achieved – 99%	Achieved- 100%	Achieved 100%	Achieved Q1 100% Q2 97.8% Q3 100% Q4 100%	94% standard
31 diagnosis to treatment all cancers	Achieved- 100%	Achieved – 100%	Achieved – 99.3%	Achieved – 100%	Achieved – 100%	Achieved 100%	Achieved 100%	96% standard
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%	Q1 90.48% Q2 90% Q3 85.71% Q4 87.50%	85% standard

2 week cancer wait	Achieved- 100%	Achieved – 99%	Achieved – 99.5%	Achieved – 99%	Achieved – 100%	100%	Achieved Q1 100% Q2 100% Q3 99.09% Q4 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%	Achieved 91.46%	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%	Not Achieved 94.81%	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%	Achieved 94.53%	92%
Access to healthcare for people with learning disabilities	NA	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	

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 has been highlighted significant work has been undertaken throughout 2014/2015 reviewing the ways in which data is reported and escalated throughout the Committee Structures, and this work will be continued further in 2015/2016 supporting the workings of the hospital by ensuring ability to access robust data, the abilities to scrutinise this data and finally the ability to escalate issues of concern.

Part 4 – Annex

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

Comment from Healthwatch Birmingham regarding the Royal Orthopaedic Hospital Quality Account 2014/15.

15 May 2015

Dear Garry Marsh,

Thank you for sending us a draft copy of your draft Quality Account Report. We, at Healthwatch Birmingham are absolute in our mission to drive forward quality for services and welcome your move to prioritising quality for the care and treatment to patients through your proposed Quality Account governing document.

We firstly pay reference to the external quality ratings for the trust, carried out by the Commission and Quality Care regulator. The overall rating from the recent CQC inspection denotes that the hospital requires improvement in some of the areas identified below:

1. Medicine safety awareness

2. To improve standards of incident investigation

3. To ensure that patients wait no longer than 60 minutes when deemed clinically well enough for transfer from the recovery unit to wards.

We are disappointed to read that the overall ratings for the hospital, also requires improving. Furthermore, we are concerned about the ratings for Critical Care with Safe being assessed as “inadequate “We fully urge the Trust to take urgent action in this area to drive up standards. We are also disappointed to see that consent rates are at Amber rating as it leaves the Trust vulnerable.

We welcome statements of reassurance on the governance of improvement, ratified by your internal scrutiny committee and board with assurance given under the CQUIN Goals of improvements in the TWO areas listed below:

Action progression seen

- **Outpatient's waits 60 minute duration (as laid out in point 1)** – Reduction has been identified and some improvements have been noted. According to your current information, Patients wait no longer than 60 minutes when deemed clinically well enough to transfer from Recovery unit to wards/HDU/ADCU. The trust now has systems in place to monitor the quality of services in Outpatients departments. Develop a specific Chaperone policy to support patients' privacy and dignity

- **Putting patients first** - Positive feedback has been received from patients around the complaints process and complaints handling. Patients feel supported to complain.

In further addressing your priority areas of improvement and growth for 2014/2015, we note that the trust has already made progress in two of the five priority areas. We note that vast improvement made in Improving VTE prevention. We believe that your risk management plans under your current proposals are central to the process of elimination of risk. Already, the monitoring and performance levels indicate clear reduction levels. Further attention is also given the highlighted areas of improvement displayed below:

- Information transmitted to GP's – There is acknowledgement made in your draft report of GP's not always being informed of findings and recommendations when information is not transmitted via electronic document or is only in one category. Your Quality account report highlights how communication with GPs needs to be improved. Healthwatch Birmingham is currently completing GP Survey for Birmingham, to address positive impact in the similar manner. The Survey has commenced in December 2014, we have spoken to over 200 patients in the last four months paying full regard to patient experience which continues to be a key theme; as for us quality is driven by the need to continuously meet and assess patients' needs.

In response to one of your priority themes around patient experience, your report highlights patient response of 25,960 during 2014/2015. It is refreshing to see that you have clear improvement priorities capturing patient experience. Although your report highlights complaint levels are still high in Outpatient emergency departments, there is information to support levels of decline in Inpatient complaints. As the leading consumer champion focusing on patient experience, we agree that priority two should remain as a key priority for the trust. This necessitates a robust approach in identifying clear strategies for improving patients' experience.

We have reviewed our own internal dataset against your priority area two and wish to confirm that we have received:

- Two reviews on your service from our internal feedback centre. Both reviews were positive overall.

- One review criticised appointments being cancelled which was a running theme throughout the quality account

- Feedback on staff was excellent and patients felt listened to and treated with dignity
- Waiting times scored average(3 &4 stars) is an issue at the hospital
- Staff attitudes, cleanliness and quality care of care rated 5 stars

Healthwatch Birmingham would like to show its support to the Royal Orthopaedic Hospital and if there is any work that we can do to help improve patient experience and drive up standards, we would be keen to be involved. Our current internal functions consist of Enter & View activities, which are designed to support the representation of patient satisfaction, working to build a stronger governance of patient feedback.

We are also pleased to see that your trust remains as one of the highest performing hospitals under the Friends and Family Test. The Friends and Family test scores are above 40% and are above the national average. We believe the work done in this area is commendable. We are also delighted to read that the Trust has signed up for local CQUIN targets and will work to deliver these priorities in accordance with the Quin framework and we believe that this will help drive up standards within the Trust. We also praise the staff for its work with Children and Young People and achieving an “outstanding” rating in this area.

We note from your recent CQC inspection and internal audits that there are some serious breaches arising from some of the findings. We are reassured to know that your provision of service is currently being assessed by the existing internal and external process of audit. We fully respect the fact that some of the audits are still in the process of being finalised with action plans under each priority area. We would like to be updated of the progress of this and we await further details on these improvements being finalised, with the relevant actions being taken to address any shortfall.

Thank you for giving us the opportunity to review the Trust’s Quality Account.

Yours sincerely,

Candy

Candy Perry

Interim Director, Healthwatch Birmingham.

4.2 Statement of Birmingham Cross City Clinical Commissioning Group

Royal Orthopaedic Hospital NHS Foundation Trust, Quality Account 2014/15

Statement of assurance from Birmingham CrossCity CCG May 2015

Birmingham CrossCity CCG, as co-ordinating commissioner for the Royal Orthopaedic Hospital NHS Foundation Trust (ROH), welcomes the opportunity to provide a statement for the Trust's Quality Account for 2014/15. Birmingham CrossCity CCG (BCC CCG) remains committed to ensuring that the services it commissions provide the very highest of standards in respect to clinical quality, patient safety and patient experience.

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 and commented on by Birmingham CrossCity CCG Patient Council.

It has been a challenging year for the Trust with regards to clinical governance and changes to the senior leadership team in 2014/15. There has been a continued focus with regards to improving quality and safety and we hope this will continue in the forthcoming year. It is pleasing to see the emphasis given to reviewing the strategy, systems and governance processes to ensure that quality is at the heart of the services the Trust provides.

BCC CCG has conducted various assurance visits at ROH to look at the WHO (World Health Organisation) checklist processes prior to surgery, processes within theatres and implementation of the 6C's (compassion, courage, care, competency, compassion and commitment): It is unfortunate that reference to these is not made. The Trust particularly misses the opportunity to reassure the public of the significant improvements made to meet the WHO safer surgical checklist requirements through actions taken in addressing non-compliance and education.

Equally only 3 of the 9 priorities identified by ROH for 2014/15 have been completed and further explanation of actions and time frames for addressing these would provide assurance to both commissioners and public that the previously planned improvements will still be implemented.

As part of Quality Improvements (section 2.2) achievements made against all of 2014/15 CQUINs should be detailed and how these would be addressed in 2015/16 if not achieved.

Safety and effectiveness improvements for 2015/16 are largely focused on improved reporting and enhanced data collection. We would like to see robust, clearly defined actions in place with appropriate timelines for implementation to appreciate how these will be embedded across the organisation in a timely manner.

Data for patient safety incidents/serious incidents for 2014/15 is missing and more on this would have been welcomed with information on how learning is being embedded; particularly as the reporting of Venothromboembolism (VTE) is the top reported serious incident for ROH.

It is pleasing to see that the Trust has made a sustained reduction in its surgical site infection rates and continues to use relevant tools to reduce infection rates further

Patient experience within the Trust is also monitored by the CCG and during the last year the Trust has responded promptly to patient experience to incorporate appropriate actions into service improvements.

Friends and Family scores have continued to increase which clearly shows that patients value the specialist care that they receive at the Trust however examples illustrating patient experience and feedback would have been assuring whilst demonstrating meeting the needs of patients from protected characteristic groups, as defined within the Equality Act. The statement of assurance from the Board would also benefit with examples of how this is translated into patient focused improvement and could be more visible throughout the quality account as a whole. Commissioners are pleased to see patient experience is included within the priorities for 2015/16.

The CQC report in June 2014 identified 5 key legally enforceable areas requiring action, in addition actions outlined in the quality account. It would be helpful for the table to include what actions have been carried out and progress made since June 2014.

Information regarding learning disabilities is missing with the exception of stating it has been achieved in the table referenced on page 169. There is no discrete section regarding safeguarding or evidence concerning feedback from children, young people and vulnerable adults who use the service. There is no mention of how the Trust ensures that 'the voice of the child' is heard, or mention of specific local or national safeguarding priorities. Reference to how the Mental Capacity Act and the Deprivation of Liberty Safeguards are being implemented effectively, should be included.

The Quality Account does not make any direct reference to key national reports such as Winterbourne View, Francis recommendations and the more recent Savile Report.

The section of the Quality Account regarding participation in clinical audit includes high number of abbreviations within this section e.g. NJR (National Joint Registry) and PROMS (Patient Reported Outcome Measures) which are not explained in the appropriate section. A glossary would be helpful including a simple explanation of what an unavoidable C.Difficile case is for the public. The local audit section of the report is also a little confusing in terms of grammar.

There is missing data for 2 week cancer waits for 2014/15. An inclusion of why referral to treatment time (RTT) was not met, (due to national prioritisation of the backlog) would be helpful to enable public understanding of failure of this target. The independent auditors report, relates to 2013/14 and not the year of the account 2014/15.

BCC CCG was pleased to see that the Trust did achieve compliance to safer staffing however this was not mentioned in the account.

The CCG is committed to working closely during 2015/16 with the Trust's clinicians and managers, monitoring service delivery and performance through monthly Clinical Quality Review Group meetings and addressing any issues with regards to the quality and safety of patient care.

In summary, we consider that overall, this Quality Account contains a 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. We hope that the gaps identified above will be

addressed within the final published document or a response be included that informs the above will be addressed in 2015/16. We look forward to a continued focus on Quality improvement work, in partnership with the Trust during 2015/16.

Barbara King

Accountable Officer

Birmingham CrossCity Clinical Commissioning Group

4.3 Overview and Scrutiny Committee

The Quality Accounts for the Royal Orthopaedic Hospital Foundation Trust have been sent to the Overview and Scrutiny Committee but it has declined to add any further comments to the accounts.

2015/16 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 2014 and Supporting Guidance*
- 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 2014 to March 2015;
- Papers relating to quality reported to the board over the period April 2014 to March 2015;
- Feedback from the commissioners, dated 13th May 2015;
- Feedback from local Healthwatch organisations, dated 15th May 2014
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated June 2014;
- the latest national patient survey, dated 14th April 2014;
- the latest national staff survey, dated 12th February 2015;
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated 21st April 2015;
- Care Quality Commission Intelligent Monitoring Report, dated December 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

Chair

Date: 26th May 2015

Chief Executive

Date: 26th May 2015

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 Garry Marsh, Director of Nursing and Governance either by email, in writing or by telephone using the details provided below.

Email: Garry.marsh@nhs.net
Telephone: 0121 685 4233
The Royal Orthopaedic Hospital NHS Foundation Trust,
Bristol Road South,
Birmingham B31 2AP

2014/15 limited assurance report on the content of the quality report and mandated performance indicators

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 2015 (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 2015, 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 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 18 week referral to treatment – incomplete pathway; and
- 62 day standard for cancer treatment

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 2014 to March 2015;
    - papers relating to quality reported to the board over the period April 2014 to March 2015;
    - feedback from Commissioners, dated 13/05/2015;
    - feedback from local Healthwatch organisations, dated 15/05/2015;
    - 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 14/04/2014;

  - the latest national staff survey, dated 12/02/2015;
  - Care Quality Commission Intelligent Monitoring Report dated December 2014;
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 21/04/2015; 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 in 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; and
- 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 testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

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 2015:

- 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 2014/15; 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 2015

G. Staff survey report

1.0 Commentary

The Trust participates in the NHS Staff Survey annually, and in the quarterly Staff Friends and Family Test, which gathers staffs views on the extent to which they would recommend the Trust as a place to work and as a place to be treated. Feedback from these sources is shared via the Workforce and Organisational Development Committee.

Results are published internally via the Intranet.

In the last year the Trust created a number of informal opportunities to gather feedback from black and minority ethnic staff, to gain additional insight to the results from the 2013 Staff Survey which was published in the Spring of 2014 and which indicated the need for further interaction and enquiry.

Additionally, the Trust holds a quarterly 'Managers Forum' which is a semi-formal communications and engagement meeting to facilitate a two-way dialogue with managers at all levels to support their development and understanding.

2.0 Summary of Performance – see appendix

The 2014 Staff Survey provided positive messages from our staff and some areas for improvement.

Over the past year we have seen positive movement in some staff welfare indicators (KFs 11 and 20) and we are pleased that concentrated effort on providing mandatory training including both health & safety and equality & diversity (KFs10 & 26) has been noted.

We are very concerned that a comparatively low number of staff responding to the survey felt secure to raise concerns about unsafe clinical practice (KF15).

A more detailed trend analysis has shown a persistent weakness in the other key findings which appear in the bottom five ranked scores, including those relating to 'job-related training' (KF6) and 'recommendation of the Trust as a place to work or be treated'(KF24)

3.0 Action plans

To address these concerning findings, the Trust has planned a large scale engagement strategy which commenced in April 2015 with a series of 25 'New Beginnings; Moving Forward' events.

These will be opportunities for leaders to listen to staff in groups of 20-40 and answer their questions about any matters relating to the Trust.

Each member of Trust staff will be invited to attend a 'New Beginnings; Moving Forward' event, each of which will be attended by at least two Executives and other senior managers.

We will be sharing the results of the 2014 Staff Survey and our longer term trend analysis, to develop understanding of the persistent sources of dissatisfaction, and asking for help from colleagues to make ROH a better place to work, by further developing our values and behaviour framework.

The outputs from all of the 'New Beginnings' sessions will be collated to form an overall feedback report to be shared across the Trust, and will inform a six-month action plan to address both Trust and staff priorities for change.

All of the activities and action plans relating to the 'New Beginnings; Moving Forward' events will be monitored and reported to Trust Board quarterly via the Workforce and Organisational Development Committee.

4.0 Future priorities

In line with our vision 'to be the number one choice for orthopaedic care', we will continue to benchmark our Staff Survey scores against other providers of orthopaedic services.

We aim to improve our engagement with staff by consistently improving two-way communication, listening to what our staff and patients are telling us and adopting the highest clinical standards for patient safety and care.

We will use the Staff Friends and Family Test to track trends within the year and respond tactically to any 'hotspots' of heightened concern.

5.0 Appendix to Staff survey report - Extract from 2014 Staff Survey

	2013 Trust score	2014 Trust score	2014 Nat'l Average	Notes
Response rate	53	52	51	National average is median score

Top five ranking scores				
KF8 % staff having well-structured appraisals in the last 12 months	46	49	42	
KF11 % staff suffering work-related stress in last 12 months	31	28	35	Low scores better
KF10 % staff receiving Health & Safety training in last 12 months	84	86	78	
KF26 % staff receiving equality & diversity training in last 12 months	71	74	68	2012 was 61%, positive trend
KF20% staff feeling pressure in last 3 months to attend work when feeling unwell	29	21	23	Low scores better

Bottom five ranking scores				
KF6 % staff receiving job-relevant training, learning or development in last 12 months	80	76	81	
KF15 % staff agreeing they would feel secure raising concerns about unsafe clinical practice	n/a	62	70	No direct comparison to 2013 available
KF25 Staff motivation at work	3.82	3.82	3.9	
KF24 Staff recommendation of the Trust as place to work or receive treatment	3.86	3.89	4.14	
KF27 % staff believing the Trust provides equal opportunities for career progression or promotion	86	86	90	

H. Regulatory ratings report – template commentary and table of analysis

1.0 Commentary

The Trust governance rating was green for each quarter against an overall plan rating of green (the quarter four rating is predicted).

The Trust breached the referral to treatment (RTT) standard in Q3 in line with the national initiative to reduce long waits as reported in the Q3 report. This was agreed and funded nationally with a contract variation in place and agreement to not levy the usual contractual fines for breaches. The Trust returned to compliance in December. This position was agreed with Monitor and Commissioners.

The Trust has experienced several patient treatments time breaches of the 52 week RTT target during quarter four. All of the patients breaching the standard are children requiring complex spinal deformity surgery. Whilst the surgery is undertaken by specialist consultants from ROH, the patients receive their operation at the Birmingham Children's Hospital NHS Foundation Trust. On average ROH operates on just one of these patients a week. Over the Christmas and New year period 11 weeks of operating was cancelled due to national bed pressures for Paediatrics Intensive Care beds. This has resulted in a backlog of patients now breaching 52 week RTT. NHS England have been working to support ROH with expanding the service and have taken the view not to issue contract penalties as the situation was unavoidable.

The Continuity of Service ratings were four for each quarter, in line with plan and were derived from Capital Servicing Capacity and Liquidity Ratio ratings as shown in the following table (the quarter four rating is predicted).

Quarter	Capital Servicing Capacity	Liquidity Ratio	Overall Continuity of service rating
1	3	4	4
2	4	4	4
3	4	4	4
4	3 (Predicted)	4(Predicted)	4 (Predicted)

There was a CQC inspection in Quarter 1 and in Quarter 2 this was followed by a Quality Summit. In Quarter 3 CQC published their formal report; the Trust accepted the overall rating and created an action plan to address the issues identified.

The Board approved the circulation of the action plan in October, with approval by the CEO and Chairman, and a monthly update was given to the Board from December onwards.

To date progress has been made against all actions, for example:

- Additional signage around the Hospital site and the welcome desk staffed in routine hospital hours,
- HDU and ward staff awareness sessions relating to medicine management,
- Trial of appropriate medical records storage solutions in OPD,
- Commencement of Outpatient Matron and Outpatient Improvement Manager,
- Chaperone policy drafted, improved signage highlighting to visitors the offer of a chaperone and greater OPD staff awareness,
- Daily bed management processes have been designed and implemented and the use of 'expected date of discharge' across the wards has improved.

There has been a review of medicines management in the Trust which has identified a number of areas for improvement which are being addressed. Board members have been kept up to date through briefings and key contacts at CQC and Monitor have been informed. Monitor have confirmed that an exception report was not required in respect of these activities.

2.0 Table of analysis

2014/15	**Annual Plan**	**Q1**	**Q2**	**Q3**	**Q4**
Continuity of service rating	4	4	4	4	4 (Predicted)
Governance rating	**Green**	**Green**	**Green**	**Green**	**Green (Predicted)**

2013/14	**Annual Plan**	**Q1**	**Q2**	**Q3**	**Q4**
Under the Compliance Framework					
Financial risk rating	4	4	4		

Governance risk rating	**Amber-Green**	**Green**	**Green**		
Under the Risk assessment framework					
Continuity of service rating				4	4
Governance rating				**Green**	**Green**

I. Income disclosures required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) 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. The Trust has met this requirement as explained in Note 3 to the accounts.

Any profits generated from other income are retained by the Trust and reinvested into patient care. The provision of goods and services for the purposes of the health service in England is always treated as a priority, and these services are not adversely affected by any other income generation schemes.

J. Other disclosures in the public interest

1.0 actions taken by the NHS foundation trust to maintain or develop the provision of information to, and consultation with, employees;

This is described in the Director's report

2.0 the NHS foundation trust's policies in relation to disabled employees and equal opportunities;

This is described in the Director's report

3.0 information on health and safety performance and occupational health;

3.1 Occupational Health

The Trust outsources provision of Occupational Health Services to Heart of England NHS Foundation Trust. The services provided include pre-employment screening, vaccinations, management advice and the facility for staff to self-refer. In addition the Trust contracts 'People First' for provision of psychological services.

3.2 Health and Safety

The Trust has an established Health and Safety Group which meets on a bi-monthly basis to discuss all aspects of health and safety (H&S). In the reporting period 2014/15 the H&S group continues to monitor incidents across a number of defined categories, the incident numbers remain low however verbal abuse and sharps/injuries are monitored more closely due to these being the highest incidents in the reporting period. There was one reported RIDDOR within the reporting period, this related to a member of staff being injured while supporting a patient.

The Central Alerting System remains up-to-date; all alerts are documented and assessed for their relevance, action plans are developed as appropriate.

Radionuclide disposal figures are monitored at the H&S group meetings, the Trust remains well below its monthly disposal amount of 1000 megabecquerels.

The Trust has provided a number of training events for its staff to become competent in First Aid. The Trust now has over 20 first aiders who have successfully completed the course. First Aiders come from a range of backgrounds including medical, nursing and non-clinical.

4.0 Information on policies and procedures with respect to countering fraud and corruption;

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. Proactive and Retrospective audit reviews are also commissioned to provide assurance in key areas. 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.

5.0 Policy adopted on payment of suppliers

The Trust paid 87.3% of invoices within 30 days against the target of 95%. The Trust did not incur any late payment penalties during 2014/15 under the Late Payment of Commercial Debts (Interest) Act 1998.

6.0 Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year;

The Trust has actively contributed responses to a range of consultations from NHS England, Monitor, the Care Quality Commission and the Health and Social Care Information Centre. In many cases the Trust makes comment to NHS Providers (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 not undertaken any formal external consultations on its own services during 2014/15; there were none during 2013/2014 and none are planned in 2015/16.

7.0 Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas; and

The ROH continues to make an active commitment to the Birmingham, Sandwell and Solihull local health economy ('unit of planning') and has worked with its partners to manage operational capacity and align strategic plans. This is exemplified by the Compact, a set of values signed up to by all health economy partners in 2012 about the need for, and the principles underlying, whole system strategic change and the stakeholder Strategy Day on 25 April 2014. This involved all patients, public members, MPs, Commissioner, other provides and local authority reps; the ROH strategic plan is aligned to the current version of the local unit of planning strategic plan. There were no specific overview and scrutiny committee activities.

8.0 Any other public and patient involvement activities.

The Patient and Carers Forum provides an opportunity for patients and carers to express their views on services , initiatives and developments within the organisation and it also is used to provide representatives to local stakeholders such as commissioners.

K. 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 him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed

Chief Executive Date: 26th May 2015

L. 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.

2.0 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 2015 and up to the date of approval of the annual report and accounts.

3.0 Capacity to handle risk

3.1 How leadership is given to the risk management process

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 committees to oversee risk management: the Clinical Governance Committee, the Audit Committee, and the Transformation Committee. The Trust Board itself receives and reviews the Board Assurance Framework (BAF) and maintains oversight of a number of strategic corporate risks which are not delegated to any Committee.

The Clinical Governance Committee (CGC) has designated responsibility for clinical risk management and is chaired by a NED of the Trust. The Director of Nursing and Governance is the lead executive for this Committee. The CGC meets around 10 times per year and regularly reviews clinical risks - in particular, Board Assurance Framework clinical risks, the Corporate Risk Register and those risks owned by advisory groups providing assurance to the CGC. Advisory groups reporting to the CGC

also meet regularly and review the risks for which they have oversight, ensuring that appropriate risk evaluation has been carried out.

This process includes the evaluation of mitigation actions that have taken place to understand and assess the outcomes of these actions.

The Audit Committee is chaired by a NED of the Trust, meets at least five times a year and reports directly to the Trust Board. The Director of Finance is the lead executive for the Committee. The Audit Committee ensures the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance. It maintains an oversight of the foundation trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements. It reviews the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

The Transformation Committee is chaired by a NED of the Trust, meets at around ten times a year and reports directly to the Trust Board. The Director of Strategy and Transformation is the lead executive for the Committee. It maintains oversight of the key risks to delivery of the Trust's Strategy and feeds back to the Trust Board where appropriate. It regularly reviews and tracks the progress of key deliverables within the Trust's Strategic Plan – via routine monitoring reports presented by seven Programme Boards. It supports the Programme Boards in understanding the impact of delays and underperformance in individual initiatives on the wider programme to ensure that risks are mitigated, interdependencies are managed and to help identify solutions where appropriate.

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

3.2 How staff are trained or equipped to manage risk in a way appropriate to their authority and duties.

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.

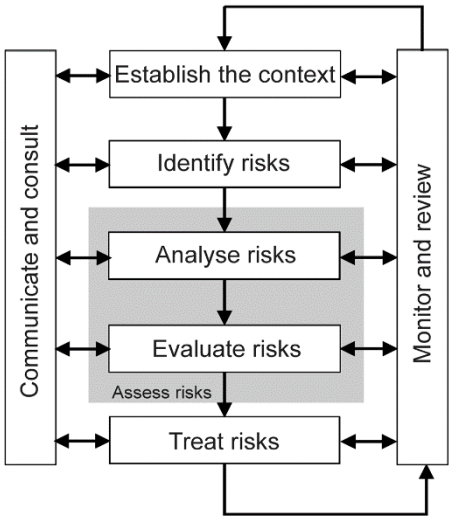
3.3 Ways in which the Trust seeks to learn from good practice.

The Trust seeks to learn from good practice in governance and the management of risk through a number of means including partnering with other organisations, external reviews by experts such as the Good Governance Institute, the King's Fund and KPMG and internal activities such as Trust Business and Learning Day learning events for staff.

4.0 The risk and control framework

4.1 The key elements of the risk management strategy

To ensure a consistent and systematic approach to risk, the Trust has adopted the Australian/New Zealand risk management standard. The prioritisation of risks is identified through the use of a risk assessment matrix which enables the Trust to assess the level of risk based upon the measurement of likelihood and consequence of occurrence.



The risk management processes include:

- Identification of hazards and risks and their communication to all stakeholders
- Risk analysis and control including prevention and reduction of loss
- Developing and maintaining a risk register
- Managing, reporting and recording of near miss and incidents
- Investigation of serious incidents and root cause analysis
- Complaints and claims management
- Education of staff on safety awareness including feedback from incidents, complaints and claims
- Ensuring compliance with law and professional or other relevant standards

4.2 How risk appetites are determined

The Trust recognises that eliminating all risk is not possible and that systems of control must not be so rigid that they stifle innovation, creativity and the imaginative use of resources. In this context the Board of Directors interpret “acceptable” levels of risk as follows:-

An acceptable risk is one which has been accepted after proper evaluation (risk assessment) and is one where effective and appropriate controls have been implemented. The acceptance of a risk should represent an informed decision to accept the likelihood of that risk. It must be:

- Identified and entered on the Risk Register
- Quantified (consequences and likelihood)
- Reviewed and have been deemed acceptable by the relevant committee
- Controlled and kept under review
- As a general principle the Trust will seek to eliminate or control risks which have the potential to:
- Harm patients, staff, volunteers, visitors, contractors and other stakeholders
- Harm the reputation of the organisation
- Have severe financial consequences which would prevent the Trust from carrying out its functions

4.3 The key elements of the quality governance arrangements, including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with CQC registration requirements

The Clinical Governance Committee reviews the quality governance framework (QGF) on a regular basis and uses it to guide its priorities. It has formed one of the key inputs to a Board workshop which covered overall governance and organisational performance and it informs the Corporate Governance Statement prepared by the Board for Monitor. The QGF is also used as an overarching framework to inform the key components of the BAF and system of internal control.

The action plans to improve the governance of quality are summarised in the Director’s Report.

The Five Year Strategic Plan was underpinned by quality of care considerations, and progress against the Strategic Plan is overseen by the Transformation Committee and the Board itself.

The Trust, in partnership with staff and key stakeholders has reviewed its values in the context of a culture driven by quality. The Board has reviewed its own capabilities in relation to the governance of quality and the promotion of a quality driven culture throughout the organization, and has recently appointed a further clinically qualified NED. The Trust has also commissioned support from

the King's Fund to promote medical engagement in clinical leadership. A "New Beginnings" programme for all staff is underway; this will engage staff in the Transformation Programme.

The Board receives assurance on the Quality of Care through the Patient Quality Report, and the BAF, and through the oversight of the Clinical Governance Committee (CGC). The CGC in turn receives more detailed reports from subgroups covering particular aspects of quality, for example drugs and therapeutics. There is a process of escalation of risk related to quality throughout the Trust; further work is being carried out to strengthen its operation. Some Board members carry out walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients and staff and others. The CEO holds regular briefings with Heads of Department for dissemination to teams and feedback from the organisation. This is an area for further development: for example it is planned to introduce the "15 step visits".

Quality information is scrutinised by advisory groups before submission to the CGC and ultimately to the Board. Work is ongoing to develop enhanced approaches to data reporting to enable greater and more informed scrutiny; in addition work is being carried out to develop further the capabilities of groups supporting the CGC in relation to quality information. The governance of clinical outcomes data is being reviewed; the role of clinical audit in providing assurance regarding quality and outcomes data is also being strengthened.

Assurance is obtained routinely on compliance with CQC registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards.

After the last CQC inspection, the Trust produced an action plan which includes strengthened internal controls, systems and responsibilities for quality.

During the year, the Trust became aware of a potential gap in controls in relation to controlled drugs where Trust policy was not being followed and audit results were not appropriately escalated to secure the support required from senior management to address the issue. As a result an external review into the management and administration of controlled drugs was undertaken and the Executive Team implemented the necessary changes to strengthen internal controls and on-going oversight. Individual registered practitioners were provided with specific feedback and all staff were reminded of the legal and professional requirements. Staff were engaged in the process of fine tuning the urgent measures and new Standard Operating Procedures now underpin the overall governance and reporting arrangements with ownership for standards appropriately placed with registered clinicians.

All key stakeholders were kept informed of the issue and steps were taken to address the issue.

The Trust Board has used this as a case study for organisational learning at every level from front line clinicians to Board members. We have taken steps to review Committee terms of reference, reporting requirements and established new expectations with expert groups regarding the flow of information from these to the Board via its committees.

We continue to develop our approaches to governance and are benefitting from appropriate external advice and support. This internal control issue has heightened awareness of the control

environment within the organization and is seen in the context of generally sound systems of control that are being generally applied consistently.

4.4 How risks to data security are being managed and controlled.

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.

4.5 Description of the organisation's major risks, including significant clinical risks, separately identifying in-year and future risks, how they are/will be managed and mitigated and how outcomes are/will be assessed

Risk	**Consequence**	**In Year/ Future**	**how they are/will be managed and mitigated and how outcomes are/will be assessed**
Inability to control the use of unfunded medical temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2	Increasing locum and agency costs and potential successful banding claims.	IY/F	Mitigation/Controls: Director of Operations approves request for locum doctor appointment. Planned assurance: appoint project manager for medical workforce project. Work on recruiting physicians' assistants being progressed by Mr Pearson, Dr Minas and Prof Begg: update to be requested Spring 2015.

Risk	Consequence	In Year/ Future	how they are/will be managed and mitigated and how outcomes are/will be assessed
			Outcome Assessment: Level of costs associated with unfunded medical temporary/agency staffing New workforce model implemented
Risk of non-delivery of strategic objectives due to leadership development needs particularly in the management of change	Care for patients that is less than the best; Lack of organisational sustainability	IY/F	Mitigation/Controls: Feedback from the Kings Fund report and leadership strategy development. Outcome Assessment : Evaluation of outcomes from leadership strategy development action plan.
The Board and organization does not have adequate capacity or capability to change or does not organize its resources to change effectively	Failure to achieve strategic goals; Regulatory action due to failure to address compliance risks; Low engagement of staff; Failure to provide the best possible care for patients; Failure to achieve or sustain cost improvements	IY/F	Mitigation/Controls: Investment in transformation capacity; recruitment of Transformation team and other senior managers to lead change in critical areas is underway; Existing work engaging staff in strategy communication. Work with the Kings Fund on medical leadership; Plans under development to restructure the operational directorates and some corporate services. Learning needs analysis for leadership community; Proposed organizational change in operations and some corporate services Outcome Assessment: Delivery of Transformation Programme initiatives and milestones.

Risk	Consequence	In Year/ Future	how they are/will be managed and mitigated and how outcomes are/will be assessed
Tariff: national tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	The Trust will not be adequately recompensed for its work increasing the risk to the organisations long term financial viability	F	Mitigation/Controls: Working with NHS England to ensure contractual baseline is adequate to deliver required level of care to our specialised patients. As part of the Strategic Orthopaedic Alliance, work with Monitor on the long term plans for the funding of specialist orthopaedic care. Outcome Assessment: Financial outturn for 2015/2016 and longer term financial projections.
Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions	Unable to fund required volume and quality of clinical care; Unable to pay staff / creditors; Reputational impact; Increased regulation; Long term viability at threat	IY/F	Mitigation/Controls:- Formal programme structure for transformation Detailed financial plan agreed and monitored Involvement in national policy direction (e.g. PbR, Specialist services) Check and challenge of financial performance at all levels of the Trust Outcome Assessment: CPR; Quarterly Performance Reviews; Transformation Board Reports; Audit Committee – Review of contract risk; CIP Board reports

4.6 The principal risks to compliance with the NHS foundation trust condition 4 (FT governance)

It should be noted that Monitor Corporate Governance ratings have consistently been at Green level throughout the year. In relation to the above risks and actions identified to mitigate those risks these can be summarised as follows:

Area	Principal risks	Actions identified to mitigate these risks
The effectiveness of governance structures,	Earlier in the year there was an issue of non-compliance with the CQC safety domain "management of medicine" relating to controlled drugs.	These risks have been substantially addressed and an external review in-year confirms that there is no evidence of harm to patients as a result of the risk identified although further work needs to be done to embed the changes made on a long term sustainable basis.
The responsibilities of directors and subcommittees; Reporting lines and accountabilities between the board, its subcommittees and the executive team;	There was a lack of clarity regarding the relationships between Board Committees and management groups.	The TOR of the CGC have been revised and a draft structure diagram for the sub groups reporting to the CGC has been produced and is being reviewed by the CGC. The status of EMT has now been clarified as a group advising the CEO.
	The purpose and levels of authority of each of the groups or committees reporting to CGC were not always clearly specified or well understood and in particular there was a risk that serious concerns might be identified but not escalated appropriately	A template (framework) created for sub-group TOR has been agreed by CGC. This will be used to inform subsequent updating of subgroup TOR. For each group reporting to CGC work will be done with those leading the group to ensure that there must be an item on every group agenda which covers exception reporting from the group to the CGC. Each group will be asked when its terms of reference were last reviewed by CGC; any ones requiring review by CGC to be scheduled for review
Continue to review the quality management system across the Trust and the ways in which the Board can be assured.	There were weaknesses identified in the Trust's quality management system as identified by the quality governance framework (QGF).	A separate QGF action plan has been created

The submission of timely and accurate information to assess risks to compliance with the trust's licence; and	There was no clear clinical audit process across the Trust and no testing of clinical audit processes by the Audit Committee	The Medical Director is leading a piece of work to improve the Trust's clinical audit programme, and the programme leadership has been strengthened by the involvement of a new manager and the temporary appointment of a clinical advisor.
	Policies were out of date.	A Policy Work Plan (which is RAG rated) has been established, aimed at ensuring a timely understanding of when Policies are up for review / renewal. Work continues on rectifying all policies and bringing them up to date.
The degree and rigour of oversight the board has over the trust's performance	The BAF did not accurately reflect key strategic and corporate risks.	BAF now incorporates Strategic and Corporate risks

4.7 How the Trust is able to assure itself of the validity of its Corporate Governance Statement

The role of the Clinical Governance Committee, the Audit Committee, and the Transformation Committee in providing assurance regarding Corporate Governance has already been described. In addition the Board itself considers the Quarterly Corporate Governance Statement during the year and reviews ways in which underpinning assurance required can be strengthened. In Q2 the Board held a Governance workshop which included inputs from an external review of Governance, the Trust 5 year strategy, consideration of the findings from the CQC inspection and an internal self-assessment of quality governance. The outputs of the workshop included revised strategic risks and action plans to address them. In Q3 and Q4 clinical governance concerns arose associated with medicines management; the external review by KPMG to mitigate these concerns has already been described.

Prior to the submission of the annual Corporate Governance Statement to Monitor a Board paper is created with input from the whole of the executive team summarising evidence for the validly of each element of the Corporate Governance Statement.

4.8 How risk management is embedded in the activity of the Trust

The Trust's risk management processes are embedded within all aspects of service planning, delivery and redesign as a means of prioritising and decision making. These key elements, processes and priorities for the management of risk are required to be applied locally to all wards, areas, departments and operational management/ Service units.

The Board Assurance Framework (BAF) 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 BAF draws together the key corporate risks from the Trust-wide Risk Register and strategic risks identified by the Board itself and is considered by the Trust Board, 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 report incorporates eight BAF themes (linked to the Trust's strategic objectives) alongside details of Trust-wide risks which could impact upon the achievement of these themes. Each BAF theme also has a lead executive with responsibility for overseeing the risks assigned to each theme, e.g.

- Standards of care (Lead Executive - Director of Nursing and Governance)
- Monitor Licence conditions (Lead Executive - Company Secretary)
- CQC registration (Lead Executive - Director of Nursing and Governance)
- Business Continuity (Lead Executive - Director of Operations)
- Contract with Commissioners (Lead Executive - Director of Operations)

- Staff engagement Lead (Executive - Director of Workforce and Organisational Development)
- Organisational Leadership (Lead Executive - Director of Workforce and Organisational Development)
- Long term viability (Lead Executive - Director of Finance)

The Lead Executive identified for a specific BAF Theme is responsible for providing assurance to the Board that all risks aligned to their designated theme are being appropriately managed.

As an example of risk management activity below the level of the BAF and potentially feeding into it, reporting of potential risk situations, adverse incidents, 'near-misses', accidents and concerns is a vital part of managing and controlling risks. The Trust has a unified system for the reporting of both clinical and non-clinical incidents. This is an electronic system called 'Ulysses'. This system enables members of staff to report incidents in a timely fashion and allows managers and other relevant individuals to receive real time notification of incidents. This system also allows managers to complete an electronic management review of incidents. All managers are expected to encourage an incident reporting culture and support their staff in utilising the incident reporting system.

Information on all incidents requiring an investigation and any clinical negligence claims is shared with key staff. Once completed 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 provide review and scrutiny of incident investigation reports.

Monthly reports on new serious incidents and actions resulting from on-going incident investigations are provided to the Trust Board, Clinical Governance Committee and Operational management teams via the Patient Quality Report. Once approved the Patient Quality report is also shared with lead commissioner and scrutinised as part of the contract review process.

Directorates receive localised quality and risk reports which are discussed as part of Directorate meetings. Key learning from investigations are also shared and discussed at the Trust's combined surgical and anaesthetic audit meeting.

4.9 How public stakeholders are involved in managing risks which impact on them.

The Trust is committed to involving stakeholders as appropriate in all areas of the Trust's risk management activities. This includes informing and consulting on the management of any significant risks. Key stakeholders include Monitor, CQC, NHS England, Commissioners, Subcontractors, Voluntary Groups, Patient Groups, Patient and Carers Forum, patients and the local community.

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

The Trust has not been placed under any special measures or conditions.

Following the publication of the CQC Inspection report on 17th October 2014, the report specified the compliance actions the Trust must take relating to regulated activities as well as actions which the Trust should take relating to non-regulated activities. The Board approved the circulation of the action plan in October, with approval by the CEO and Chairman.

The table below provides an overview of progress to date against regulated activities.

For actions not yet achieved (eg. those graded as 'Amber'), details of outstanding future actions are outlined.

Compliance action (Regulated activities)	**RAG status**	**Outstanding future actions**
Medicines are managed at all times in line with legal requirements.		None
A chaperone policy is developed and chaperones made available to support patients' privacy and dignity		First draft of Chaperone policy went out for comment until the 31st March. Comments have been received from two senior medical leads and numerous nursing staff. An implementation working group is being established to progress implementation of this policy.
Equipment is properly checked and maintained in accordance with electrical safety requirements		The Head of Estates and Facilities has given assurance to the Director of Nursing and Governance that all clinical areas hold registers of non-medical equipment which require PAT testing. The Director of Nursing has identified a new risk to the organisation which relates to the maintenance of medical equipment. The Trust has a Service Level Agreement with University Hospitals Birmingham which has a rolling maintenance schedule. The schedule shows that between January 2015 and April 2015, 176 pieces of equipment need to be serviced and 109 of these are infusion devices. A detailed risk assessment will be presented to the May meeting of the CGC as part of the CGC risk register update.

Confidential patient information and records are not left unsupervised in unrestricted public areas of the outpatient department		An issue was realised in respect to the locked notes trolleys, whereby a potential risk for staff injury was assessed. This required the trolleys to be sent back to the company for a bespoke safety application. During the episode were the trolleys were returned to the company the older models were placed back into these areas. During this time the notes trolleys were chaperoned to ensure compliance with the CQC regulated activity. 1 of the lockable trolleys has now been returned with the other being returned mid-May.
Appointments are organised for all clinics to reduce waiting times for patients and improve their experience in the outpatient department		ROH has 330 clinic templates. All have received an initial review and also a review of their capacity and utilisation over the last 15 months. Following review, 227 of these templates do not require any amendments whilst the remainder continue to undergo capacity and demand reviews. A recurring theme of delays within diagnostics between outpatients and x-ray has been raised by clinicians and work has commenced to identify and address delays. Capacity within diagnostics is not matching demand in the outpatient department. This has led to delays and pathway work continues. Standard Operating Procedures are being developed to describe how administration procedures should be undertaken, and will include clinic cancellations, overbooking and clinic reinstatements.

4.11 NHS Pension Scheme

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 into 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.

4.12 Equality and Diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

4.13 Emergency Preparedness and Carbon Reduction

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust submitted an updated assessment based on the 2014 NHS Emergency Preparedness, Response and Resilience (EPRR) Core Standards in April 2015. In assessing against the standards, the Trust has identified 37 areas of compliance, 4 areas of partial compliance and 1 area of non-compliance, and based on this assessment the Trust would confirm it is substantially compliant with the 2014 core standards.

The areas of non/partial compliance are as follows:

Area	Non/Partial Compliance	Action
Business Continuity Policy is currently under review	Partial	It is proposed to be complete within six months
Managing VIP's on site, area identified, action card to be developed	Partial	To be completed by October 2015
Knowledge and skills training in Emergency Planning/response to be further developed for key staff	Partial	To be reviewed in six months
Access 24/7 to radiation protection officer to be agreed	Non	To be completed by October 2015
Further training/attendance of multi-agency exercises to be scheduled	Partial	To be reviewed in six months

5.0 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, which have been updated and formally approved by the Trust Board during 2014/15. This process enables regular review of financial performance by highlighting areas of concern via variance analysis.

The Trust is structured into clinical directorates, with five surgical and two 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. Performance against the Trust's Cost Improvement Programme, both in terms of financial delivery and quality impact, is monitored on a monthly basis by the Cost Improvement Programme Board. 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. 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 oversee, by appropriate monitoring of actions taken by responsible officers any required corrective action. The Director's report provides further information regarding the Committee structure, attendance records and coverage of each of the Committees' work.

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 four awarded by Monitor, the independent regulator, represents a strong and robust financial performance in 2014/15. This is the highest rating that can be achieved. Despite this, the Trust was not immune to the financial challenges being faced by the NHS and the impact of high savings targets and recruitment difficulties combined to impact on our overall financial position during 2014/15. The Trust posted a deficit of £432,000 before impairments and the consolidation of charitable funds accounts, and is planning for a deficit position in 2015/16. The strength of the Trust's current cash position ensures that a sensible and measured approach can be taken to bring the Trust back into financial balance, with the current investment in transformation alongside plans in place to reduce the reliance on temporary staffing providing a platform to deliver the increase in savings and efficiencies required.

The governance rating of Green awarded by the independent regulator represents full achievement of all Monitor governance indicators in 2014/15 with the exception of a planned and approved underperformance against the 18 Week RTT target for admitted and non-admitted patients in October and November 2014. This was part of an agreed national amnesty to support the reduction of backlog waiting lists. The Trust ensured that performance returned to above target levels after the end of the amnesty period in December 2014.

6.0 Information Governance

During the year the Trust had fifteen serious incidents relating to Information Governance. None of these incidents were reportable to the Information Commissioner as a Level 2 incident. The majority of serious incidents related to information that was disclosed to individuals in error, such as a patient receiving another patient's appointment letter as well as their own. The Trust's Information Governance Manager investigates all serious incidents, and learning from these is shared at the IG Group and with the individual stakeholders involved. The Trust's Information Governance Manager has also recently increased the frequency of unplanned audits and walkarounds to raise awareness of IG issues.

7.0 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 the Development and Approval of Policies", which ensures consistency of approach when developing, monitoring and auditing policies and which was reviewed and amended during the year. During the year a significant number of out of date policies were identified (both clinical and non-clinical) and a programme of work is in place to rectify this.

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.

Professional leads provide some of the data for the quality report; these are experts in their quality fields. This is done in conjunction with the informatics team.

An activity review group meets on a weekly basis. At that group a prospective view is taken of patient volume and waiting time pressures; they also take a prospective look to ensure the national standards are being met. Issues of concern regarding data validation are received at this group along with related activity performance data. The Trust's internal auditors have undertaken two audits relating to waiting time data and associated documentation. These audits have indicated that the Trust is fully compliant with all national monitoring standards; this was subsequently reported to the Audit Committee.

8.0 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 and clinical governance committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I can place reliance on the Head of Internal Audit Opinion for 2014/15, which states that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The opinion also notes the continuing development of the reporting around the Board Assurance Framework. The framework has evolved significantly over the last 12 months, with improvements being made in the way in which our key risks are highlighted and in the way in which actions and mitigations are reviewed. Greater focus has also been given to the Trust's strategic risks, and these are now included within the overall framework.

The effectiveness of our systems has also been considered during 2014/15 through a range of external reviews including a formal CQC visit and internally commissioned reviews relating to controlled drugs and overall governance arrangements. Our CQC visit provided a range of learning opportunities, and actions have been taken to address the key findings relating to patient experience in our outpatients service and equipment and out of hours support within our High Dependency Unit, in addition to a handful of other compliance actions.

The Trust commissioned a review of our compliance with controlled drugs standards and associated flow of information to the Board.. This enabled us to take swift action in addressing significant control gaps, to bring compliance back in line with expected levels and improve reporting and escalation of issues. Likewise, the Good Governance Institute was commissioned to review our overall governance systems, and made a number of recommendations around improvements that could be made to our structures, particularly around the reporting and escalation route from local groups and committees to the Trust Board. These recommendations have been fully accepted and have supported changes in these structures during the year.

The Clinical Governance Committee provides assurance and oversight on behalf of the Board regarding clinical risks, quality of care, patient safety, patient experience. The CGC has a planned schedule of reports received with arrangement for exception reporting each month from its sub-groups which oversee particular aspects of specialist areas within its overall remit. This is informed by key groups acting as experts in their field providing scrutiny and direction.

The most significant conclusions of the Clinical Governance Committee were:

- Recognition that clinical audit is an important activity in support of the CGC's objectives. Further work is being undertaken to strengthen this area and to review its oversight including review of the role and function of the Clinical Outcomes and Effectiveness Committee.

- The need to reinforce the importance of coherent risk management including appropriate escalation of risk and clear accountability for managing risks. The Trust has brought in additional short-term expert advice and support through an external expert whose remit

includes assisting the Trust to strengthen clinical engagement and raise awareness of the role of clinical governance in safe high-quality patient care.

- Ensuring that CGC's own role in scrutiny is robust and focussed; CGC has examined its own role and function, including its terms of reference and is building a process of close engagement with groups reporting to it and the way in which they report.

Other steps taken during 2014/15 to maintain and review the Trust's systems of internal control include:

- The Board has reviewed and updated the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation & Delegation

- The Audit Committee receiving regular reports on reviews undertaken by the Internal and External Auditors, and follow up any recommendations 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.

- Quality rounds undertaken by the Director of Nursing & Governance and his team of matrons.

- Following feedback from the organisation, a new format for the Trust Business and Learning Days has been put in place to share good practice, learn from experience and improving local clinical governance processes, ensuring there is protected time for teams to come together on a regular basis to review the quality of care provided.

9.0 Conclusion

During the year the Trust has proactively reviewed its systems of control through external review and internal developments. A significant amount of work has been undertaken to strengthen systems and processes of control in response to recommendations from the commissioned reviews. Additionally, there has been substantial learning from the weaknesses identified in relation to the management of controlled drugs which was a significant issue for a period of time during the year. Whilst acknowledging the issue identified, I am assured by the advice I have received about the effective operation of controls across the Trust during the year as confirmed by internal audit, managers, committees of the board, the quality account and external audit opinion, and on balance I am able to take sufficient assurance that overall the Trust has a sound system of internal control.

We continue to develop our approaches to governance and are benefitting from appropriate external advice and support.

Moving forward, the Trust is committed to the continued development of our governance and control system building on the progress and learning undertaken in 2014/15.

Signed

Chief Executive Date: 26th May 2015

The Royal Orthopaedic Hospital NHS Foundation Trust

Consolidated Accounts for the year ended 31 March 2015

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

Opinion on financial statements of The Royal Orthopaedic Hospital NHS Foundation Trust

In our opinion the financial statements:

- **give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2015 and of the Group's and 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.**

The financial statements comprise the Consolidated Statement of Comprehensive Income, the Consolidated and Trust Statement of Financial Position, the Consolidated and Trust Statement of Changes in Equity, the Consolidated and Trust Statement of Cash Flows and the related notes 1 to 26. 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.

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.

Going concern

We have reviewed the Accounting Officer's statement contained within the Strategic Report that the Group is a going concern. We confirm that

- we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Group's ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Group's ability to continue as a going concern.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team:

Risk	How the scope of our audit responded to the risk
Recognition of NHS Revenue There are significant judgments in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: • the complexity of the Payment by Results regime, in particular in determining the level of overperformance and Commissioning for Quality and Innovation revenue to recognise; and • the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4. The Trust earns revenue from a wide range of	We evaluated the design and implementation of controls over recognition of Payment by Results income. We performed detailed substantive testing of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with

Risk	How the scope of our audit responded to the risk
commissioners, increasing the complexity of agreeing a final year-end position and increasing the significance of associated judgements. This risk refers to revenue from activities as shown in note 3.1 of £72,867,000, and accounting policies 1.1 and 1.3.	commissioners.
Property valuations The Group holds property assets within Property, Plant and Equipment at a modern equivalent use valuation, as set out in note 1.6. The valuations are by nature significant estimates which are based on specialist and management assumptions, such as indices and estimated useful lives, and which can be subject to material changes in value. As at 31 March 2015 these assets are valued at £44,190,000 and are included in note 9.	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. We used internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including through benchmarking against revaluations performed by other Trusts at 31 March 2015. We assessed whether the valuation and the accounting treatment of the adjustments were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Statement of Comprehensive Income.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on pages 209 to 212.

Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

We determined materiality for the Group to be £924,000, which is below 1% of revenue and below 2% of equity.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £46,000 as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit	Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level. The focus of our audit work was on the Trust, with work performed at the Trust's offices in Northfield directly by the audit engagement team, led by the audit partner. We performed specified audit procedures on the Trust's subsidiary, The Royal Orthopaedic NHS Foundation Trust Charity, where the extent of our testing was based on our assessment of the risks of material misstatement and the materiality of the Charity to the Group. Our audit covered all of the entities within the Group, which account for 100% of the Group's net assets, revenue and surplus. Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality. At the Group level we also tested the consolidation process. All testing was performed by the main audit engagement team, led by the audit partner.
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	
Annual Governance Statement, use of resources, and compilation of financial statements	Under the Audit Code for NHS Foundation Trusts, we are required 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 is inconsistent with information of which we are aware from our audit; • the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or • proper practices have not been observed in the compilation of the financial statements. We have nothing to report in respect of these matters. 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.
Our duty to read other information in the Annual Report	Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is: • materially inconsistent with the information in the audited financial statements; • apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of

performing our audit; or
- otherwise misleading.

In particular, we have considered whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

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. We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

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.

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.

Gus Miah (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Birmingham, United Kingdom
27 May 2015

FOREWORD TO THE ACCOUNTS

The accounts for the period ended 31 March 2015 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.

Mrs. Jo Chambers

Chief Executive

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2015

	Notes	Consolidated Year Ended 31 March 2015 £000	Consolidated Year Ended 31 March 2014 £000
Operating Income	3.1	78,075	75,966
Operating Expenses	4	(77,277)	(72,522)
Net valuation gain/(impairment loss) on land and buildings	9.3	1,919	(2,660)
Operating Surplus		**2,717**	**784**
Finance Expenses			
Finance income	6	74	103
Finance expense - financial liabilities	6	(19)	(24)
Finance expense - unwinding of discount on provisions	16	(12)	(1)
PDC Dividends payable		(1,338)	(1,280)
Gain on investment	6, 10	27	16
Net Finance Expenses		**(1,268)**	**(1,186)**
SURPLUS/(DEFICIT) FOR THE YEAR		**1,449**	**(402)**
Other comprehensive income/(expense)			
Valuation gains/(impairment loss) on land and buildings	9.3	325	(296)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**1,774**	**(698)**

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, a gain has been identified, and recognised in the accounts. The full impact of this gain has been described in further detail in note 9.3. The element recognised in the Statement of Comprehensive Income is £1,667,000 (2013/14: £2,660,000 impairment loss) as shown above. This is a technical non-cash adjustment. For 2014/15 the consolidated Trust had an overall deficit excluding this valuation gain of £470,000 (2013/14: £2,258,000 surplus).

The notes on pages 228 to 278 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

		Consolidated		Trust only	
		31 March 2015	31 March 2014	31 March 2015	31 March 2014
Non-current assets	**Notes**	**£000**	**£000**	**£000**	**£000**
Intangible assets	8	595	438	595	438
Property, Plant and Equipment	9	44,190	40,122	44,190	40,122
Investments	10	735	781	0	0
Total non-current assets		**45,520**	**41,341**	**44,785**	**40,560**
Current assets					
Inventories	11	3,786	3,922	3,786	3,922
Trade and other receivables	12	5,290	2,942	5,290	2,942
Other non-financial assets	12	285	532	283	530
Other current assets	12	714	1,126	713	1,126
Short term investments and deposits	13.1	7	106	0	0
Cash and cash equivalents	14	13,896	19,484	13,749	19,357
Total current assets		**23,978**	**28,112**	**23,821**	**27,877**
Current liabilities					
Trade and other payables	15	(8,332)	(9,760)	(8,314)	(9,656)
Borrowings	15.2	(157)	(153)	(157)	(153)
Provisions	16	(242)	(116)	(242)	(116)
Other liabilities	15.1	(397)	(640)	(397)	(640)
Total current liabilities		**(9,128)**	**(10,669)**	**(9,110)**	**(10,565)**
Total assets less current liabilities		**60,370**	**58,784**	**59,496**	**57,872**
Non-current liabilities					
Borrowings	15.2	(384)	(541)	(384)	(541)
Provisions	16	(254)	(285)	(254)	(285)
Total non-current liabilities		**(638)**	**(826)**	**(638)**	**(826)**
Total assets employed		**59,732**	**57,958**	**58,858**	**57,046**
Financed by taxpayers' equity					
Public Dividend Capital		38,996	38,996	38,996	38,996
Revaluation reserve		2,741	2,416	2,741	2,416
Charitable Fund reserve		874	912	0	0
Income and expenditure reserve		17,121	15,634	17,121	15,634
Total taxpayers' equity		**59,732**	**57,958**	**58,858**	**57,046**

The financial statements were approved by the Audit Committee and authorised for issue on behalf of the Board of Directors on 26 May 2015 and are signed on its behalf by:

Mrs. Jo Chambers – Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2015

	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

	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 2014	57,958	38,996	2,416	912	15,634	57,046	38,996	2,416	15,634
Surplus for the year	1,449	0	0	(38)	1,487	1,487	0	0	1,487
Valuation gains on property, plant and equipment	325	0	325	0	0	325	0	325	0
Taxpayers' Equity at 31 March 2015	**59,732**	38,996	2,741	874	17,121	**58,858**	38,996	2,741	17,121

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 2015

	Consolidated		Trust only	
	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
Cash flows from operating activities				
Operating surplus	2,717	784	2,812	739
Non-cash income and expense				
Depreciation and amortisation	2,334	2,143	2,334	2,143
Donated assets	(80)	(103)	(80)	(103)
Loss on disposal	27	37	27	37
Impairments	383	2,939	383	2,939
Reversal of impairments	(2,302)	(279)	(2,302)	(279)
Increase in Trade and Other Receivables	(1,795)	(1,182)	(1,796)	(1,156)
Decrease in other assets	186	21	16	21
Decrease/(Increase) in Inventories	136	(1,081)	136	(1,081)
(Decrease) in Trade and Other Payables	(209)	(983)	(123)	(950)
Decrease in Other Liabilities	(146)	(140)	(146)	(140)
Increase in Provisions	83	66	83	66
NET CASH GENERATED FROM OPERATING ACTIVITIES	**1,334**	**2,222**	**1,344**	**2,236**
Cash flows from investing activities				
Interest received	75	102	45	73
Purchase of intangible assets	(299)	(417)	(299)	(417)
Purchase of Property, Plant and Equipment	(5,276)	(2,466)	(5,276)	(2,466)
NET CASH USED IN INVESTING ACTIVITIES	**(5,500)**	**(2,781)**	**(5,530)**	**(2,810)**
Cash flows from financing activities				
Interest element of finance lease	(19)	(24)	(19)	(24)
Capital element of finance lease rental payments	(171)	(171)	(171)	(171)
PDC Dividend received	0	91	0	91
PDC Dividend paid	(1,232)	(1,413)	(1,232)	(1,413)
NET CASH USED IN FINANCING ACTIVITIES	**(1,422)**	**(1,517)**	**(1,422)**	**(1,517)**
Decrease in cash and cash equivalents	**(5,588)**	**(2,076)**	**(5,608)**	**(2,091)**
Cash and Cash equivalents at 1 April	**19,484**	**21,560**	**19,357**	**21,448**
Cash and Cash equivalents at 31 March	**13,896**	**19,484**	**13,749**	**19,357**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

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 2014/15 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

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 the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its control over the fund.

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 statement of financial position 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 CHARITABLE FUND STATEMENT OF FINANCIAL ACTIVITIES

	31 March 2015 Total Funds Pre Consolidation £000	**Consolidation Adjustments £000**	**31 March 2015 Post Consolidation £000**
Total incoming resources	**106**	**0**	**106**
Total resources expended	**(171)**	**0**	**(171)**
Net outgoing resources before other recognised gains and losses	**(65)**	**0**	**(65)**
Other recognised gains/losses			
Gains on investment assets	**27**	**0**	**27**
Net movement in funds	**(38)**	**0**	**(38)**
Fund balances brought forward at 31 March 2014	**910**	2	**912**
Fund balances carried forward at 31 March 2015	**872**	**2**	**874**

	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 (outgoing)/incoming 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

SUMMARISED CHARITABLE FUND BALANCE SHEET

	31 March 2015 Pre Consolidation £000	Consolidation Adjustments £000	31 March 2015 Post Consolidation £000
Total Fixed Assets	**735**	**0**	**735**
Total Current Assets	**155**	**2**	**157**
Creditors: Amounts falling due within one year	**(18)**	**0**	**(18)**
Net Current Assets	**137**	**2**	**139**
Total Assets less Current Liabilities	**872**	**2**	**874**
Total Net Assets	**872**	**2**	**874**
Total Funds	**872**	**2**	**874**

	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

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 2015 £000	31 March 2014 £000
Funds of the Charity	377	474	23	874	912
Total Funds	**377**	**474**	**23**	**874**	912

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 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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 2012.

The Scheme Regulations 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.

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 2015 the Trust has made contributions of £2,396 to this fund, (2013/14 £971).

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 2015 as follows:

- Land £3,936,100
- Buildings and Dwellings £33,505,828

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 2015. The Trust has not entered into any regular way purchases or sales in the year to 31 March 2015.

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 16 on page 270 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling

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

The Trust has also taken out additional insurance to cover claims in excess of £1 million.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 19 on page 271 where an inflow of economic benefits is probable.

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

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

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

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

1.19 Value Added Tax

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

1.20 Corporation Tax

All surpluses are generated by activity authorised as an activity relating to the provision of core healthcare 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 year 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.

Change published	Published by IASB	Financial year for which the change first applies
IFRS 13 Fair Value Measurement	May 2011	Adoption delayed by HM Treasury. To be adopted from 2015/16.
IFRS 15 Revenue from contracts with customers	May 2014	Not yet EU adopted. Expected to be effective from 2017/18.
IFRS 9 Financial Instruments	July 2014	Not yet EU adopted. Expected to be effective from 2018/19.
IAS 36 (amendment) – recoverable amount disclosures	May 2013	To be adopted from 2015/16 (aligned to IFRS 13 adoption)
Annual Improvements 2012	December 2013	Effective from 2015/16 but not yet EU adopted
Annual Improvements 2013	December 2013	Effective from 2015/16 but not yet EU adopted
IAS 19 (amendment) – employer contributions to defined benefit pension schemes	November 2013	Effective from 2015/16 but not yet EU adopted
IFRIC 21 Levies	May 2013	EU adopted in June 2014 but not yet adopted by HM Treasury.

1.26 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.

1.27 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 2015		Year Ended 31 March 2014	
	£000	%	£000	%
Income from whole HM Government	75,778	97.06%	73,827	97.18%
Income from non HM Government	2,297	2.94%	2,139	2.82%
	78,075	100.00%	**75,966**	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 2015 £000	Year Ended 31 March 2014 £000
Elective income	45,142	43,672
Non elective income	1,756	1,833
Outpatient income	6,833	6,639
Other NHS clinical income	18,526	17,369
Private patient income	610	928
Total income from activities	**72,867**	**70,441**
Other operating income		
Research and development	656	564
Education and training	2,441	2,495
Charitable and other contributions to expenditure	53	266
Income in respect of staff costs where accounted on gross basis	1,142	1,071
Other	916	1,129
Total other operating income	**5,208**	**5,525**
TOTAL OPERATING INCOME	**78,075**	**75,966**

Other income includes £206,127 from onsite catering services (2013/14: £170,750); staff accommodation rentals of £90,827 (2013/14: £87,655); car park income of £64,534 (2013/14 - £60,517); clinical tests of £21,138 (2013/14: £14,418) and private guests accommodation rentals of £30,069 (2013/14: £27,123).

Other NHS clinical income includes £5,928,504 (2013/14: £6,012,291) for oncology block contract income from the National Specialist Commissioning Team, £452,000 (2013/14 : £513,341) for oncology income from Wales, £2,377,053 (2013/14: £2,316,910) for critical care bed days, £1,397,009 for CQUIN (2013/14: £1,259,109), £1,941,436 (2013/14: £1,602,965) for physiotherapy services, £478,338 for podiatry services (2013/14: £100,595), £719,192 for patient travel (2013/14: £672,797), £523,496 for pre-operative assessments (2013/14: £520,281), £304,188 in relation to high cost drugs (2013/14: £270,599), £1,569,244 for diagnostic imaging (2013/14: £1,363,201), £329,203 (2013/14: £148,225) in relation to the Bone Infection Unit and £359,477 for hospital at home (2013/14: £363,436). Other NHS clinical income also includes and £1,016,300 for orthotic appliances (2013/1:4 £907,191).

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 2015 £000	Year Ended 31 March 2014 £000
NHS Foundation Trusts	47	238
NHS Trusts	507	310
Strategic Health Authorities	32	(9)
CCGs and NHS England	70,961	68,000
NHS Other	237	0
Non NHS: Private patients	391	696
Non-NHS: Overseas patients (non-reciprocal)	219	232
NHS injury scheme (was RTA)	31	29
Non NHS: Other	442	945
TOTAL INCOME FROM ACTIVITIES	**72,867**	**70,441**

The income for the Charity is not included here as this has been classified as other operating income only.

3.3 Overseas visitor income

	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
Income recognised this year	219	232
Cash payments received in-year	172	141
Amounts added to provision for impairment of receivables	107	0
Amounts written off in-year	0	0

4 Operating Expenditure

	Consolidated	
	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
Services from NHS Foundation Trusts	18	18
Services from other NHS Trusts	642	563
Services from CCGs and NHS England	15	0
Purchase of healthcare from non NHS bodies	1,962	1,676
Employee Expenses - Executive directors	703	678
Employee Expenses - Non-executive directors	102	114
Employee Expenses - Staff	43,744	40,452
Drug costs	478	423
Supplies and services - clinical (excluding drug costs)	10,399	8,966
Supplies and services - general	630	789
Establishment	957	954
Transport	12	16
Premises	3,018	2,968
(Decrease)/Increase in bad debt provision	(309)	538
Inventories write down	26	11
Inventories consumed	9,290	9,042
Depreciation on property, plant and equipment	2,208	2,094
Amortisation on intangible assets	126	49
Audit services - statutory audit	44	44
Other auditor's remuneration - further assurance services	23	34
Internal audit and counter fraud fees	69	84
Clinical negligence	1,571	1,428
Loss on disposal of other property, plant and equipment	27	37
Legal fees	(4)	37
Consultancy costs	497	157
Training, courses and conferences	250	333
Patient travel	16	15
Hospitality	3	5
Insurance	83	77
Other services eg external payroll	246	218
Losses, ex gratia & special payments	67	133
Rentals under operating leases	85	68
Charitable Fund expenditure	73	216
Other	206	285
TOTAL OPERATING EXPENDITURE	**77,277**	**72,522**

5 Operating leases

5.1 Payments recognised as an expense

	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
Lease payments	85	68
TOTAL PAYMENTS	**85**	**68**

This note relates to the main Trust only as the Charity does not hold any operating leases.

The Trusts operating leases for 2014/15 consists of £12,000 for the use of an offsite car park, £50,000 for Histopathology property lease and the remainder of £23,000 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 2015 £000	Year Ended 31 March 2014 £000
- not later than one year;	19	50	55	124	69
- later than one year and not later than five years;	29	201	188	418	430
- greater than five years	0	176	2	178	0
TOTAL FUTURE PAYMENTS DUE	**48**	**427**	**245**	**720**	**499**

This note relates to the main Trust only as the Charity does not hold any operating leases.

6 Finance income and expense

	Consolidated	
	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
Interest from deposit account investments	74	103
Gain on investment	27	16
TOTAL FINANCE INCOME	**101**	**119**

	Consolidated	
	Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
Finance lease interest	19	24
TOTAL FINANCE EXPENSE	**19**	**24**

7 Employee expenses and numbers – Trust only

	2014/15 Total £000	2014/15 Permanently Employed £000	2014/15 Agency £000	2013/14 Total £000	2013/14 Permanently Employed £000	2013/14 Agency £000
Salaries and wages	33,396	33,396	0	31,951	31,951	0
Social security Costs	2,897	2,897	0	2,756	2,756	0
Employers contributions to NHS Pensions	3,517	3,517	0	3,245	3,245	0
Agency and contract staff	4,637	0	4,637	3,178	0	3,178
TOTAL EMPLOYEE EXPENSES	**44,447**	**39,810**	**4,637**	**41,130**	**37,952**	**3,178**

7.1 Employee expenses

The total Employer Pension contribution payable for the period to 31 March 2015 is £3,516,961 (31 March 2014: £3,244,446).

7.2 Average number of persons employed

	2014/15 Total Number	2014/15 Permanently Employed Number	2014/15 Agency Number	2013/14 Total Number	2013/14 Permanently Employed Number	2013/14 Agency Number
Medical and dental	122	99	23	108	102	6
Administration and estates	278	258	20	249	243	6
Healthcare assistants and other support staff	85	85	0	81	81	0
Nursing, midwifery and health visiting staff	377	329	48	342	329	13
Nursing, midwifery and health visiting learners	5	5	0	3	3	0
Scientific, therapeutic and technical staff	151	138	13	134	125	9
Other	5	5	0	6	6	0
TOTAL PERSONS EMPLOYED	**1,023**	919	104	**923**	889	34

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

	2014/15			2013/14		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies Number**	**Number of other departures agreed Number**	**Total number of exit packages by cost band Number**	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages by cost band Number
<£10,000	**0**	**0**	**0**	0	0	0
£10,001 - £25,000	**0**	**0**	**0**	0	0	0
£25,001 - 50,000	**0**	**1**	**1**	0	0	0
£50,001 - £100,000	**0**	**0**	**0**	0	0	0
£100,001 - £150,000	**0**	**0**	**0**	0	0	0
£150,001 - £200,000	**0**	**0**	**0**	0	0	0
>£200,001	**0**	**0**	**0**	0	0	0
Total number of exit packages by type	**0**	**1**	**1**	0	0	0
Total resource expense (£000s)	**0**	**40**	**40**	0	0	0

This note relates to the Trust only as the Charity does not have any employees.

7.4 Retirements due to ill health

During the year to 31 March 2015 there was one early retirements from the Trust agreed on the grounds of ill-health costing £19,000 (31 March 2014 – three retirements, £168,000). 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 2014	379	390	769
Additions - purchased	239	60	299
Reclassifications	450	(450)	0
Disposals	(119)	0	(119)
Gross cost at 31 March 2015	**949**	**0**	**949**
Amortisation at 1 April 2014	331	0	331
Provided during the year	135	0	135
Reclassifications	(9)		(9)
Disposals	(103)	0	(103)
Amortisation at 31 March 2015	**354**	**0**	**354**
Net book value			
NBV - Purchased at 31 March 2015	595	0	595
NBV - Donated at 31 March 2015	0	0	0
NBV total at 31 March 2015	**595**	**0**	**595**

	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**

This note relates to the Trust only as the Charity does not hold any intangible assets.

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 2015

	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 2014	46,950	3,247	30,953	1,011	1,470	8,092	39	2,063	75
Additions - purchased	3,966	0	1,142	0	1,057	1,625	0	143	0
Additions - donated	80	0	80	0	0	0	0	0	0
Impairments charged to operating expenses	(383)	0	(218)	(165)	0	0	0	0	0
Reversal of impairments credited to operating income	2,302	0	2,302	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(363)	0	(363)	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	688	688	0	0	0	0	0	0	0
Reclassifications	6	0	418	0	(1,502)	2	0	1,088	0
Revaluation impact on cost and depreciation	(1,329)	0	(1,289)	(40)	0	0	0	0	0
Disposals	(461)	0	0	0	0	(88)	(19)	(354)	0
Cost or Valuation at 31 March 2015	**51,456**	**3,935**	**33,025**	**806**	**1,025**	**9,631**	**20**	**2,940**	**75**
Accumulated depreciation at 1 April 2014	6,828	0	62	0	0	4,713	21	1,987	45
Provided during the year	2,208	0	1,380	40	0	653	5	123	7
Reclassifications	9	0	0	0	0	0	0	9	0
Revaluation impact on cost and depreciation	(1,329)	0	(1,289)	(40)	0	0	0	0	0
Disposals	(450)	0	0	0	0	(82)	(19)	(349)	0
Accumulated depreciation at 31 March 2015	**7,266**	**0**	**153**	**0**	**0**	**5,284**	**7**	**1,770**	**52**
Net book value									
NBV - Purchased at 31 March 2015	41,446	3,935	30,650	806	1,025	3,825	13	1,170	23
NBV - Finance lease at 31 March 2015	522	0	0	0	0	522	0	0	0
NBV - Donated at 31 March 2015	2,222	0	2,222	0	0	0	0	0	0
NBV total at 31 March 2015	**44,190**	**3,935**	**32,871**	**806**	**1,025**	**4,347**	**13**	**1,170**	**23**

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 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
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

9.3 Gains/(Impairments)

	Total 31 March 2015 £000	Operating income * £000	Operating expenses * £000	Revaluation reserve £000
Changes in market place	(58)	0	(383)	325
Reversal of impairments	2,302	2,302	0	0
TOTAL GAINS AT 31 MARCH 2015	**2,244**	**2,302**	**(383)**	**325**

	Total 31 March 2015 £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)**

* The net of these numbers has been shown on the face of the Consolidated Statement of Comprehensive Income as a gain of £1,919,000 (2013/14 £2,660,000 impairment loss)

This note relates to the Trust only as the charity does not hold any assets.

10 Investments

	Consolidated	
	31 March 2015	**31 March 2014**
Fixed Asset Investments:	**£000**	**£000**
Market value at 31 March	**781**	765
Net gain on revaluation	**27**	16
Transfer equity to cash pool	**(73)**	0
Market value at 31 March	**735**	781
Historic cost at 31 March 2015	**785**	785

Market value at 31 March	**31 March 2015**	**31 March 2014**
	£000	**£000**
Securities - managed funds	**785**	785
	785	785

Analysis of gross income from investments

Total gross income	**31 March 2015**	**31 March 2014**
	£000	£000
Investments in a Common Deposit Fund or Common Investment Fund	**30**	29

Note: all investments are held by the Trust's associated charity which has been consolidated into these accounts.

11 Inventories

	Consolidated	
	31 March 2015	**31 March 2014**
	£000	£000
Consumables	3,786	3,922
TOTAL INVENTORIES	**3,786**	3,922

	31 March 2015	**31 March 2014**
	£000	£000
Inventories recognised in expenses	9,290	9,042
Write-down of inventories recognised as an expense	26	11
TOTAL	**9,316**	9,053

This note relates to the Trust only as the Charity does not hold any inventories.

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		Financial Assets		Non-Financial Assets	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Current financial assets								
NHS Receivables	5,522	3,449	0	0	5,522	3,449	0	0
Other receivables with related parties	91	125	0	0	91	125	0	0
Provision for impaired receivables	(323)	(632)	0	0	(323)	(632)	0	0
	5,290	2,942	**0**	0	**5,290**	2,942	**0**	0
Prepayments	0	0	285	532	0	0	283	530
Accrued income	31	340	0	0	31	340	0	0
Interest receivable	3	5	0	0	3	5	0	0
PDC receivable	53	159	0	0	53	159	0	0
VAT receivable	115	155	0	0	115	155	0	0
Other receivables	512	467	0	0	511	467	0	0
	714	1,126	**285**	532	**713**	1,126	**283**	530
Total Current Financial Assets	**6,004**	4,068	**285**	532	**6,003**	4,068	**283**	530
Non-Current financial Assets								
Trade and other receivables	0	0	0	0	0	0	0	0
TOTAL TRADE AND OTHER RECEIVABLES	**6,004**	4,068	**285**	532	**6,003**	4,068	**283**	530

BAD DEBT PROVISION

	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Balance at 1 April	631	93	631	93
Increase in provision	0	538	0	538
Utilised	(48)	0	(48)	0
Unused amounts reversed	(260)	0	(260)	0
Balance at 31 March	**323**	631	**323**	631

12.1 Impairment of receivables

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

	Consolidated		Trust only	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
0 - 30 days	2	380	2	380
30 - 60 days	0	0	0	0
60 - 90 days	0	0	0	0
90 - 180 days	321	252	321	252
TOTAL AGEING OF IMPAIRED RECEIVABLES	**323**	**632**	**323**	**632**

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

	Consolidated		Trust only	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
0 - 30 days	1,766	700	1,765	700
30 - 60 days	283	16	283	16
60 - 90 days	93	56	93	56
90 - 180 days	84	54	84	54
Over 180 days	15	215	15	215
TOTAL AGEING OF NON IMPAIRED RECEIVABLES	**2,241**	**1,041**	**2,240**	**1,041**

13 Other current assets

13.1 Short-term investments and deposits

The Trust did not hold any current asset investments or non-current asset investments in the year ending 31 March 2015, (31 March 2014, £nil). The Royal Orthopaedic Hospital NHS Foundation Trust Charitable Fund held short-term cash deposits within a multi-asset fund, of £7,000 (2013/14: £106,000).

14 Cash and cash equivalents

	Consolidated		Trust only	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Cash and cash equivalents at 1 April	19,484	21,560	19,357	21,448
Net change in year	(5,588)	(2,076)	(5,608)	(2,091)
Cash and cash equivalents at 31 March	13,896	19,484	13,749	19,357
Broken down into:				
Cash at commercial banks and in hand	147	127	0	0
Cash with the Government Banking Service	13,749	19,357	13,749	19,357
Cash and cash equivalents as in Statement of financial position and Statement of Cash Flows	**13,896**	**19,484**	**13,749**	**19,357**

15 Trade and other payables

	Consolidated		Trust only	
	Financial liabilities		Financial liabilities	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
NHS Payables	1,669	2,196	1,669	2,196
Trade payables - capital	749	2,064	749	2,064
Social security costs	389	386	389	386
Taxes payable	450	441	450	441
Other trade payables	4,798	3,838	4,798	3,838
Accruals	277	835	259	731
TOTAL TRADE AND OTHER PAYABLES	**8,332**	9,760	**8,314**	9,656

Other Trade Payables include £500,941 outstanding pension contributions at 31 March 2015 (31 March 2014: £468,999).

15.1 Other liabilities

	Consolidated				Trust only			
	Current		Non-Current		Current		Non-Current	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Deferred income	397	640	0	0	397	640	0	0
TOTAL OTHER LIABILITIES	**397**	640	**0**	0	**397**	640	**0**	0

15.2 Borrowings

	Consolidated				Trust only			
	Current		Non-Current		Current		Non-Current	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Obligations under finance leases	157	153	384	541	157	153	384	541
TOTAL BORROWINGS	**157**	153	**384**	541	**157**	153	**384**	541

15.3 Finance lease obligations

	Consolidated				Trust only			
	Net lease liabilities		Gross lease liabilities		Net lease liabilities		Gross lease liabilities	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
Within one year	157	153	172	190	157	153	172	190
Between one and five years	384	541	415	612	384	541	415	612
After five years	0	0	0	0	0	0	0	0
	541	694	**587**	802	**541**	694	**587**	802
Included in :								
Current borrowings	157	153			157	153		
Non-Current borrowings	384	541			384	541		
	541	694			**541**	694		

16 Provisions

	Legal claims	Other	Total
	£'000	£'000	£'000
At 1 April 2014	63	338	401
Arising during the year	16	97	113
Utilised during the year	(10)	(20)	(30)
Reversed unused during the year	0	0	0
Unwinding of discount	0	12	12
At 31 March 2015	**69**	**427**	**496**
Expected timing of cash flows:			
not later than one year	69	173	242
later than one year and not later than five years	0	55	55
later than five years	0	199	199
Total expected timing of cash flows	**69**	**427**	**496**

	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**

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 2014/15:

- Short-term (less than one year) (1.9%)
- Medium-term (one – five years) (0.65%)
- Long-term (later than 5 years) 2.2%

Other claims also contain a dilapidations provision for the leased histopathology laboratory at the University of Birmingham, £30,000 (2013/14: £30,000) and a provision for staff related employment claims of £97,000 (2013/14: £nil).

The NHS Litigation Authority as at 31 March 2015 has £16,834,061 (2013/14: £11,127,215) in respect of clinical negligence liabilities of the Trust included in its accounts.

17 Contractual Capital Commitments

	31 March 2015 £000	31 March 2014 £000
Property, plant and equipment	623	3,654
TOTAL CONTRACTUAL CAPITAL COMMITMENTS	**623**	3,654

Capital commitments include £180,675 in relation to general site building works,£236,146 in relation to replacement medical equipment and £206,647 in relation to IT hardware replacement.

18 Revaluation Reserve

	Total Revaluation Reserve	Revaluation Reserve - property, plant and equipment
	£'000	£'000
Revaluation reserve at 1 April 2014	2,416	2,416
Revaluation gain	325	325
Revaluation reserve at 31 March 2015	**2,741**	2,741
	£'000	£'000
Revaluation reserve at 1 April 2013	2,712	2,712
Impairments	(296)	(296)
Revaluation reserve at 31 March 2014	**2,416**	2,416

This note relates to the Trust only as the Charity does not hold and assets subject to revaluation.

19 Contingent Liabilities

There are no contingent liabilities or contingent assets for the year ending 31 March 2015 (2013/14: £nil).

20 Post Balance Sheet Events

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

21 Related party Transactions

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

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

The Department of Health is regarded as a related party. During the year The Royal Orthopaedic Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. 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 2014/15 £'000	Payables 2014/15 £'000	Revenue 2014/15 £'000	Expenditure 2014/15 £'000
Birmingham and the Black Country Area Team	352	0	19,545	0
Birmingham Children's Hospital NHS Foundation Trust	0	446	369	1,487
Birmingham Community Healthcare NHS Trust	0	0	0	578
Health Education England	0	0	2,241	0
HM Revenue & Customs - Other taxes and duties	0	839	0	2,897
NHS Birmingham Crosscity CCG	497	0	16,948	0
NHS Birmingham South And Central CCG	459	0	8,785	0
NHS Cannock Chase CCG	0	0	425	0
NHS Coventry And Rugby CCG	0	0	528	0
NHS Dudley CCG	0	0	3,465	0
NHS Herefordshire CCG	0	0	504	0
NHS Litigation Authority	0	0	0	1,571
NHS Pension Scheme	0	0	0	3,517
NHS Redditch And Bromsgrove CCG	482	0	3,469	0
NHS Sandwell And West Birmingham CCG	310	0	4,710	0
NHS Solihull CCG	0	0	2,083	0
NHS South East Staffs And Seisdon Peninsular CCG	0	0	1,506	0
NHS South Warwickshire CCG	0	0	551	0
NHS South Worcestershire CCG	0	0	1,754	0
NHS Walsall CCG	0	0	1,714	0
NHS Warwickshire North CCG	0	0	491	0
NHS Wolverhampton CCG	0	0	452	0
NHS Wyre Forest CCG	0	0	1,237	0
The Royal Wolverhampton NHS Trust	0	0	328	0
University Hospitals Birmingham NHS Foundation Trust	0	0	427	2,700
Walsall Healthcare NHS Trust	335	0	336	0

	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	19,003	0
Birmingham Childrens Hospital NHS Foundation Trust	110	382	318	1,160
Birmingham Community Healthcare NHS Trust	0	83	0	530
Health Education England	0	0	2,155	0
HM Revenue & Customs - Other taxes and duties	0	441	0	0
National Insurance Fund	0	386	0	2,756
NHS Birmingham Crosscity CCG	604	52	16,837	0
NHS Birmingham South And Central CCG	0	281	8,327	0
NHS Cannock Chase CCG	0	0	380	0
NHS Coventry And Rugby CCG	0	0	318	0
NHS Dudley CCG	0	108	3,128	0
NHS Herefordshire CCG	0	0	406	0
NHS Litigation Authority	0	0	0	1,428
NHS Pension Scheme	0	0	0	3,245
NHS Redditch And Bromsgrove CCG	179	126	2,936	0
NHS Sandwell And West Birmingham CCG	174	0	4,301	0
NHS Solihull CCG	106	0	2,057	0
NHS South East Staffs And Seisdon Peninsular CCG	163	0	1,342	0
NHS South Warwickshire CCG	80	0	451	0
NHS South Worcestershire CCG	90	0	1,753	0
NHS Walsall CCG	0	62	1,698	0
NHS Warwickshire North CCG	0	114	496	0
NHS Wolverhampton CCG	0	0	347	0
NHS Wyre Forest CCG	0	55	1,178	0
University Hospital Birmingham NHS Foundation Trust	265	105	901	2,483

The Trust has also received revenue payments from the associated charitable funds where the Trustees are also members of the NHS Trust Board. The Trust charged the charity for finance administration services totalling £12,855 during the year (2013/14: £13,848).

22 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 2015 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 2015. 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'.

22.1 Financial Assets

	Consolidated			
	Carrying value 31 March 2015 £000	Fair value 31 March 2015 £000	Carrying value 31 March 2014 £000	Fair value 31 March 2014 £000
Current financial assets				
Trade and other receivables	5,290	5,290	2,942	2,942
Other current assets	714	714	1,126	1,126
Short term investments and deposits	7	7	106	106
Cash and cash equivalents	13,896	13,896	19,484	19,484
TOTAL FINANCIAL ASSETS	**19,907**	**19,907**	23,658	23,658

	Trust only			
	Carrying value 31 March 2015 £000	Fair value 31 March 2015 £000	Carrying value 31 March 2014 £000	Fair value 31 March 2014 £000
Current financial assets				
Trade and other receivables	5,290	5,290	2,942	2,942
Other current assets	713	713	1,126	1,126
Cash and cash equivalents	13,749	13,749	19,357	19,357
TOTAL FINANCIAL ASSETS	**19,752**	**19,752**	23,425	23,425

22.2 Financial Liabilities

	Consolidated			
	Carrying value 31 March 2015	Fair value 31 March 2015	Carrying value 31 March 2014	Fair value 31 March 2014
Current financial liabilities	**£000**	**£000**	**£000**	**£000**
Finance leases	157	157	153	153
Trade and other payables	8,332	8,332	9,760	9,760
Provisions under contract	242	242	116	116
	8,731	8,731	10,029	10,029
Non-current financial liabilities				
Finance leases	384	384	541	541
Provisions under contract	254	254	285	285
TOTAL FINANCIAL LIABILITIES	**9,369**	**9,369**	10,855	10,855

	Trust only			
	Carrying value 31 March 2015	Fair value 31 March 2015	Carrying value 31 March 2014	Fair value 31 March 2014
Current financial liabilities	**£000**	**£000**	**£000**	**£000**
Finance leases	157	157	153	153
Trade and other payables	8,314	8,314	9,656	9,656
Provisions under contract	242	242	116	116
	8,713	8,713	9,925	9,925
Non-current financial liabilities				
Finance leases	384	384	541	541
Provisions under contract	254	254	285	285
TOTAL FINANCIAL LIABILITIES	**9,351**	**9,351**	10,751	10,751

23 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:

	2014/15 Total number of cases Number	2014/15 Total value of cases £000's	2013/14 Total number of cases Number	2013/14 Total value of cases £000's
LOSSES:				
1. Losses of cash due to:				
a. theft, fraud etc	0	0	1	2
b. overpayment of salaries etc.	0	0	0	0
c. other causes	2	0	0	0
2. Fruitless payments and constructive losses	0	0	1	12
3. Bad debts and claims abandoned in relation to:				
a. private patients	1	55	0	0
b. overseas visitors	0	0	0	0
c. other	0	0	0	0
4. Damage to buildings, property etc. (including stores losses) due to:				
a. theft, fraud etc	0	0	0	0
b. stores losses	0	0	0	0
c. other	0	0	0	0
TOTAL LOSSES	**3**	**55**	**2**	**14**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	5	50	13	23
6. Extra contractual to contractors	0	0	0	0
7. Ex gratia payments in respect of:				
a. loss of personal effects	0	0	2	0
b. clinical negligence with advice	0	0	0	0
c. personal injury with advice	0	0	0	0
d. other negligence and injury	0	0	0	0
e. Other employment payments (should not include special severance payments which are disclosed below)	0	0	1	94
f. Patient referrals outside the UK and EEA Guidelines	0	0	0	0
g. other	8	0	22	2
h. maladministration, no financial loss	0	0	0	0
8. Special Severance payments	0	0	0	0
9. Extra statutory and regulatory	0	0	0	0
TOTAL SPECIAL PAYMENTS	**13**	**50**	**38**	**119**
TOTAL LOSSES AND SPECIAL PAYMENTS	**16**	**105**	**40**	**133**

For the year ending 31 March 2015 the Trust had 16 (31 March 2014: 38) separate losses and special payments, totaling £105,105 (31 March 2014: £132,780). Of this £54,966 relates to a provision for bad debt relating to a private patient. The remainder were in relation to cash losses and ex-gratia payments to patients.

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.

24 Third Party Assets

The Trust held £100k in relation to advance payments from private patients in relation to treatment which is yet to take place (2013/14 £nil). These payments have been included within the Trusts accounts for 2014/15.

25 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.

26 Auditor's Liability

The auditors have a limitation of their liability in accordance with their engagement letter signed on the 22 April 2015 for the amount of £1 million.