The Royal Orthopaedic Hospital NHS Foundation Trust

Annual Report and Accounts 2011/12

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

Contents **2011/12**

1. Chairman's Message

The trust has once again had a successful year as a result of turning challenge into opportunity.

I spend much of my time walking round the organization bumping into staff and patients and keeping a finger on the pulse and it heartens me to hear such consistently positive messages about the great surgery we provide and the support given by or staff.

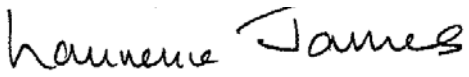
It's always satisfying to hear compliments about cleanliness and clinical care and I'm pleased to say that these far outweigh the complaints we receive. Nonetheless, there can be no room for complacency and there is always much to learn from any patient feedback. It is often said that we seem to be really good at the most difficult things, but that our attention to detail on some of the other aspects of patient contact could be better. This is something we really want to seize in the next year and make sure all our interfaces with patients are as positive as possible, whether through administration, car parking, food or clinical activity.

Last year we submitted entries under several award categories and while it is always sad not to win, the staff teams had a number of 'near-misses' that demonstrated how strongly the trust can compete with some much bigger public sector organisations. We did win one award, however, the Green apple Award in recognition of the contribution ROH had made to environmental impact through its planting of trees and engagement of staff and the community in creating a sustainable future.

Every organization can track its success to the door of the CEO and this year we faced the big challenge of replacing our excellent Chief Executive, Penny Venables who availed herself of an opportunity to move into a bigger acute trust in December 2011. Penny had led a culture of delivering targets, putting the patient first and building a strong team of staff, so the bedrock for any newcomer was solid. We were lucky to be able to attract a new CEO with an appetite for the role and a background that was just right to add value from 2012. Donal O'Donoghue cut his teeth as a spinal surgeon and then won his management spurs as a medical director. ROH has now brought him on board to take the next leap forward – really putting clinicians in pole position to develop exemplary services for patients. I hope that he will help smooth the transition period where several key people have made recent career moves and given opportunity to bring in new blood.

I am grateful to my NED colleagues and the Members' Council for their support in a year when the NHS was such high profile news. The Health Bill heralds change for the whole system of patient care and we must make the most of its benefits and maintain our endeavours to do what is right for our patients.

I believe this annual report accurately reflects our good practice.



Laurence James

2. Chief Executive's Report

In December 2011 the Trust Chief Executive, Penny Venables, left the organisation after a period of over 5 years' service. Her views of the organisation are reflected in this report which has been prepared by Graham Bragg, Acting Chief Executive from January 1st to March 15th 2012 when the substantive CEO, Donal O'Donoghue took up post. Both the Acting CEO and incumbent CEO at the time of report submission have signed this report as a fair record of the year.

In 2011/12, the trust continued to maintain high levels of performance in patient care and financial performance. The greatest underpinning strategy was its approach to project management of efficiency savings which brought to fruition a number of initiatives planned in the previous year.

The most visible change was the new Outpatient department which opened its doors early in this financial year. Patients and clinicians have all benefited from a new building designed with their involvement and as a result, patients experience a much greater degree of comfort while waiting and a more confidential clinic environment in which to discuss their treatment options. A new MRI scanner was installed which allows much more efficient scanning and there have been changes to the way patients are referred to X-ray which have streamlined systems that had been less than patient focused in the past.

Patients can now benefit from a WRVS coffee shop serving a variety of snacks and drinks and despite the outstanding completion of the build of a new restaurant on site, patient and staff food has improved over the year with greater variety and much higher standards of presentation.

For patients there were a number of real benefits to ensure that their treatment was effective and their time in hospital as brief as was clinically appropriate – healing is always faster at home.

Service redesign was used to develop a bone infection unit which allowed patients to leave hospital earlier rather than remain inpatients on anti-biotics for protracted periods. Enhanced recovery was supported through changes to anaesthetics practice and improved support for patients and the theatre rota was systematically reviewed to make the most of available sessions and pave the way for future repatriation of patient care from the additional ward operated by ROH at the BMI Hospital in Edgbaston.

The trust also looked to its support functions to see how these could be streamlined to provide a better focused support structure for the patient experience. This included a major review of administration and therapy services and as a result of looking at these services from a patient perspective, real improvements were put in place that will be cemented in subsequent years.

The trust had real success in developing its research capability securing a significant increase in research income with far more clinicians actively engaged. The first

academic strategy was adopted and both strands will underpin the ambition of the trust to be a leader in the field of orthopaedic innovation and teaching excellence.

The coming year will see the trust capitalise on its efficiencies and bring into play a much greater degree of clinical engagement – particularly of our surgeons who work in the engine room of a centre of surgical excellence. They will have the opportunity to become key players in the management of the organisation and will be expected to display a forward-looking approach to service design and delivery.

ROH is fiercely independent and has a proud tradition and history. Its success as a Foundation Trust lies in anticipating and relishing those elements of change that can be harnessed to the benefit of patients and in challenging wasteful activity that is of no tangible benefit to patients at all. We will try to involve our patients still more, listen and learn from their experiences and understand their core expectations. They will be the ones who sing our praises to the GPs and make our vision of being first choice an undeniably right choice for anyone needing great orthopaedic care.

Graham Bragg and Donal O'Donoghue

3. Operating and Financial Review 2011/12

Summary of Financial Performance

The financial environment for 2011/12 was a challenging for the whole health economy as all organisations grappled with reducing costs and maintaining quality within an uncertain political climate. Commissioners reduced the investment in services at the ROH by 3.7% which included the following initiatives:

- A reduction of follow-up outpatient attendances and the design of clinical outpatient pathways for arthroplasy and arthroscopy; and
- A reduction in procedures deemed to be of limited clinical value;

The national tariff was deflated by 1.5% and there were a number of unavoidable cost pressures of 1.5%. The ROH was required to set itself challenging efficiency and surplus targets aiming to reduce cost, improve quality and continue to invest in the site and infrastructure to deliver world class healthcare.

With this in mind the following financial strategy was agreed by the Board of Directors and Members' Council and the following key objectives were set:

Financial Objective	**Outcome**
Deliver a minimum surplus of £1 m net of the revaluation of the new outpatient building	Surplus achieved £1.2m 
Achieve a Monitor Financial Risk Rating of 4	Achieved a rating of 5 
Deliver £4.1m in cost reduction	Achieved £4.1m 
Deliver a capital programme of £5m	Delivered £3.2m 

The Trust exceeded it surplus target of £1m by £0.2m despite treating less patients than planned. It did this by:

- Much improved cost control across all directorates. All areas worked tirelessly throughout the year on delivering quality services within the resources allocated and this was overseen by the Executive Team at the quarterly review process;
- Achievement of a challenging 6% cost reduction programme. This was achieved by a challenging procurement and non-pay spend programme, undertaking a review of administration, increasing theatre efficiency, improved service line management, improved resource scheduling allowing a ward to close at weekends and local department schemes;
- Treating a more complex cohort of patients increasing the average tariff charged; and

- A number of non-recurrent benefits including the recovery of amounts previously written off.

The Trust finished the year with a strong liquidity position £19.7m against a plan of £13.5m which will enable us to continue to invest in improving property, plant and equipment and the Trust has a £17.2m capital plan for the next three years including:

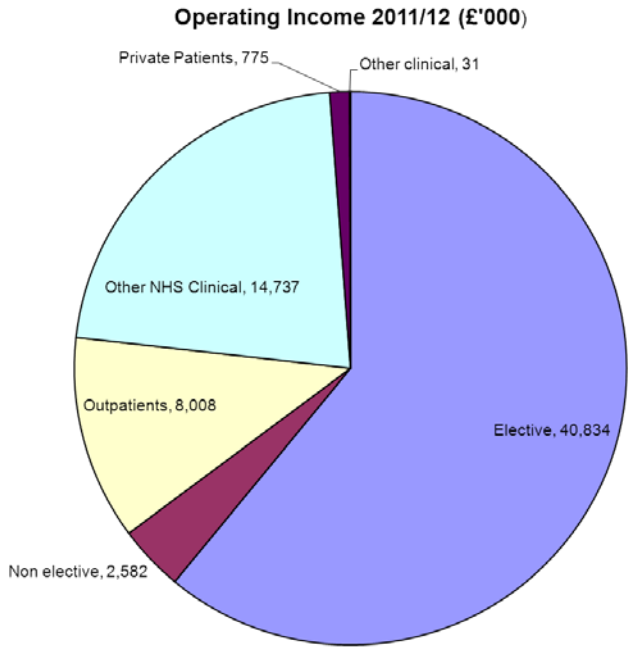
- Theatre development including a new Admissions and Day Case Unit;
- Improved decontamination facilities;
- Medical equipment and an equipment replacement programme; and
- Improved information.

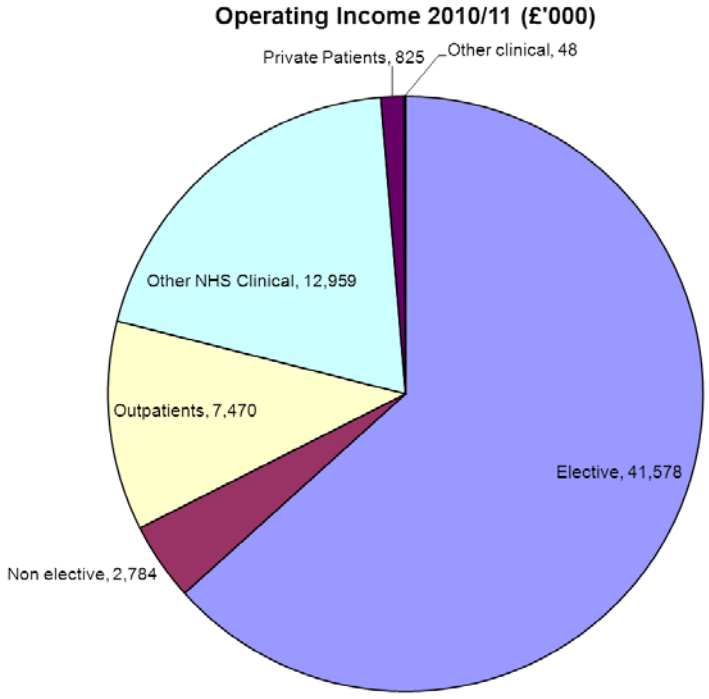
The final Monitor financial metrics were as follows:

Monitor Financial Metric	**Actual**	**Plan**
EBITDA margin	**3** (8.1%)	**3** (7.1%)
EBITDA Achieved (%)	**5** (118.6%)	**5** (100.0%)
Return on Assets	**5** (6.1%)	**3** (3.8%)
I&E Margin	**5** (3.3%)	**3** (1.4%)
Liquidity Risk (days)	**5** (98 days)	**5** (83 days)

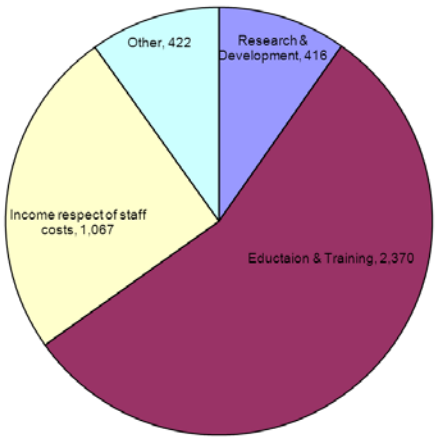
This excellent position is the culmination of a lot of hard work from the clinical staff and managers across the Trust who have successfully balanced the pressures of delivering excellent care within a tight financial envelope.

	2011/12			**2010/11**	
	Actual Treated	**Plan Treatment**	**Variance**	**Actual Treated**	**Variance**
Admitted Patient Care					
Elective	7,344	7,616	(272)	7,573	6,910
Non-Elective	535	519	16	502	526
Day Cases	6,560	6,914	(354)	7,344	8,446
Total Admitted Patient Care	**14,439**	**15,049**	**(610)**	**15,419**	**15,882**
Outpatients					
First Appointment	17,355	17,072	283	17,781	18,169
Follow Up Appointment	42,361	40,585	1,776	51,103	51,210
Outpatients with Procedures	8,330	8,634	(304)	3,331	1,853
Total Outpatients	**68,046**	**66,291**	**1,755**	**72,215**	**71,232**

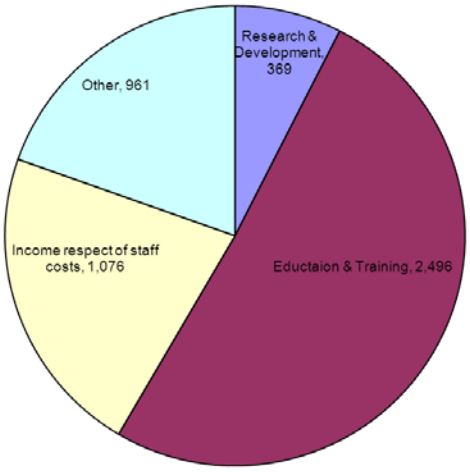

Operating Income 2011/12 (£'000)
Private Patients, 775
Other clinical, 31
Other NHS Clinical, 14,737
Outpatients, 8,008
Elective, 40,834
Non elective, 2,582


Operating Income 2010/11 (£'000)
Private Patients, 825
Other clinical, 48
Other NHS Clinical, 12,959
Outpatients, 7,470
Elective, 41,578
Non elective, 2,784

Other Income 2011/12 (£'000)



Other Income 2010/11 (£'000)

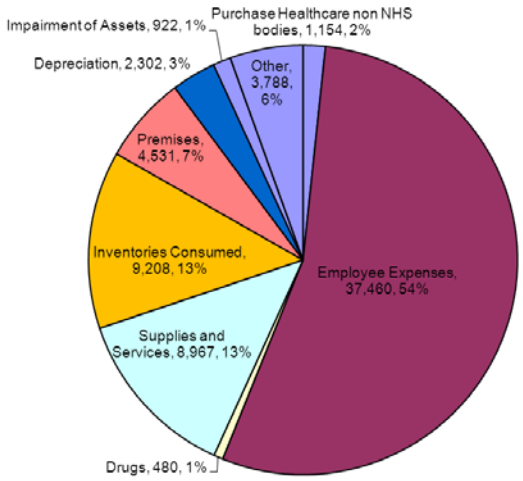


Private Patient Cap

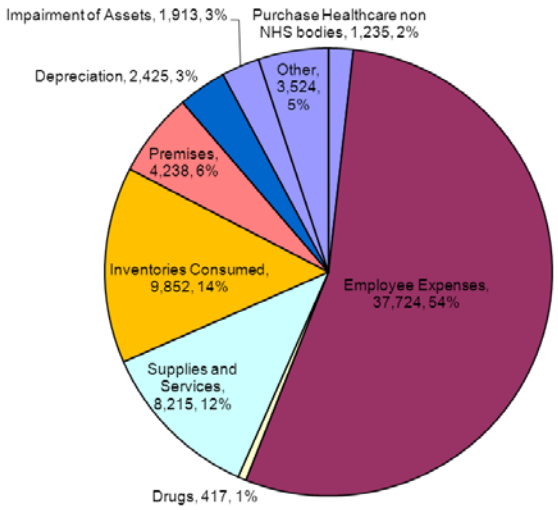
In accordance with section 44 of the Health and Social Care (Community Health and Standards Act 2003), the Trust must not exceed the proportion of income generated from treating private patients compared to total patient income as generated in 2002/3. This measure is used to show that the trust has not moved away from its fundamental aim to treat NHS patients despite its greater commercial freedoms.

The Trust's cap is set at 4.3% and during 2011/12 the Trust percentage of private patient income was 1.16% (1.26% 10/11).

Operating Expenditure 2011/12 (£'000)



Operating Expenditure 2010/11 (£'000)



Improving efficiency and ensuring continued value for money

The Trust continued to deliver its Excellent Health Programme which concentrates on eliminating waste, standardisation and whole pathway design from a patient's perspective. The programme is run from a Programme Management Office (PMO) which has increased the number of staff involved in change projects and helped staff from all levels and disciplines work together to create innovative solutions to improving quality whilst reducing cost.

The Trust achieved a challenging £4.1m in cost improvement whilst working on a number of enabling schemes that will allow the 2012/13 programme to be achieved.

For the foreseeable future the Trust will need to reduce its costs in excess of 4% per annum. The focus for this work will be through the Lean Academy, quality initiatives and partnership working with our commissioners and other Trusts.

The Audit Committee play an important role in monitoring the programme and ensuring that there is no evidence to show a loss of quality or increase in patient harm caused by any of the schemes. The Committee regularly attends the PMO and looks at key performance indicators in detail so it can assure the Trust Board that quality is being improved not reduced.

Capital Investment

Having achieved foundation status, the Trust has increased freedom to select the most appropriate capital schemes to ensure the most modern equipment and technology are available in a clinically appropriate environment to support patient care. The Trust funds these developments by generating cash surpluses. Despite pressures generated by the financial environment the trust must invest in its facilities and site to ensure that they remain fit for purpose and safe for patient care. Capital investment should also save costs by helping to improve processes and services.

The schemes delivered in the year were:

- The commissioning of the new outpatient building including new road access and signage;
- A replacement kitchen with work started on a replacement restaurant and servery;
- An investment in medical equipment and clinical equipment replacement programme; and
- A refresh of information technology assets.

Charitable Funds

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

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

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

Regulator Risk Ratings

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

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

2011/12	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	4	3	4	5	5
Governance risk rating	Amber	Amber	Amber	Green	Green
Mandatory services	Green	Green	Green	Green	Green

2010/11	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	4	3	4	4	4
Governance risk rating	Amber	Amber	Amber	Amber	Amber - Green
Mandatory services	Green	Green	Green	Green	Green

The Forward Look

The Trust will continue to be under significant financial pressure from the health economy and it is clear that there will be continued pressure on reducing the availability of secondary care so despite a strong financial performance and position there will continue to be much work to do.

We are committed to working with the local health economy to find an affordable solution for the local health economy and have worked on savings schemes for the whole economy most notably the Bone Infection Unit which reduces the economy cost of treating complex bone infections and a reduction in the follow-up of outpatients.

We will deliver a £3.8m cost reduction including repatriating a ward and theatre offsite facility and delivering the same total volume of patients as 2011/12 on the Woodlands site only. This will be made possible by the enabling schemes completed in 2011/12 on resource scheduling, improved patient discharge and reducing the average length of stay from the bone infection unit and arthoplasty pathway.

We are planning to achieve to achieve a £2m surplus in 2012/13 and to invest in an ambitious capital programme of £17.3m over the next three years as explained above.

The key risks facing the Trust in 2012/13 are split into two areas, regulatory and financial. They are shown in the tables below:

Key Regulatory Risks			
Risk	**Nature of risk**	**Actions to rectify/mitigate, and responsibilities**	**Measures 2012/13 2013/14 2014/15**
Governance processes and procedures	The Health Bill may changes governance arrangements for FTs with regard to the board and governors.	Working to amend the constitution - Chair, CEO and Company Secretary	2012/13
Having regard to the NHS Constitution	Failure to uphold patients' right to treatment within 18 weeks.	Retain 18 weeks route to treatment target as headline performance indicator.	Delivery of 18 weeks each quarter for duration of plan.
Patient Safety & Experience	Risk of never events and failure to complete SIRI action plans	Introduction of enhanced action planning and monitoring by clinical directorates	Number of events recorded
Hospital-acquired infection targets	Risks associated with having unrealistic reduction targets imposed that are undeliverable in an organisation with low levels of MRSA, MSSA, e-coli and C Diff.	Continue to lobby locally and nationally. Continue to negotiate realistic targets with commissioners. The trust was pleased to note the de-minim is limit for CDiff included in the Monitor compliance framework	HCAI targets are delivered.
Meeting information governance standards	Standards are raised and insufficient resource available to improve.	Dedicated information governance manager in-post. Agreed work plan and regular board scrutiny. Information governance group chaired by deputy CEO.	Agree necessary toolkit scores. Confirm this at Board in declaration. Include as part of quality measurement for organisation and review through Integrated Governance Committee.

Key Financial Risks		
Risk	**Amounts**	**Mitigating actions and delivery risk**
Tariff changes reduce specialist tariff further or set unrealistic best practice pathways for specialist providers	£1m	By leading the work of the Strategic Orthopaedic Alliance, the Trust is working with the PbR team at the DoH to work on coding and resources for specialist orthopaedic work.
Change in referral patterns due to instability created by NHS Reform	£0.5m	The Trust is working with all local commissioners and is committed to patient quality and experience and has a strategy to promote its good outcomes and to demonstrate quality.
Failure to achieve challenging KPIs or CQUIN targets triggering contractual risk	£1.0m	All targets and schemes have leads who have signed off the targets and put in place strong plans for achievement

4. Quality Account and Report 2011/12

PART 1

Our commitment to continual quality improvement

In 2011/12, the Trust continued to embed its Strategy for the hospital that is built around quality and excellence in all that we do.

Our Vision is: 'To be the first choice for orthopaedic services for patients, carers and commissioners'.

We will continue to be an organisation with:

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

We will:

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

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

- Quality
- Integrity
- Leadership
- Innovation
- Partnership

Actively involving our staff

We have continued to pursue our service transformation programme based on lean methodology and have seen major quality improvements during the course of the year linked to this. Our Excellent Health programme has demonstrated improvements for staff as well as patients and has empowered our staff to lead and implement quality improvements within their own areas of work. As a result of some of this focus we have seen a reduction in falls and pressure ulcers for the second consecutive year. We have also seen the implementation of the Bone Infection Unit providing a much better patient experience, reducing length of stay and improving antibiotic prescribing as well as delivering efficiencies.

Visibility of the senior management team

The senior management team have developed the 'patient safety walkabouts' into wider 'leadership walkabouts' where, by visiting wards and service areas, they can see for themselves the standards of care and service we offer and hear from staff at all levels, what issues they feel need to be addressed.

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

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

Putting systems in place to give assurance

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

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

We have also received external and independent assurance on a number of key quality issues such as adult safeguarding, health and safety, tissue viability, privacy and dignity to identify areas of good practice and areas for improvement.

‘I have been kept fully informed of all aspects of my treatment including what will happen on my discharge’

‘There were no problems with waiting, staff always respond promptly’

Patient feedback to the CQC team

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

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

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

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

Donal O’Donoghue

Chief Executive Officer

PART 2

Priorities for improvement and statements of assurance from the Board

2.1 Progress against quality improvement priorities for 2011/12

In our 2010/11 Quality Account/report we set a range of priorities for 2011/12 that were agreed by the Board and stakeholders as important areas to focus on. The following tables show how we have performed against those priorities with further information available in Part 3.

Table 2 – Quality improvement priorities for 2011/12 that were achieved

Achieved	
Improvement priority	**Performance**
SAFETY	
90% of patients will be assessed for risk of venous thrombo-embolism	Target > 90% Achieved 92%
>90% of patient will have on-going falls risk assessments completed and evidence of care plans in place for those at high risk.	Target > 90% Achieved 92%
100% of patients whose condition deteriorates and requires transfer to the High Dependency Unit or an Intensive Care Unit will have their case notes reviewed to ensure trends are identified and actioned	Target 100% Achieved 100%
EFFECTIVENESS	
To establish readmission rates of our patients back to us and other hospitals	Achieved Implementation of the HED information system
To reduce length of stay for patients on the enhanced recovery programme	Achieved Primary hip length of stay reduced from 5 to 3 days Primary knee length of stay

	reduced from 5 to 3.5 days
EXPERIENCE	
To reduce the number of patients cancelled on the day of surgery by the hospital from an average for the year of 1.2% to <1%	Target <1% Achieved 0.9%
To increase the numbers of patients reporting in the national patient survey that they had received written information before admission to >65%	This question has changed in the national survey this year so a direct comparison is not possible. 88% of patients reported that they received the right amount of information about their treatment/condition

Table 3 Quality improvement priorities for 2011/12 that were not achieved

Not achieved	
Improvement priority	**Performance**
EXPERIENCE	
To reduce the % of patients who rated hospital food as poor as reported in the national survey to <12%	Target <12% Not achieved -13.6%
EFFECTIVENESS	
To reduce the length of time patients are starved before surgery to < 10 hours	Target < 10 hours Not achieved – 13.8hours

2.2 Quality improvement priorities for 2012/13

PRIORITIES	RATIONALE	MEASURING, MONITORING AND REPORTING
1. SAFETY		
90% of patients will be assessed for risk of venous thrombo-embolism (*This is also sometimes known as deep vein thrombosis or DVT and there are national guidelines on how to reduce this risk)*	This continues to be both a national and local priority	This will be measured monthly and reported via the corporate performance report to the Board.
Zero 'never' events	National and local improvement target following 2 never events during 2011/12	This will be measured monthly and reported via the corporate performance report to the Board.
To ensure actions from all SIRIs are completed within agreed timescales	This has been identified as a local improvement target to ensure learning from SIRIs is embedded	This will be measured quarterly and reported via the Quality Report to the Integrated Governance Committee.
2. EFFECTIVENESS		
To reduce the length of time patients are starved before surgery to < 10 hours *(Reducing starvation times before surgery is known to improve recovery)*	This continues to be a local priority as, although improvements have been made with increasing fluid intake, food intake has not seen the same improvement	This will be measured bi-annually and reported via the Quality Report to the Integrated Governance Committee.
To reduce the number of grade 3&4 pressure ulcers by	This continues to be a national and local	This will be measured monthly and

30%	priority ensuring the progress made last year in reducing these continues over the forthcoming year	reported via the corporate performance report to the Board.
To improve adherence with appropriate chemical vte prophylaxis in line with the CQUIN target	This continues to be both a national and local priority	This will be measured quarterly and reported via the corporate performance report to the Board.
3. EXPERIENCE		
To improve the % of patients reporting in the national survey that they receive information about their medication	This has been identified as a local priority by patients and commissioners	This will be measured quarterly and reported via the Quality Report to the Integrated Governance Committee.
To reduce the numbers of patients experiencing delays in the x-ray department	This has been identified by stakeholders and the Trust as an area where the patient experience could be improved	This will be measured via the PMO and reported quarterly via the Quality Report to the Integrated Governance Committee.
To reduce the numbers of patients reporting in the national patient survey that the quality of the food was poor*(Although we have made some improvements in this area patients are telling us they would like us to do more)*	The patient survey continues to identify that this is an area where we have not achieved the improvements we had hoped for. Our real time survey informs us that whilst the quality of food has improved we need to improve how it is served at ward level	This will be measured quarterly and reported via the Quality Report to the Integrated Governance Committee.

2.3 Statements of assurance from the Board

2.3.1 Review of services

During 2011/2012 The Royal Orthopaedic Hospital NHS Foundation Trust provided 4 NHS services (trauma and orthopaedic, neurosurgery, pain management and general medicine).

The Royal Orthopaedic NHS Foundation Trust has reviewed all the data available to it on the quality of care in all 4 of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 95% of the total income generated from the provision of NHS services by The Royal Orthopaedic Hospital NHS Foundation Trust for 2011/12.

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

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

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

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

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

- The Trust has been involved in a number of peer reviews including Safeguarding Vulnerable Adults (led at regional level) and Pressure Ulcer review (led by commissioners) and has welcomed the external scrutiny this has provided. These reviews provided assurance in these areas and supported the areas for further work that had already been identified within the organisation

- During the year the Trust has been inspected by the CQC in relation to Dignity and Nutrition and Outcomes 4, 9, 14 and 16 within the Essential standards of Quality. These inspections identified that the Trust met the requirements of these standards.

- A Trust Board workshop on quality and risk was held in March 2012 where a detailed review of the quality governance framework was undertaken. This included a review of the assurance received by the Board in relation to the quality governance framework and the identification of some areas for further work.

2.3.2 Participation in clinical audit

During 2011/2012 4 national clinical audits and 3 national confidential enquiries covered NHS services that The Royal Orthopaedic Hospital NHS Foundation Trust provides.

During that period The Royal Orthopaedic Hospital NHS Foundation Trust participated in 4 national clinical audits and 3 national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and the national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2011/12 were:

1. *National Joint Registry – hip and knee replacement*
2. *Patient Reported Outcome Measures – hip and knee replacement*
3. *Pain Database*
4. *NCEPOD Cardiac Arrest*
5. *Blood Transfusion audits*
6. *NCEPOD Peri-operative care*
7. *NCEPOD Surgery in Children*

The national clinical audits and national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust participated in during 2011/12 are as follows:

1. *National Joint Registry – hip and knee replacement*
2. *Patient Reported Outcome Measures – hip and knee replacement*
3. *Pain Database*
4. *NCEPOD Cardiac Arrest*
5. *Blood Transfusion audits*
6. *NCEPOD Peri-operative care*
7. *NCEPOD Surgery in Children*

The national clinical audits and national confidential enquiries that The Royal Orthopaedic Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, 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*	*100% either submitted or awaiting completion before submission.*
PROMS	*Yes*	*97% hips (Apr 11-Jan 12)* *96.5% knees (Apr 11-Jan 12)*
Pain Database	*Yes*	*N/a – no individual cases. Audit is about registration which has been completed.*
NCEPOD Cardiac Arrest	*Yes*	*Report due in June 2012. All eligible cases submitted.*
Blood Transfusion	*Yes*	*Trust has registered interest for this audit, not yet started.*
NCEPOD 'Peri-operative monitoring	*Yes*	*All eligible cases submitted.*
NCEPOD Surgery in Children	*Yes*	*All eligible cases submitted.*

The reports of these 7 national clinical audits were reviewed by the provider in 2011/2012 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- NCEPOD 'Knowing the Risk' report for peri-operative monitoring: this has generated a number of areas which the Trust will target in the coming year. Many of these relate to the Pre-Operative risk appraisal process and are being integrated into the workflows of the Pre-Op Questionnaire working group
- The level of compliance with the NJR and PROMS has continued to attain high levels this year. NJR data is now being used in performance appraisals of surgeons by clinical directors. PROMS data has been reviewed at Integrated Governance and has provided assurances regarding the quality of outcomes in hip and knee replacement.
- NCEPOD 'Are We There Yet' – Surgery in Children: the October 2010 report has been disseminated to the paediatric orthopaedic service.

The reports of 73 local audits were reviewed by the provider in 2011/12 and The Royal Orthopaedic Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- To review and improve locking procedures for drug fridges
- To re-audit day case conversions, to see if numbers have been reduced.

- To continue to improve and re-audit the review of venous thrombo-embolism (blood clot) risk assessments carried out and the frequency in which they are done
- To ensure all staff as well as patients and relatives are aware of the importance of plaster care instructions.
- To educate nursing staff and incoming junior medical staff about the serious risks/complications of epidural blocks/infusions.
- Review the recent multidisciplinary health records audit with a view to continuing to improve the layout of patients medical notes and implement multi-disciplinary records
- Continue to monitor changes to planned order of theatre lists and ensure appropriate list planning.

"This year we have concentrated on the hospital audit meeting; in particular efforts to bring the themes relating to risk management, root cause analysis and individual and corporate learning. We hope that these ideas will continue to mature and improve next year. We have an IT solutions planned for 2012 and 2013 that aim to facilitate improved audit commissioning in line with the strategic objectives of the Trust"

Matt Revell, Clinical Director, Clinical Outcomes

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

2.3.3 Participation in clinical research

The number of patients receiving NHS services provided by The Royal Orthopaedic Hospital NHS Foundation Trust in 2011/2012 that were recruited during that period to participate in research approved by a research ethics committee was 201.

*The Royal Orthopaedic Hospital NHS Foundation Trust was involved in conducting 31 clinical research studies in orthopaedics during 2011/12. Over the same period, mortality amenable to healthcare/mortality rate from causes considered preventable in orthopaedics changed from the previous year by **x** %. 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 41 clinical staff participating in research approved by a research ethics committee at The Royal Orthopaedic Hospital NHS Foundation Trust during 2011/12. These staff participated in research covering 7 sub -specialties.

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

There have been 13 publications generated from other research activity (appendix 1).

2.3.4 Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of The Royal Orthopaedic Hospital NHS Foundation Trust's income in 2011/2012 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 2011/12 was £837,152. The payment made to the Trust was £784,830, an achievement of 94% of the total potential value.

Further details of the agreed goals for 2011/2012 and for the following 12 month period are available on request from the Trust's Head of Commissioning, Gareth Hyland, Gareth.Hyland@nhs.net.com)

2.3.5 Statements from the Care Quality Commission

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

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

The Care Quality Commission has not taken any enforcement action against The Royal Orthopaedic NHS Foundation Trust during 2011/2012.

The Royal Orthopaedic Hospital NHS Foundation Trust has participated in special reviews or investigations by the CQC relating to the following areas during 2011/12, Dignity and Nutrition for Older people (Outcomes 1 and 5). The Royal Orthopaedic Hospital NHS Foundation Trust was found to be compliant with the requirements of both of these standards and intends to continue work in both these areas. The Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- *Improve availability of information for patients and visitors on how to raise concerns*
- *Undertake review of meal delivery at ward level to identify ways to improve this*

The Royal Orthopaedic Hospital NHS Foundation Trust has made the following progress by 31st March 2012 in taking such action:

- *Posters and leaflets advising patients and visitors on how to raise concerns are available*
- *Review is underway of meal delivery at ward level looking at different ways of working for the nursing and catering teams.*

2.3.6 Data Quality

The Royal Orthopaedic Hospital NHS Foundation Trust will be taking the following actions to improve data quality.

- We have refreshed the Data Quality Policy
- We have re written the Clinical Coding Policy
- Put a rolling Data Quality audit in place to enable regular checks
- Created a Clinical Communication Strategy to engage clinicians in the importance of accurate clinical notes and added this to the re written Clinical Coding Policy
- We have added a Risk Log to Data Quality Group to ensure problem areas are discussed in our Data Quality Meetings.

2.3.7 NHS Number and General Medical Practice Code Validity

The Royal Orthopaedic Hospital NHS Foundation Trust submitted records during 2011/2012 Secondary Uses Service for inclusion in Hospital Episode Statistics which are included in the latest published national data.

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

98.1% for admitted care (taken from month 9 2011/12 SUS DQ reports from Information centre)

99.9% for outpatient care (taken from month 9 2011/12 SUS DQ reports from Information centre)

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

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

- *100% for admitted care (taken from month 9 2011/12 SUS DQ reports from Information centre)*
- *100% for outpatient care (taken from month 9 2011/12 SUS DQ reports from Information centre)*

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

The Royal Orthopaedic Hospital NHS Foundation Trust's Information Governance Assessment Report score overall score for 2011/2012 was 76 % and was graded 'satisfactory'

2.3.8 Clinical Coding error rate

The Royal Orthopaedic Hospital NHS Foundation Trust was subject to a 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 diagnosis and treatment coding were an average HRG error rate of 3.5% (national average 9.1%) and an average error rate of 4.2% (national average 11%)

All services were included in the audit sample and these results should not be extrapolated further than the actual sample audited.

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PART THREE

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

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 2011/12 has been to embed our strategy alongside a culture of continual quality improvement. This has become increasingly important in the current financial climate and has made our commitment to providing a quality service even stronger

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

The Board receives feedback from patients in a number of different ways and is aware of where our services do not meet patient expectation. The focus of the Board is to continually champion improvements in these areas whilst ensuring that we continue to balance the books.

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

All of these interests can sometimes compete, but the challenge remains to make them complementary to one another.

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

We set a range of priorities for 2011/12 that were agreed by the Board and stakeholders as important areas to focus on. The following tables show how we have performed against those priorities.

3.1 Quality improvement priorities for 2011/12 that were achieved

	Achieved			
Improvement priority	**Performance 2011/12**	**Performance 2010/11**	**National definition**	**Data source**
SAFETY				
90% of patients will be assessed for risk of venous thrombo-embolism	Target > 90% Achieved 92%	>90%	Yes - national CQUIN	Unify
>90% of patient will have on-going falls risk assessments completed and evidence of care plans in place for those at high risk.	Target > 90% Achieved 92%	Not measured	No	Audit data
100% of patients whose condition deteriorates and requires transfer to the High Dependency Unit or an Intensive Care Unit will have their case notes reviewed to ensure trends are identified and actioned	Target 100% Achieved 100%	Not measured	No	Monthly review meetings
EFFECTIVENESS				
To establish readmission rates	Achieved with the	No target set	Yes	HED

of our patients back to us and other hospitals	implementation of the HED information system			
To reduce length of stay for patients on the enhanced recovery programme	Achieved Primary hip length of stay reduced from 5 to 3 days Primary knee length of stay reduced from 5 to 3.5 days	5 days	Yes	Enhanced recovery programme
EXPERIENCE				
To reduce the number of patients cancelled on the day of surgery by the hospital from an average for the year of 1.2% to <1%	Target <1% Achieved 0.9%	1.2%	No	Corporate performance report
To increase the numbers of patients reporting in the national patient survey that they had received written information before admission to >65%	This question has changed in the national survey this year so a direct comparison is not possible. 88% of patients reported that they received the right amount of information about their treatment/condition	<65%	National inpatient survey	National inpatient survey

3.2 Quality improvement priorities for 2011/12 that were not achieved

Not achieved			
Improvement priority	**Performance**	**National definition**	**Data source**
Experience			
To reduce the % of patients who rated hospital food as poor as reported in the national survey to <12%	Target <12% Not achieved - 13.6% (2010/11 = 12%)	National patient survey	National patient survey
Effectiveness			
To reduce the length of time patients are starved before surgery to < 10 hours	Target < 10 hours Not achieved – 13.8hours (2010/11 = 13.9 hours)	Yes – standards based on Royal College of Anaesthetists	Audit data

3.3 Excellent Health

The Board is committed to ensure that all decisions have the patient and service quality at the centre of every decision made even when considering how to respond to the financial challenge faced by the Public Sector and the Health Service. A key element of our strategy to ensure that we do this even when it is difficult is the Excellent Health Programme.

The programme places the patient and quality at the centre of a process and aims to cut across traditional silo working and by bringing front line staff into project teams it empowers them to redesign processes and pathways to cut waste whilst improving the patient experience.

The programme has seen the introduction of resource scheduling model and process which will reduce waiting times and service peaks and troughs whilst saving £2.5m,

improvement projects in specific areas e.g. theatres where new working models have been introduced, physiotherapy where a review enabled a more flexible service with longer opening hours and a cost saving and x-ray where work has improved the patient experience and waiting times and projects that have decreased the average length of stay and helped an earlier discharge.

The programme is run from a Programme Management Office which has increased the number of staff involved in change projects and helped staff from all levels and disciplines work together to create innovative solutions to improving quality whilst reducing cost.

3.3 Building for the Future

"We have been planning our new and exciting Admissions and Day Case facility over the last few months and we are pleased to report that the building of Phase One of the project is on site. This facility will bring together our Admissions and Day Case facilities right next to our current Theatres in a pleasant environment and will greatly improve the service to our patients"

Colin Rea – Head of Estates

We have also been planning a new restaurant which will be located in the foyer of the Treatment Centre. It contains a state-of-the-art servery, a restaurant for 40 people, a small coffee area and a dedicated staff coffee room. We will have a patio for those who wish to dine alfresco in the summer.

Work will start in March 2012 and be completed by July 2012.

During the year we have also installed a new three Teslar MRI machine in our existing MRI suite. A temporary MRI scanner was hired to provide a service whilst the current department was upgraded. Extensive engineering works were required to provide new air conditioning for both the patients and plant areas. The building was completely rewired and reheated along with the new internal finishes creating a pleasant environment for both staff and patients.

We are currently on-site with our next major project which involves the Trust in providing a new Admissions and Day Case facility.

This project combines our current Admissions facility with our Day Case Unit.

Phase One involves us providing new foundations and structural support to the area below Ward 10 which will eventually be the Admission and Day Case Unit (ADCU) once completed. This will accommodate 20 patients in chairs or on a trolley. Phase

One will be completed in June 2012 which will be immediately followed by Phase Two which is the work to the main department and will use the building known as the Octagon as its entrance where all patients will be received. The new department is located right next to our existing Theatres so patients requiring an operation only have to travel a short distance to Theatres. Work will be completed on this project by March 2013.

3.4 Putting Patients First

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

As part of the improvement process, PALS and Complaints, Patient Experience and Patient Information were moved into the Public Engagement Department to create a new Public and Patient Services Department. The merging of these services has ensured the facilitation of comparison of all sources of data. As a result, the Trust is able to respond more quickly to identified trends and take action where necessary to improve issues identified by Patients and their families. It is also able to identify areas of good practice in real time and share this quickly across all areas.

There has been a 9% reduction in Complaints compared to the previous year. The department has been subject to major changes in the last year, including changes to how complaints are managed and line management responsibilities. The on-going work to evaluate, streamline and improve Complainant satisfaction with the process will continue into the forthcoming year.

The new department of Public and Patient Services is creating a different way for clinical and non-clinical services to work together to improve the care that patients receive. We continue to collect feedback from patients in a number of different ways including a 'real time' survey, local departmental surveys, patient stories and by observing the care that patients receive. By reacting quickly to and collating this information, we have made a number of changes to services including, staggering admission times, challenging poor care, changing menus and providing information about the side effects of new medicines more clearly.

In order to improve information for patients we have introduced an Information Hub for Oncology patients in the OPD which gives patients access to a wide variety of information and signposts to other services for help and support

This work is part of our programme in developing Information Prescriptions for patients so that each individual receives all the information relevant to them and their needs.

The hospital continues to perform well in the national inpatient survey scoring 'better than expected' in seven out of the eight areas published by the Care Quality Commission. The hospital scored 'as expected' in one domain.

The outpatient survey demonstrated a number of areas for improvement including appointment arrangements, waiting times and patient information. Work has commenced to ensure improvements in this area.

3.5 Patient falls

Building on from our success of last year we have continued to focus on making improvements in this area. Overall the number of adult inpatient falls has reduced for the second consecutive year with a total of 82 falls, a further 4% reduction from 2010/11.

Whilst we continue to reduce the absolute number of falls our focus this year has been on improving the risk assessments and care of those patients that do fall.

Our quarterly audits of practice in this area have demonstrated that we have achieved significant improvement in a number of areas:

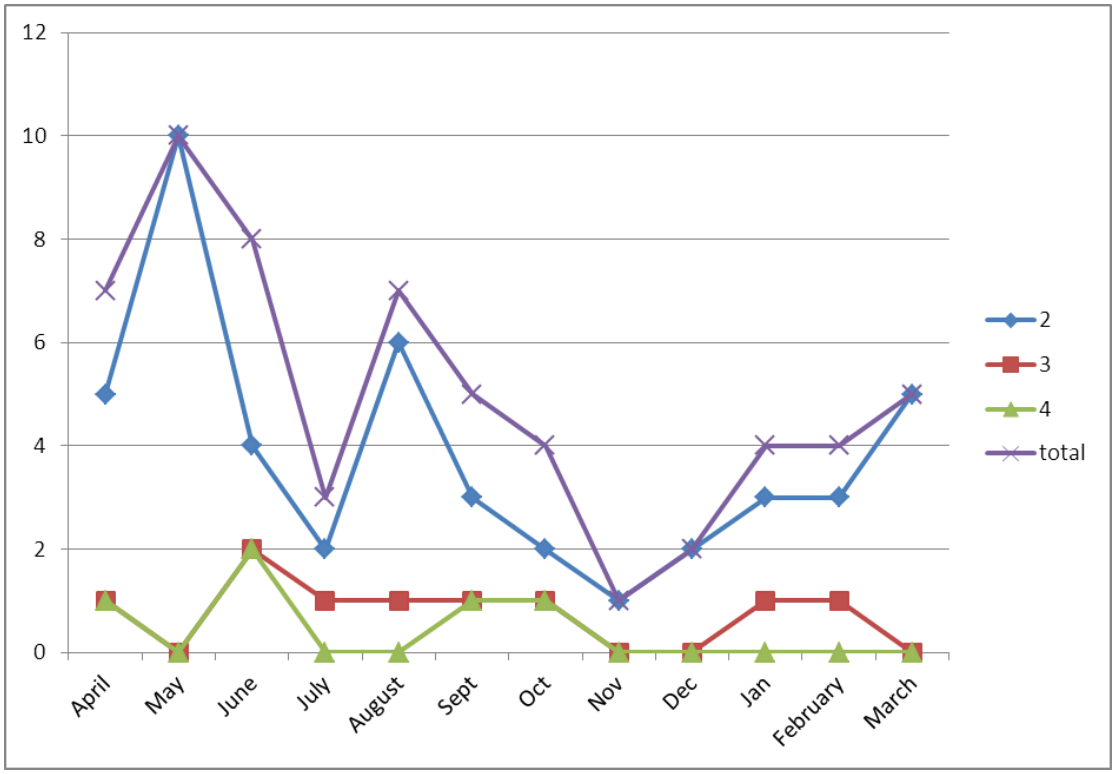
Quarterly falls audit results 2011-12

		Q4	Q3	Q2	Q1
Q1.	Has the patient had a falls risk assessment completed?	95%	94%	92%	81%
Q2.	Has the patient been reassessed as per falls risk assessment and management plan?	90%	80%	65%	62%
Q3.	All patients highlighted at risk have an appropriate plan of care and preventative steps outlined and acted upon?	92%	82%	72%	76%
Q4.	Has the patient had neurological observations taken and recorded (using the Glasgow Coma Score)?	100%	80%	57%	
Q5.	If patient has fallen, is there a post fall management care plan in use?	100%	90%	100%	62%
Q6.	Has the Post Fall Management Protocol been followed?	100%	80%	57%	

3.6 Pressure ulcer prevention

The prevention of hospital acquired pressure ulcers and providing the best care for patients with pressure ulcers has continued to be a priority this year.

Good progress continues to be made in reducing pressure ulcers with the table below demonstrating the reduction in the number of hospital acquired pressure ulcers over the year. Overall numbers have reduced for the second consecutive year from 64 in 2010/11 to 54 in 2011/12 (15%). In year there has been a reduction in grades 3&4 from 6 in Q1 to 2 in Q4.



All nursing staff groups receive training in the prevention and management of pressure ulcers. A total of 213 members of staff including students have received training during the year.

A training event day was organised to combine the services of infection prevention and control, Tissue viability and Nutrition. The training day on 27th September was attended by our link nurses from each of these groups. Lectures were provided by the infection control nurse specialist, dietician, consultant microbiologist, Nurse Lecturer specialist in pain management and Tissue viability nurse. A total of 39 nurses attended the training day and the feedback was very positive.

Additional pressure relieving equipment was brought in the summer resulting in a reduction in Grade 2 pressure ulcers across the Trust and additional mattresses have been brought at the beginning of this year to reduce pressure ulcers in the higher risk

areas i.e. spinal and oncology. The increase in numbers in March has reduced in April.

Patients at increased risk of developing pressure ulcers or those nutritionally at risk are now being identified with “AT RISK” stamped on their pre-operative documentation to ensure wards and theatres are aware of their vulnerability to developing pressure ulcers.

3.7 Nutrition

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

This year we have seen a significant increase in compliance with on-going assessment of patient’s nutritional status. Referral to the dietetic service and the implementation of appropriate plans of care for at risk patients has also improved.

Patients who are identified as being nutritionally “AT RISK” are now having this stamped in red on their admission documentation, and also on their pre-operative checklist, to highlight those as cause for concern. This is been commenced in pre op assessment clinic and followed through to admission.

We also introduced a link chef system whereby each ward has their own link chef with whom they can discuss nutrition and address issues.

The delivery of food to patients at ward level will be a key focus moving forward as we know from the patient survey and our own inspections that this is an area that could be improved.

Audit work has demonstrated that we have successfully reduced the length of time patients are not receiving fluids before surgery from 8.3hrs to 7.3 hours. Disappointingly similar improvements have not been seen in starvation times and this will remain a focus for the coming year. Work to identify best practice has started and plans are in place as part of the enhanced recovery programme to pilot new initiatives in this area.

3.8 Healthcare acquired infections

We know how important not getting an infection is for patients and we have continued to build on our successful infection prevention and control programme. For the fourth successive year we have not had any MRSA bloodstream infections

Compliance with our antibiotic guidelines has continued to improve to reduce the risk of patients getting *clostridium difficile* (c.diff) and we have achieved our target of less than 7 cases with a total of 6 cases for the year.

Scrutiny of antimicrobial prescribing and handwashing during the year has resulted in improvements in both areas and this will continue into next year.

Our wound helpline has continued to be successful with an increasing number of patients contacting us for help and support in this area

3.8.1 Bone Infection Unit

During the year we piloted the implementation of a Bone Infection Unit to try and improve the way we care for patients with bone infections. This was a great success and has now been implemented as a permanent service enabling patients to be cared for in their own homes, in many cases preventing the need for long stays in hospital for antibiotics.

The pilot demonstrated much improved patient satisfaction, shorter lengths of stay, improved antibiotic prescribing and better management of complex wounds enabling the trust to reduce the number of beds it needs to provide for these patients

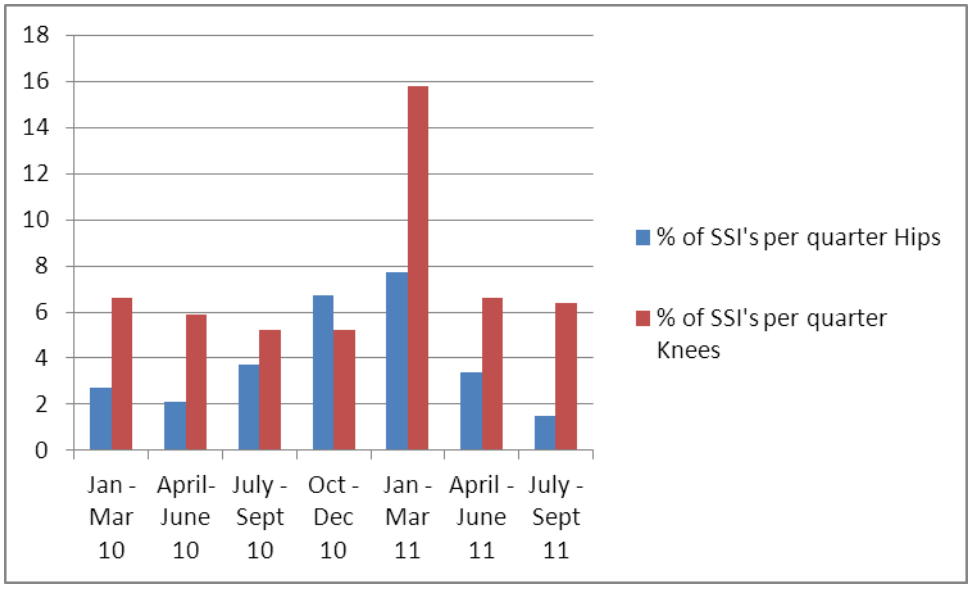
'I felt better being at home from simply being at home in my own environment and was able to enjoy the freedom that brings with it.'

'First class care, one-to one attention, phone calls, visits – absolutely excellent care'

Bone Infection unit patients

3.8.2 Surgical Site Infection (SSI)

Nationally reportable SSI data shows the Trust as having very low SSI rates but we felt that we wanted to follow these patients more closely for a longer period of time to get a more accurate picture. We are now able to collect robust data as we follow patients up for 30 days. This data is shown below.



*Jan-Mar 2011 - low response rate has impacted on results

By August of 2012 we will have collected 3 years of SSI data allowing us to pick up significant trends that can be actioned accordingly. Some of these infections can lead to deep infections which are very difficult to treat and very distressing for patients which is why it is important we do all we can to reduce these.

As a result of monitoring these infections we have reviewed our antibiotic prescribing, use of skin preparation and patient warming during surgery and will be moving towards implementing the full SSI care bundle duing the coming year.

3.9 Ensuring the privacy and dignity of our patients

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

We held a celebration event during the year to continue to engage with all staff in the Trust and highlight the areas of good practice and demonstrate how small changes made can make a big difference to our patients care experience. We used a 'Future Tree' where staff and the general public were asked to write up what they want to see in the Trust in the future regarding privacy and dignity

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

We have continued to use feedback received from mystery shopper patients providing another voice. Patients are supported to provide feedback to help us then

take action to look at some of the following areas: facilities, sign posting to information, help and advice, staff interactions

Our 7 P's for Privacy and Dignity has been launched via staff training and the celebration event - process, people, place, polite , professional , patient, prepared.

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

'As a champion I try to ensure that I keep in mind at all times the importance of seeing the person in the patient and that patient centred care is a human right'

"Providing good care matters to us as staff and our everyday interactions with patients are very important"

Privacy and dignity champions

3.10 Safeguarding

During the year there has been additional resource allocated to safeguarding (adult and children) to strengthen training, provide better links with external agencies and to deliver the recommendations from the peer review.

3.11 Chaplaincy services

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

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

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

Religious Calendar Events are held throughout the year and are displayed on the noticeboard outside the Prayer, Contemplation and Meditation Room and on the Trust Intranet. Currently, there are regular Anglican and Roman Catholic Services lead by our Chaplains for patients and staff to attend. Leaflets about the chaplaincy service are available via the Trusts internet site under patient information.

3.12 Our workforce

Our staff have continued their work to improve quality during the year. A programme of customer care training has been put in place for all staff in a customer facing role with the aim of the programme to improve the quality of service given to patients, carers and to colleagues. The review of our patient administration is underway with the overall aim to improve the experience of patients in their initial contact with the Trust in particular to create a single point of contact for patients at any stage in their care.

During the year we focused on ensuring all staff attended mandatory and statutory training to ensure their knowledge and skills of key activities that impact on patient safety and quality was up to date. This was an area of risk that we had identified during the year and we have made significant improvements, from 59% to 85%, in this area and will continue this during 2012/13.

We continue to welcome undergraduate, post-graduate and work experience students. Feedback from undergraduate nursing students and post-graduate doctors consistently indicate the learning opportunities at the Trust contribute greatly to their knowledge, ability and confidence to practice. We continue to offer apprenticeships in a variety of roles and over half of those who completed the apprenticeship programme have now gained employment at the Trust in a variety of administration, IT and health-care roles.

Progress towards our strategic aim of enhancing academic research in the Trust continues with an agreement to appointment jointly with the University of Birmingham an additional surgical consultant to focus on oncology research. We hope this will be the first of several appointments to support the continued development of improved ways of treating and caring for orthopaedic patients.

We have re-launched our approach to appraisal to enable a discussion of both performance and personal development and how each member of staff lives the Trust's values. This is now being embedded across the Trust. Our progress to implement the requirements of revalidation of medical staff is advanced in readiness for the formal start of the process by the General Medical Council later in 2012.

We have continued to prioritise staff health and well-being during 2011/12 to enhance patient care through improved staff attendance and retention. In January 2012 we held a health and well-being event for staff which enabled over 300 of our staff to learn about managing stress, understand their health risks and participate in rowing and running challenges to increase their levels of physical activity. These were well received by staff and will continue during 2012/13.

During December 2011 and January 2012 the underlying trend of sickness absence deteriorated which was a cause for concern, particularly the potential impact on quality of care provided to patients as a result. The Trust put in place a number of interventions to both improve the health and well-being of staff and improve the management of staff who are absent including sharing best practice, increased support for line managers and health education events. Early indications are that these actions are reducing absence and these will be sustained during 2012/13

3.12.1 Staff survey

This year our response rate in the national staff survey increased to 61%. This is above average for acute specialist trusts.

Our top four ranking scores were:

Key Factor	This Year's Score	National Average	Comparison to last year
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	99%	96%	No significant change
Quality of job design (clear job content, feedback and staff involvement)	3.56	3.44	No significant change
Impact of health and well-being on ability to perform work or daily activities	1.49	1.55	No significant change
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	11%	14%	No significant change

Our bottom four ranking scores were:

Key Factor	This Year's Score	National Average	Comparison to last year
Percentage of staff receiving job-relevant training, learning or development in the last 12 months	73%	77%	No significant change
Percentage of staff witnessing potentially harmful error, near misses or incidents in month	36%	31%	No significant change
Percentage of staff suffering work-related injury in last 12 months	16%	13%	No significant change
Percentage of staff saying hand washing materials are always available	61%	67%	No significant change

Disappointingly the number of staff who recommend the Trust as a place to work or receive treatment is worse than average, compared to other acute specialist trusts and we will work with staff to understand the reasons for this in 2012/13. We will also continue to engage with staff to improve patient safety as indicated in this report which will assist in reducing the number of potentially harmful incidents witnessed by staff.

3.13 Public engagement

Public Engagement in 2011/12 continued to be key to the trust's work with increasing numbers of staff across the trust using member surveys to inform their work as well as external NHS bodies seeking views from our membership on public health matters.

Volunteers have become more involved in the delivery of patient surveys securing much higher return rates and also allowing the trust to implement surveys across almost all patient contact areas.

This year the Trust also produced a promotional video screened in the Birmingham Bullring to a footfall in excess of 50,000 people and this also gave feedback on public awareness of the trust and its reputation.

The introduction of car parking charges later in the financial year necessitated significant consultation with the public and patients and this has allowed a relatively smooth introduction of a controversial decision.

The trust has held workshops for its Members' Council to prepare for the introduction of the new legislative framework for the NHS and this has helped frame governance intentions for the coming year. The role of membership as a large and segmented customer panel will be maintained and the trust will consider the benefits of liaison with the new Health Watch bodies as their role emerges in 2012/13.

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

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

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

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

Many members of the public are familiar with the 18 week target and this gives patients the right to expect that from their initial referral to the necessary treatment (such as an operation or physiotherapy), they have to wait no more than 18 weeks. There will always be exceptions – sometimes for clinical reasons and sometimes because of the sheer level of demand on the surgeons and the absence of colleagues elsewhere with the skills to offer treatment. For us, this is particularly true in spinal surgery and paediatric spinal deformity where we have now influenced a national review of the sub-specialty.

The table below shows our track record against these targets. When we benchmark ourselves against other orthopaedic departments we continue to find that our achievements are better than most.

National target	08/9	09/10	10/11	11/12	Target
Fully meet all core standards	Achieved	Achieved	n/a	n/a	
MRSA	Achieved 2 cases	Achieved – 0 cases	Achieved – 0 cases	Achieved – 0 cases	
C diff	Achieved 7 cases	National target - achieved Local target – not achieved 9 cases	National target – achieved Local target – not achieved 8 cases	Achieved 6 cases	Local target of 7 since 09/10
31day subsequent treatment all cancers	NA	Achieved – 100%	Achieved – 100%	Achieved – 99%	94% standard
31 diagnosis to treatment all cancers	Achieved- 100%	Achieved – 100%	Achieved – 99.3%	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%	85% standard
2 week cancer wait	Achieved- 100%	Achieved – 99%	Achieved – 99.5%	Achieved – 99%	93% standard
18 week referral to treatment admitted	Achieved- 88%	Achieved – 91.6%	Achieved – 90.5%	Achieved 90.2%	Target since 09/10 is >90%
18week referral to treatment non admitted	Achieved- 87%	Achieved – 95.2%	Achieved – 95.2%	Achieved 95.1%	Target since 09/10 is 95%
Screening all emergency / elective	NA	Achieved- 102.9%	Achieved – 105%	Achieved – 106%	100% target

admissions for MRSA					
Access to healthcare for people with learning disabilities	NA	Achieved	Achieved	Achieved	

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3.15 Measuring quality as we move forward

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

The Board have agreed to a move towards a system developed by the University Hospital Birmingham NHS Foundation Trust, known as the Health Evaluation Data tool. This system in development allows us to have much closer collaboration with the system designers, so that reporting on a unit level is planned across the major outcomes domains. A new post has been created within the IT department. This emphasises the importance the Trust intends to give to outcomes and should to allow the best possible integration and the coordinated use of our information to measure performance.

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

Appendix 2 of this report identifies the current position with the quality indicators that have been identified by the DH for inclusion in Quality Reports as of 2012/13.

There is never a day passes that I or any of my colleagues lose sight of the importance of quality at our hospital and it is central to the way we go about our business. We set ourselves very high standards and we are never satisfied with mediocre performance. We constantly look at ways in which we can improve quality and we have made many improvements throughout the hospital over the past year. Of course we don't always get in right but our culture is such that we are open about our shortcomings and we learn from them.

At the Board quality is a topic that is dealt with in an informed and challenging manner. We have comprehensive measures to inform us of our performance against key safety measures and these are supplemented by first-hand accounts gained by non-executive directors undertaking regular organised and informal visits to all parts of the hospital. It is an approach that ensures that quality is always top of our agenda and dealt with comprehensively.

We are eager to be the best and in doing so strengthen our reputation as a specialist orthopaedic centre. In a world where patients are having greater influence over their healthcare provision we want to be the first choice for patients based upon our reputation for excellent care and superior outcomes. We are lucky that we have such a loyal group of staff and proud members to support us in this challenge and it is through them that we shall further our ambition.

Everyone within the Trust has a passion and commitment for quality and whatever their role they recognise that individually and collectively they are key to our success. Our focus on quality is what differentiates us from other hospitals and is central to the achievement of our goals.

Laurence James - Chairman

4.0 ANNEX

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

4.1 Statement of Birmingham LINk

No statement provided

4.2 Overview and Scrutiny Committee

No statement provided

4.3 Statement of Birmingham and Solihull NHS Cluster

This statement from Birmingham and Solihull NHS Cluster as Lead commissioner for the Royal Orthopaedic Hospital Trust has been developed in consultation with key leads within the Birmingham and Solihull NHS Cluster (including shadow clinical commissioning groups). The Quality *Account for 2011/12 has been reviewed in line with the Department of Health guidance* and we can confirm that to the best of our knowledge that this quality account is a fair and accurate reflection of the 2011/12 outcomes against the identified quality standards.

We have taken particular account of the identified priorities for improvement and the rationale for its inclusion to the quality improvement programme. We have also taken into account mechanism for monitoring and reporting the outcomes within the action plan to ensure delivery; of which we are encouraged will deliver real improvements in the care of patients. Commissioners are particularly pleased to observe the references (1) to improving the percentage of patients reporting that they receive information about their medication and (2) to ensure the actions from all Serious Incidents Requiring Investigation are actioned and completed within the agreed timescales.

The Trust recognises that the improvement priority for 2011/12 to reduce the number of patients reporting in the national survey that the quality of the food was poor; was not achieved. However, Commissioners are assured that this priority has been maintained in the Trusts objectives for 2012/13.

Birmingham and Solihull NHS Cluster have a well-established quality assurance monitoring programme with the Trust which includes monthly contract monitoring meetings, bi-monthly Quality Committee meetings and quarterly performance meetings. To strengthen this process we have undertaken both announced and unannounced visits and themed reviews during 2011/12. In addition, during financial

year 2011/12 the Royal Orthopaedic Hospital and Birmingham and Solihull Cluster undertook an Assurance Review following an identified increase in the number of Serious Incidents Requiring Investigation (SIRI). As a result, a joint action plan was developed and actions implemented within the defined timescales. Commissioners have been assured by the demonstrated marked improvement in the implementation and compliance of use with the WHO safer surgery checklist. Commissioners are also pleased to see a 'zero tolerance' for NEVER events as a priority within their safety agenda. The monitoring mechanisms described above provide commissioners with a good understanding of the issues being addressed by the Trust and the internal systems and processes that are in place to provide quality assurance. Regular meetings with the Trust have also contributed to sustaining and improving an effective working partnership during this period. Given the considerable changes that lie ahead across the Birmingham and Solihull NHS Cluster health economy and the new developments in commissioning we welcome our strengthened engagement with the Royal Orthopaedic Hospital Foundation Trust to deliver the quality agenda.

In summary, the Quality Account provides a balanced view of the Trusts achievements throughout 2011/12 and highlights areas for development for financial year 2012/13.

Observations and comments made - which requires attention by the provider

- Page 22 refers to surgical site infection and the chart illustrates an increase in Jan 2011 – March 2011. Whilst I appreciate that this is out of the period for this report I understand that work carried out this year was in part prompted by this and I think that there should be mention that the numbers have reduced. The trust would be encouraged to comment on their achievements in meeting CDI objective and any work that they have undertaken in terms of antimicrobial prescribing to bring this about. I understand that the trust have made improvements in their hand hygiene compliance in this financial year.

- Not a great deal of information regarding adult safeguarding. Have had discussions with safeguarding adults lead about MCA/DOLS but these figures have improved recently.

- Yes with the exception of little reference to service provided to children and safeguarding responsibilities. ROH provide a Paediatric orthopaedic ward there is no reference to Quality indicators for Paediatric care or safeguarding of children within their care, I am aware from the Named Nurse of the trust they are developing their safeguarding children arrangements and it seems a missed opportunity not to acknowledge the developments made.

- Improvement priority target 3 transfer to intensive care surely this is an essential and requires 100% compliance. Readmission rate using HED system, lack of details and no actual data.

- Several areas of report mentioned significant improvement in services e.g. mandatory training and policy changes & data quality but not substantiated by

any figures/comparisons. Several audits mentioned but not attached e.g. staff survey/nutrition audit. Clinical research section not complete.

- Report is disappointing and does not go into sufficient detail in a number of areas e.g. NHS Number and General Medical Practice Code Validity (page 14) – overall score was 76% graded as satisfactory, but no details on areas on strengths and weaknesses.

- Improve the % of patients reporting that they receive information about their medication - lack of any details or data

- Not clear to me what local CQUINs has been agreed or defined

- Lots of areas that have no detail at all. Page 12 and 13 – lots of XXXX and blank spaces. Lots of comments about food and Nutrition (page 7) but later in the document they report that are CQC compliant – no details. They reference improvements but do not state numerical data to support this.

- Overall total pressure ulcer numbers seems to be rising again.

- Quality rounds by senior nurses/matrons/non executives /leadership all very vague. Lack of any detail of what is measured, recorded /quality metrics that are captured etc. and how quality issues are disseminated /feedback to the workforce.

- Has an equality analysis been undertaken around the priorities of providing information on medication and also quality of food? For example: the provision of information needs to be in an accessible format an equality analysis might drive quality improvements in this area.

- An equality analysis around the quality of food might reveal that people who share a particular characteristic are not having their dietary needs met and so are not satisfied with the quality of the food.

Denise McLellan

Chief Executive

NHS Birmingham & Solihull Cluster.

How to provide feedback on the account

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

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

Email:Lindseywebb@nhs.net.com

Telephone: 0121 685 4233

Address: The Royal Orthopaedic Hospital NHS Foundation Trust, Bristol Road South, Northfield, Birmingham B15 2TH

Appendix 1: Research publications

1: McBride TJ, Jewell DP, Deshmukh SC.
BONE GRAFTING IN FOUR-CORNER MID-CARPAL FUSION.
Hand Surg. 2012 2012;17(1):143-144. PubMed PMID: 22351554.

2: Thomas MS, O'Hara JN, Davies AM, James SL.
Profunda femoris pseudoaneurysm following Birmingham hip resurfacing: an important differential diagnosis for a periarticular cystic mass.
Skeletal Radiol. 2011 Dec 24. [Epub ahead of print]
PubMed PMID: 22197889.

3: Haniball J, Sumathi VP, Kindblom LG, Abudu A, Carter SR, Tillman RM, Jeys L, Spooner D, Peake D, Grimer RJ.
Prognostic factors and metastatic patterns in primary myxoid/round-cell liposarcoma.
Sarcoma. 2011;2011:538085. Epub 2011 Nov 28. PubMed PMID: 22190864; PubMed Central PMCID: PMC3236386.

4: Gaston CL, Bhumbra R, Watanuki M, Abudu AT, Carter SR, Jeys LM, Tillman RM,Grimer RJ.
Does the addition of cement improve the rate of local recurrence after curettage of giant cell tumours in bone?
J Bone Joint Surg Br. 2011 Dec;93(12):1665-9. PubMed PMID: 22161931.

5: Smith GM, Johnson GD, Grimer RJ, Wilson S. Trends in presentation of bone and soft tissue sarcomas over 25 years: little evidence of earlier diagnosis.
Ann R Coll Surg Engl. 2011 Oct;93(7):542-7. PubMed PMID: 22004638.

6: Matharu G, Thomas A, Pynsent P. Hip abductor re-attachment audited using a wire marker.
Acta Orthop Belg. 2011 Aug;77(4):494-6. PubMed PMID: 21954758.

7: Douis H, James SL, Grimer RJ, Davies MA. Is bone scintigraphy necessary in the initial surgical staging of chondrosarcoma of bone? Skeletal Radiol. 2012 Apr;41(4):429-36. Epub 2011 Sep 3. PubMed PMID: 21892729.

8: Snow M, Cheung W, Mahmud J, Evans S, Holt C, Wang B, Chizari M. Mechanical assessment of two different methods of tripling hamstring tendons when using suspensory fixation.
Knee Surg Sports Traumatol Arthrosc. 2012 Feb;20(2):262-7.
Epub 2011 Jul 21. PubMed PMID: 21779795.

9: Malhas AM, Grimer RJ, Abudu A, Carter SR, Tillman RM, Jeys L. The final diagnosis in patients with a suspected primary malignancy of bone.
J Bone Joint Surg Br. 2011 Jul;93(7):980-3. PubMed PMID: 21705575.

10: Dawlatly SL, Dramis A, Sumathi VP, Grimer RJ. Stewart-Treves syndrome and the use of positron emission tomographic scanning.
Ann Vasc Surg. 2011 Jul;25(5):699.e1-3. Epub 2011 Apr 21. PubMed PMID: 21514109.

11: Gaston CL, Tillman RM, Grimer RJ. Distal femoral physeal growth arrest secondary to a cemented proximal femoral endoprosthetic replacement.
J Bone Joint Surg Br. 2011 May;93(5):708-10. PubMed PMID: 21511941.

12: Fisher NE, Patton JT, Grimer RJ, Porter D, Jeys L, Tillman RM, Abudu A, Carter SR.
Ice-cream cone reconstruction of the pelvis: a new type of pelvic replacement: early results.
J Bone Joint Surg Br. 2011 May;93(5):684-8. PubMed PMID: 21511936.

13: Pradhan A, Grimer RJ, Spooner D, Peake D, Carter SR, Tillman RM, Abudu A, Jeys L.
Oncological outcomes of patients with Ewing's sarcoma: is there a difference between skeletal and extra-skeletal Ewing's sarcoma?
J Bone Joint Surg Br. 2011 Apr;93(4):531-6. PubMed PMID: 21464495.

Appendix 2
Current position against mandatory indicators for inclusion in the 2012/13 Quality Report/Account

Indicator summary	Location of latest available published data	Latest available published data	Commentary
Summary Hospital-level Mortality Indicator: • SHMI value and banding • % of admitted patients whose treatment included palliative care; and • % of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (context indicator)	www.ic.nhs.uk	This is not currently available for specialist trusts	
Patient reported outcomes for: • Hip replacement • Knee replacement	www.ic.nhs.uk		
Emergency readmissions to hospitals within 28 days of discharge	www.ic.nhs.uk	09/10 data Significantly better than the national average at the 95% level but not at the 99.8% level; Some improvement from previous year	
Responsiveness to inpatients personal	National CQUIN	78.1%	CQUIN target

needs			achieved
% of staff who would recommend the provider to family or friends needing care	www.nhsstaffsurveys.com	85% (2011 results)	
% of patients risk assessed for vte	www.dh.gov.uk	92.6% (Q2 data)	CQUIN target achieved
Rate of *Clostridium difficile*	www.hpa.org.uk	6 cases	Target of <7 achieved
Rate of patient safety incidents and percentage resulting in severe harm or death	www.nrls.npsa.nhs.uk	3.1/100 (April-Sept 2011) 2.9% severe harm / 1.7% death	This is reflective of the known reduced rates of reporting and covers a period when all deaths were reported as SIRIs prior to investigation. Deaths are fully investigated and are now reported only if safety concerns are identified.

5. Sustainability/Climate Change report 2011/12

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

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

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

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

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

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

Greenhouse Gas Emissions – direct gas boilers

The target for 2011/12 was 1340 tonnes. The ROH has achieved its 2011/12 and 2015 target of 1278 tonnes by using only 1170 tonnes, thereby achieving its target 3 years ahead of schedule, although this excellent achievement has been delivered in part as a result of mild winter conditions.

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

Greenhouse Gas Emissions – indirect Electricity

The target for 2011/12 was 1,540 tonnes, the ROH met its yearly target by using 1,512 tonnes. The target for 2015 is 1,385 tonnes which will be achieved by:

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

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

Staff Travel to Work

The target for 2011/12 was 924 tonnes, the ROH has met its 2011/12 target and the 2015 target of 990 tonnes using only 900 tonnes.

Area:	**Travel**				
Type:	**Staff Travel**				
2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**
Tonnes					
				1,180	900
Financial ((£)					

Waste

The Trust continues to endeavour to reduce its waste and, wherever possible, recycle waste itself. The Trust does recycle aluminium cans, cardboard, printer cartridges and batteries and will begin collection of data on this from 1 April 2011.From 1 April 2011 we have a new disposable waste Contract which has improved our data collection to include:

- Waste sent to landfill.
- Waste recycled.
- Confidential waste.
- Skip waste.

Consequently, we are reporting on new data which has increased our total waste.

Area	**Waste**					
	2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**
	Tonnes					
Total Waste	-	-	139	152	148	327
Waste sent to Landfill	-	-	139	152	148	125
Waste recycled	-	-	0	0	0	4
Confidential Waste	-	-	-	-	-	171
Skip Waste	-	-	-	-	-	27

Area	**Waste**					
	2006/7	**2007/8**	**2008/9**	**2009/10**	**2010/11**	**2011/12**
	Financial (£)					
Total Waste			12,764	15,830	18,381	60,000
Waste sent to Landfill			12,764	15,830	18,381	23,000
Waste recycled			0	0	0	
Confidential						37,000

Waste						
Skip Waste						

This new data will enable us to set specific reduction targets in these areas from 2012/13 onwards.

Finite Resources – water consumption

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

The Trust has already achieved this target. In 2011/12 we set a target of 2,300 cubic metres of water. The ROH achieved 20,424 cubic metres which was within the yearly target and well within the 2015 target.

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

Green Apple Award

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

6. Valuing People, Diversity and Staff Engagement Report 2011/12

Staff Engagement

The Trust continues to engage with staff about what matters to them in a number of ways. The Executive Directors continue to meet with staff, outside of their own area of responsibility to discuss and address both patient safety and staff issues. At the beginning of the year staff participated in events to explore the Trusts plans, including the important role staff play in continuing to ensure the organisation succeeds in delivering excellent patient care. These events were very well received by staff as an opportunity to hear directly from the Chief Executive about the challenges ahead, to understand their role and contribute ideas for financial savings and improvements in the quality of patient care delivered.

An increasing number of staff are participating in change projects managed through our Programme Management Office with clear improvements seen in care of patients and use of Trust resources.

Our staff took part in the national staff opinion survey. This year our response rate increased to 61% which is above average for acute specialist trusts.

Our top four ranking scores were:

Key Factor	This Year's Score	National Average	Comparison to last year
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	99%	96%	No significant change
Quality of job design (clear job content, feedback and staff involvement)	3.56	3.44	No significant change
Impact of health and well-being on ability to perform work or daily activities	1.49	1.55	No significant change
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	11%	14%	No significant change

Our bottom four ranking scores were:

Key Factor	This Year's Score	National Average	Comparison to last year
Percentage of staff receiving job-relevant training, learning or development in the last 12 months	73%	77%	No significant change
Percentage of staff witnessing potentially harmful error, near misses or incidents in month	36%	31%	No significant change
Percentage of staff suffering work-related injury in last 12 months	16%	13%	No significant change
Percentage of staff saying hand washing materials are always available	61%	67%	No significant change

Disappointingly the number of staff who recommend the Trust as a place to work or receive treatment is worse than average, compared to other acute specialist trusts and we will work with staff to understand the reasons for this in 2012/13.

During 2012/13 we will embark on a significant change programme, Service Line Management to empower clinical teams to deliver the best possible clinical care through delegation of decision making and accountability to clinical leaders in each area of patient care.

Consultation with Staff

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

The Trust has undertaken a number of change programmes during the year including the closure of the facility at BMI Edgbaston. All staff from the BMI facility were retained in alternative roles within the Trust.

Equality and Diversity

Our Equality Objectives set out the way the Trust intends to meet its Public Sector Equality Duties in the next four years. These will be reviewed after twelve months to measure progress. In the development of our Equality Objectives the Trust has sought to involve and

consult with representatives and groups from different protected characteristics on whom the Equality Objectives will have an impact. Its success is dependent on how well we communicate it to others as well as how we deliver the actions within it.

The implementation of our Equality Objectives will be monitored through mainstream business planning processes and the Better for Staff group will report annually on progress to the Trust Board. It is critical that we monitor our services to ensure that there are no disproportionate impacts on the Protected Characteristics provided by the Equality Act 2010. The Trust is committed to gathering and analysing data information on Personal Protected Characteristics and acting upon the results of this analysis.

The Trust has a commitment to openness and transparency. We will publish information on our workforce and report the progress made in the delivery of the action plans within this document, using language appropriate to the intended audience.

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

Sickness Absence

Achieving improvements in sickness absence have proven to be a challenge during the year with the overall level of absence increasing by 0.45%. Achieving improvements in this area including implementing approaches to improve the overall health and well-being of staff have already commenced and will continue during 2012/13.

Workforce Statistics

	Staff 2010/11	%	Staff 2011/12	%	Membership 2010/11	%	Membership 2011/12	%
Age								
0-16	0	0.00	0	0	0	0.00	0	0
17-21	18	2.02	27	3.09	18	2.02	27	3.09
22+	872	97.98	848	96.91	872	97.98	848	96.91
Ethnicity								
White	684	76.85	678	77.48	684	76.85	678	77.48
Mixed	27	3.03	16	1.82	27	3.03	16	1.82
Asian or Asian British	109	12.25	104	11.88	109	12.25	104	11.88
Black or Black British	33	3.71	33	3.77	33	3.71	33	3.77
Other	37	4.16	44	5.05	37	4.16	44	5.05
Gender								
Not Stated	0	0.00	0	0	0	0.00	0	0
Male	261	29.33	256	29.26	261	29.33	256	29.26
Female	629	70.67	619	70.74	629	70.67	619	70.74
Recorded Disability								
Not Declared	89	10.0	1.31	14.97	89	10.00	1.31	14.97
Undefined	1	0.11	6.30	72.0	1	0.11	6.30	72.0
Yes	799	89.78	2	0.23	799	89.78	2	0.23
No	1	0.11	112	12.8	1	0.11	112	12.8

7. The Board of Directors' Report on Activity and Obligations 2011/12

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

The Royal Orthopaedic Hospital was established as an NHS Trust in 1995 and founded under the National Health Services Act 2006 as the Royal Orthopaedic Hospital NHS Foundation Trust on the 1 February 2007. The Trust is located within the South Birmingham Primary Care Trust health economy area. Its main hospital location is 5 miles from Birmingham City Centre and 2 miles from the University of Birmingham. It is one of a number of acute trusts in Birmingham and primarily serves patients from the West Midlands. The Trust operates no branches outside the UK.

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

The Board of Directors' activity 2011/12

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

The Board of Directors is chaired by Mr Laurence James whose appointment was renewed for a second period of three years to the end of October 2014.
The Chief Executive was, until December 31st 2011, Mrs Penny Venables. From March 15th 2012 it was Mr Donal O'Donoghue and in the intervening weeks the role was assumed on an acting basis by the Deputy Chief Executive, Mr Graham Bragg.

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

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

Following consultation in February 2006, Monitor issued a final version of the NHS Foundation Trust Code of Governance in October 2006 for implementation. The Code applies with effect from 1st April 2006. The Code is issued as best practice advice and is not mandatory;

however, the Code imposes disclosure requirements on NHS Foundation Trusts. The Board of Directors considers that throughout the year 20010/11 it was fully compliant with the Principles of the NHS Foundation Trust Code of Governance.

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

The Members' Council supported the appointment of Mr Chris Monk as Senior Independent Director (SID and Vice Chairman The SID has held no meetings with Non-Executive Directors without the Chairman during the period covered by this report. Non-Executive Directors have met with the Chairman prior to each board meeting during this period.

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

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

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

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

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

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

Directors holding office during 2011/12 The following Directors held office throughout the period of this report unless otherwise indicated:
Mr Laurence James - Chair 2nd term of office expires 31/10/14)
Professor Taunton Southwood – Non-Executive Director (1st term of office expires 31/01/2014)
Dr Elizabeth Hensel - Non-Executive Director (2nd term of office expires 31/12/12)
Mr Robert Millinship - Non-Executive Director (2nd (term of office expires 4/10/14)
Mr Chris Monk - Non-Executive Director (2nd term of office expires 31/12/12)
Mr Roger Otto - Non-Executive Director (2nd term of office expires 31/12/12)
Mrs Frances Kirkham – Non-Executive Director (1st term of office expires 10/02/2014)
Ms Penny Venables - Chief Executive Officer, resigned with effect from 31st December 2011
Mr Donal O'Donoghue – Chief Executive Officer, appointed with effect from 15th March 2012
Mr Graham Bragg - Deputy Chief Executive and Director of Strategy and Business Development, (Acting CEO from January 1st to March 14th 2012)
Mr Stephen Bloomer – Director of Finance
Mrs Valerie Doyle - Director of Operations
Mr Andrew Thomas - Medical Director
Mrs Lindsey Webb - Director of Nursing and Governance

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

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

Audit Committee
Membership:
Mr R Otto (Chair)
Mr C Monk
Dr E Hensel
Mr R Millinship
Mr S Bloomer as Finance Director attends

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

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

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

Integrated Governance Committee
Membership:
Professor Taunton Southwood (Chair)
Mr L James
Dr E Hensel
Mrs F Kirkham
Ms P Venables
Mrs V Doyle
Mrs L Webb
Mr A Thomas

Purpose
The work of the Committee is primarily to:

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

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

Nominations and Remuneration Committee

Membership:

Mr L James (Chair)

Mr C Monk

Mr R Otto

Mrs F Kirkham

(Any NED may attend this committee as a full member)

Professional advice is provided from time to time by the Trust's Director of Workforce and Organisation Development, Mrs Anne Gynane. Financial guidance is provided by Mr Steve Bloomer as Finance Director.

Purpose

The Remuneration and Nominations Committee of the Board undertakes to:

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

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

In the case of Executive Director vacancies, the Remuneration and Nominations Committee draws up the job description and person specification, and undertakes the recruitment process

and then makes a recommendation to the Trust Board which may accept or reject the recommendation. The committee benchmarks remuneration annually.

The Committee addressed the need to fill the post of CEO during autumn 2011with the support of external headhunters and made an appointment approved by the Members'Council in early December 2011. The Director of Operations tendered her resignation on January 2012. Mr Michael Woods was appointed as interim designate during March 2012 whist Mrs Doyle remained in post as the substantive director until March 301th 2012.
It is for the Non-Executive Directors to appoint and remove the Chief Executive and such an appointment requires the approval of the Members' Council.

Investment Committee

Membership:
Mr C Monk (Chair)
Mr R Millinship
Mr L James
Mr S Bloomer
Mrs P Venables to December 2011.
Mr G Bragg

Purpose

The work of the committee is to:

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

Charitable Funds Committee

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

Evaluation of Board Performance

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

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

In early 2012, the Board used external advisors to independently assess its performance for report to the Members' Council. This involved the review of Board meetings and papers and comment on the challenge and engagement of all Directors.

The Trust does not have a formal process for evaluating the performance of the Members' Council or its members, but will consider this early in 2011/12 as part of the evaluation of effectiveness for its work and that of its new committees.

Non-Executive Directors' attendance at meetings

Brief synopsis of major areas of responsibility of the Board and its committees:

Trust Board **12 meetings**	**Audit Committee** **6 meetings**	**Integrated Governance Committee** **8 meetings**	**Remuneration and Nomination Committee** **2 meetings**	**Charitable Funds Committee** **4 meetings**	**Investment committee** (from October 2009) **5 meetings**
Development of long term strategy Monthly performance review; Key national target review; Strategic planning; Capital project development	Review of overall assurance with internal and external auditors; major project reviews.	Ongoing review of Assurance Framework; Clinical Governance; Policy review	Approval of pay awards; Agreement of external advertising and specification for NED (with MC N&R Committee); HR Review	Review of investment strategy; Prioritisation of fund allocation	Considers early stage investment proposals and then makes recommendations to trust board about major strategic investments of corporate, financial or reputational risk.

Laurence James Chairman	Trust Board	Integrated Governance Committee	Remuneration & Nomination Committee	Charitable Funds	Investment committee
	Chairman12/12	6/8	**Chairman** 2/2	**Chairman** 4/4	4/5

Professor Taunton Southwood	**Trust Board**	**Integrated Governance Committee**	**Remuneration and Nomination Committee**	**Charitable Funds Committee**
Mr Southwood is a professor at Birmingham nd University also works at Birmingham Children's Hospital	(10/12 Undertaking chair appraisal and feedback to Members' Council	**Chairman** 8/8 Chairman Focus on clinical guidance and outcomes	0	3/4

Chris Monk	**Trust Board**	**Audit Committee**	**Charitable Funds Committee**	**Investment committee**
Mr Monk is retired as a Partner in King Sturge, a firm of property agents and also serves on Advantage West Midlands and several other bodies He was both SID and Vice Chair during the period of this report	11/12 Leading on capital development and estates	6/6 Particular focus on best practice HR & OD	3/4	**Chairman** 5/5

Roger Otto	**Trust Board**	**Audit Committee**	**Remuneration and Nomination Committee**	**Charitable Funds Committee**
Mr Otto is a qualified accountant and was a partner with Baker Tilly. He has also served as a non-executive director on a PCT	10/12 Reporting on work of audit and annual report to Members' Council	**Chairman 5/6** Acts independently of Trust Chairman in holding the organisation to account.	2/2	3/4

Dr Elizabeth Hensel	**Trust Board**	**Audit Committee**	**Integrated Governance Committee**	**Charitable Funds Committee**
Dr Hensel is a clinical psychologist and has been a non-executive director of an NHS ambulance trust	9/12 Leading on information systems and patient flows	5/6 Acts as link person with integrated governance	(Deputy Chairman) 7/8 Acts as link person with audit; particular focus on governance structures	2/4

Robert Millinship	**Trust Board**	**Audit Committee**	**Charitable Funds Committee**	**Investment committee**
Mr Millinship has a background in manufacturing and production businesses and acts as an interim director or consultant	12/12 Leading on 18 weeks project delivery	5/6 Key focus on performance criteria	2/4	5/5

Mrs Frances Kirkham	**Trust Board**	**Integrated Governance committee**	**Charitable Funds Committee**	**Investment committee**
Mrs Kirkham is a retired judge.	7/12 Leading on legal issues and complaints/PALs	7/8 Key focus on reputational awareness of performance	1/4	0

Executive Director attendance at Board and Committee meetings.

	Trust Board	Audit Committee	Integrated Governance Committee	Investment Committee	Remuneration Committee	Charitable Funds Committee
	12 meetings	meetings	8 meetings	meetings	2 meetings	meetings
Penny Venables	9/9		3/6	3/5	1/1	4/4
Donal O'Donoghue	1/1					
Graham Bragg	10			5/5		3/4
Steve Bloomer	12	6/6		5/5		4/4
Andrew Thomas	11		7			4/4
Lindsey Webb	12		8			4/4
Valerie Doyle	11		1			3/4

Board of Directors' Discharge of Obligations 2011/12

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

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

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

Responsibilities.

Trust Contractual Arrangements

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

Audit arrangements

The Trust's external auditor is

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

The external auditors' remuneration for 2011/12 was £41,000.

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

Valuation of fixed assets

During 2010/11 the Trust completed a new outpatients department and upon completion it was valued in line with International Financial Reporting Standards which created a write off of £1.8m this is recognised as an exceptional loss on the revaluation in the Statement of Comprehensive Income with a total write down of assets of £2m.

Political and Charitable Donations

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

Post Balance Sheet Events

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

Consultation with staff

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

Equal Opportunities

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

Health and Safety at Work

The Trust takes its responsibilities for the health and safety of its staff and patients very seriously. During 2011/12, responsibility for this area of worked was assumed by the Director of Operations. Throughout the year work has taken place to raise awareness of security issues and improve lockdown procedures. Robust procedures for staff in dealing with violent and aggressive individuals and lone working have been maintained and links with the local police station have been established, with a variety of drop-in sessions and police initiatives taking place on site.

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

Health and Safety Executive

The Trust has received one visit from the HSE during this period in response to a RIDDOR reportable incident. By the time of the visit an action plan had been drawn up and was be delivering within the given timescales. This was enhanced by some advice and input from the HSE inspector and his expert assistant. There was no improvement notice or special conditions imposed following this visit.

Risk Assessment Training

Health and Safety/Risk Assessment training courses run by the Trust's Health and Safety Advisor have been ongoing in 2011/12. During this year the Trusts in-house COSHHH risk assessment training has also been delivered as part of this. Towards the end of the year this training has incorporated Stress risk assessment and DSE risk assessments. All clinical areas now have Ward Managers/Head of Department or a nominated member of staff trained in carrying out risk assessments.

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

Policies

Policies have been updated in advance of the NHSLA assessment in February. In addition to this the COSHH policy was revised in line with training changes.

Orthotics

The local exhaust ventilation (LEV) equipment previously reported has undergone routine monitoring via an external agency towards the end of 2011/12.

Mandatory Training

Annual mandatory training for all Trust staff continues to be provided by the Health and Safety Advisor. This includes patient/load handling, Health and Safety Policies and issues. This element of training also includes the e-vac chair which is the Trust's emergency patient evacuation equipment for use during a fire. The Trust has upgraded the fire evacuation equipment and has purchased new fire e-vac chairs, which are much easier to use and the Trust is complementing the e-vac chairs with fire e-vac ski pads which will give the Trust more options/flexibility when evacuating in an emergency. Training is planned to ensure the safe implementation of these changes during 2012/13.

Central Alerting System (CAS

The Health & Safety Advisor continues to monitor the Medicine Healthcare Regulatory Authority (MHRA) alerts the Trust receives and disseminates information to relevant staff/departments. The status of all CAS alerts are reported at Quality Committee meetings and escalated to the Board. The Trust will be considering use of the Ulysses Risk Management system for the monitoring of CAS alerts during 2011/12.

External Consultations

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

The Trust has not undertaken any formal external consultations on its own services during 2011/12.

Emergency Planning

The Trust is classified as a Category 1 Responder under the Civil Contingencies Act 2004. The Major Incident plan was reviewed in September 2011 and tested via a table top exercises in March 2012. Training of Loggists took place in April 2011 in addition to bespoke training for the Emergency Planning Group April/May 2011.

An extensive flu vaccination programme was undertaken during winter and vaccination rate targets were achieved. Access to electronic plans and emergency response information has been made available to all on-call staff and managers.

The ROH takes part in local resilience forums for the economy and the Chief Executive takes part in the regional ERMA rota to fulfil responsibilities of partnership working under the Civil Contingencies Act.'

Environment

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

Better Payment Practice

The Trust paid 99.6% of invoices within 30 days against the target of 95%. The Trust did not incur any late payment penalties during 2011/12 under the Late Payment of Commercial Debts (Interest) Act 1998.

Compliance with the cost allocation and charging requirements

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

Freedom of Information (FOI) Act

The Trust continued to meet the requirements of the act and responded to requests in a compliant fashion.

Use of Information Technology

The Trust continues to use products developed under Connecting for Health where its offerings meet the Trust's requirements. During 2011/12 the Trust has focused on the development of clinical systems and the strengthening of the IT infrastructure as well as introducing NHSmail to improve efficiency and security of information.

As part of its drive to improve patient experience, the tru8st has introduced an electronic booking system in the outpatients department. This has reduced queuing and anxiety for patients who are waiting to be called for an appointment as well as providing clinic management information which enables the trust to improve its services to patients still further. In addition, there has been a focus on exploiting existing systems to provide comprehensive information sets to improve decision making.

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

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

The Trust achieved level 2 in all of the 22 key requirements of the Information Governance Toolkit for 2011/12.

Serious untoward incidents relating to data loss and breaches of confidentiality

During 2011/12 the Trust had no serious untoward incidents relating to data loss and breaches of confidentiality.

Policies and procedures relating to counter

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

Remuneration Report

Salary and Pension Entitlements of Senior Managers

A) Salaries*						
	2011-12 (12 months to 31st March 2012)			**2010-11 (12 months to 31st March 2011)**		
Name and Title	**Salary (bands of £5000) £000**	**Other Remuneration (bands of £5000) £000**	**Benefits in Kind Rounded to the nearest £100**	**Salary (bands of £5000) £000**	**Other Remuneration (bands of £5000) £000**	**Benefits in Kind Rounded to the nearest £100**
Mr. L. James – Chairman (from 1st November 2008)	35-40	**0**	0	40-45	**0**	0
Mr. D. O'Donoghue – Chief Executive (from 12th March 2012)	5-10	**0**	0	0	**0**	0
Mrs. P Venables – Chief Executive (left 31st December 2011)	90 - 95	**0**	0	120-125	**0**	0
Mr. G. Bragg-Director of Strategic and Business Development	105-110	**0**	0	100-105	**0**	0
Mr. A. Thomas-Medical Director	20-25	**115-120**	0	20-25	**110-115**	0
Mrs. L. Webb – Director of Nursing & Governance	80-85	**0**	0	80-85	**0**	0
Mrs. V. Doyle – Director of Operations (left 31st March 2012)	85-90	**0**	0	85-90	**0**	0
Mr. S. Bloomer – Director of Finance and IM&T (from 1st May 2010)	85-90	**0**	0	85-90	**0**	0
Dr. E. Hensel-Non Executive Director	10-15	**0**	0	5-10	**0**	0
Mr. R. Otto–Non Executive Director	10-15	**0**	0	10-15	**0**	0
Mr. R. Millinship -Non Executive	10-15	**0**	0	10-15	**0**	0

Director						
Mr. C. Monk -Non Executive Director	10-15	**0**	0	10-15	**0**	0
Mrs. F. Kirkham – Non Executive Director (from 1st February 2011)	5-10	**0**	0	10-15	**0**	0
Mr. T. Southwood – Non Executive Director (from 1st February 2011)	10-15	**0**	0	0-5	**0**	0

*This element of the annual report has been audited.

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

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

Salary and Pension Entitlements of Senior Managers

B) Pension Benefits*

Name and title	Real increase/ (decrease) in pension and related lump sum at age 60 (bands of £2500) £000	Total accrued pension and related lump sum at age 60 at 31 March 2012 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Real Increase/ (decrease) in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Mr. D. O'Donoghue – Chief Executive (started 12th March 2012)	2.5 - 5	255 - 260	1,183	1,043	108	0
Mrs. P. Venables - Chief Executive (left 31st December 2011)	17.5 – 20	190 - 195	886	705	159	0
Mr. G. Bragg – Director of Business and Strategic Development	5 – 8.5	185 - 190	1,077	969	78	0
Mr. A. Thomas – Medical Director	8.5 - 10	220 - 225	1,210	1,090	86	0
Mrs. V. Doyle – Director of Operations (1st July 2009)	10 – 12.5	110 - 115	563	612	(68)	0
Mrs. L. Webb - Director Of Nursing and Governance	0 – 2.5	80 - 85	337	277	52	0
Mr. S. Bloomer - Director Of Finance and IM&T	2.5 – 5	80 - 85	303	235	61	0

*This element of the annual report has been audited

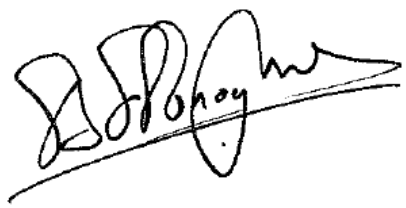
As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

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

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

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

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



Signed: Donal O Donoghue Date: 29 May 2012

Chief Executive

Details of senior employees' remuneration can be found in the Remuneration Report on pages 79 and accounting policies for pensions can be found on pages 113.

Going concern

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

Research and development

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

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

The work of the Members' Council 2011/12

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

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

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

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

Doing its job – as a whole Council

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

Members' Council involvement in strategy

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

In committees

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

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

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

Constituencies

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

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

There are five public constituencies within Public membership:

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

There are two constituencies within Staff membership:

- Clinical
- Non-clinical

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

number of key organisations that work closely with the Trust appoint representatives for the Members' Council.

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

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Elections

There were no election results to report during 2011/12
(In two of the smaller constituencies (less than 400 members in each) it proved impossible to secure eligible nominations for office. The Members' Council agreed in principle to seek approval to amendments to the trust's constitution to change the definition of patient and public area constituencies but felt this should take place following the final assent to the Health Bill. – anticipated during the latter part of the 2011/12 financial year. Elections to these roles were scheduled for early in April 2012.)

Elected Members serving during the year 2011/12 meeting attendance

South Birmingham (5 seats)

1. ROSKELL, Gary - appointed March 08 until end January 2010 and re-elected for 3 years until end January 2013
Attended 2 Council meetings (of 4) and serves on the Membership Engagement Committee
2. HART, Neil - appointed for 3 years until end January 2010, re-elected for 3 years until end January 2013
Attended 4 Council meetings (of 4) and serves on the Remuneration Committee (Chair)
3. MULLINEX, David, appointed for 3 years until end January 2013.
Attended 0 Council meeting (of 4) and served on the Membership Engagement Committee
4. RICHMOND, **Isobel Ingrid** – re-elected for 3 years to 15th April 2012. Attended 3 Council meetings (of 4) and serves on the Environment Committee
5. BLACKLEDGE, Joseph – appointed for 3 years to end January 2014. Attended 3 Council meetings (of 4)

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

Rest of the West Midlands (4 seats)
1. NOON, Stella - appointed for 3 years until end January 2010, re-elected for 3 years until end January 2013
Attended 4 Council meetings (of 4) and serves on the Patient Experience Committee
2. SCOTT, Yvonne - appointed on re-election, for 3 years until 15th April 2012
Attended 4 Council meetings (of 4) and serves on the Patient Experience Committee
3. LAST Alan, appointed for 3 years until end January 2014. Attended 4 Council meetings (of 4) and serves on the Membership Engagement Committee
4. Williams, Kenneth – appointed for 3 years until end January 2014. Attended 3 Council meetings (of 4)

East and North Birmingham (2 seats)
1. COUTHARD, Elaine – appointed for 3 years until end of January 2014. Resigned May 2011. Attended 1
2. Vacant (failure to secure nominations from a very small constituency membership)

Rest of England (1 seat)
1. TALBOYS, Robert – appointed for 3 years to end January 2013, Attended 0 meetings (of 4)

Clinical Staff Representatives

1. CHURCHMAN, John re-elected for 3 years until end March 2012
Attended 4 Council meetings (of 4) and serves on the Member Engagement Committee
2. GRIMER Robert – appointed for 3 years until end March 2012
Attended 0 Council meetings (of 4) and serves on the Patient Experience Committee

Non-Clinical Staff Representatives

1. **WALSHAW, Janet,** elected for 3 years until end of May 2013. Attended 4 meetings of 4 and serves on the Member Engagement Committee

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

South Birmingham PCT
Sandra Cooper (Resigned on PCT reconfiguration) No further nomination made

Heart of Birmingham PCT
Jacqui Francis (Resigned on PCT reconfiguration) No further nomination made

Birmingham City Council
Cllr. Keith Barton Attended 4 Council meetings (of 4) and served on the Governance Committee

University of Birmingham
Professor Catherine Sackley (Now resigned, awaiting new nominee). Attended 2 Council meetings (of 4)

Birmingham City University
Marion Thompson Attended 2 Council meetings (of 4) and serves on the Remuneration Committee

Bournville Village Trust
Paul Sabapathy from February 2012 No Attended 1 of 1 Council meetings

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

Member of Parliament
Richard Burden MP Attended 0 Council meetings (of 4)

Birmingham Council of Faiths
Parwez Hussain
Attended no Council meetings (of 4).

(It should be noted that several members experienced periods of ill-health during the year and several attended workshops but were unable to attend public meetings.)

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

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

Engaging Our Membership

As agreed with the Members Council, the focus of membership activity in the last year has been to create more opportunities for members to engage directly with the Trust, rather than on growth of numbers.

With the creation of a new Public and Patient Services department, the Trust has been able to diversify ways in which members can engage including:

- Increase in Simulated Patient opportunities
- Helping to conduct the real-time Patient Survey
- Mystery shopping
- A virtual Patient and Carers Council (alongside the existing face to face council) who offer feedback on written Patient Information before it is used
- Assisting with outcomes data collection, including the new Friends and Family Test question
- Involvement with the Project Management Office, to offer Patient and Carer views on efficiency saving projects
- Involvement with the Research and Development Department in delivering trials and collecting information.

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

Membership size and movements

Public constituency	**2011 - 12**	**2012 - 13 (estimated)**
At year start (April 1)	6010	6004
New members	113	150
Members leaving	119	120
At year end (March 31)	6004	6034
Staff constituency		
At year start (April 1)	872	848
New members	36	20
Members leaving	60	48
At year end (March 31)	848	820

Analysis of current membership

At the end of 2011/12 the Trust had maintained its membership to 6000 and ensured it remained representative to the population as a whole. The trust will continue to develop its membership base in 2012/13 but again, will not seek significant growth and continue to focus on more varied opportunities for engagement with existing members. It is expected that Staff numbers may reduce slightly over this period due to natural wastage and service reconfiguration.

Public constituency	Number of members	Eligible membership
Age (years):		
0-16	10	
17-21	165	5,690, 271
22+	5476	
Not stated	353	
Ethnicity		
White	4207	1,138,054
Mixed	112	16,501
Asian or Asian British	385	83,078
Black or Black British	288	44,384
Other	104	4,408,254
Not Stated/Do not wish to state	908	

Public constituency	Number of members	% of membership
Socio-economic Category		
ABC1	3160	53
C2	1141	19
D	1287	21
E	416	7
Data not available		
Gender		
Male	2337	39
Female	3623	60
Unspecified	44	1

The Royal Orthopaedic Hospital NHS Foundation Trust

Accounts for the Year Ended 31 March 2012

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

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

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

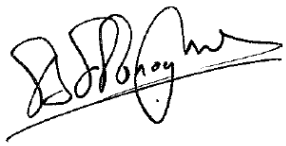
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and
  disclosure requirements, and apply suitable accounting policies on a consistent basis;

- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.



Donal O'Donoghue

Chief Executive

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

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

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

The system of internal control has been in place in The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31st March 2012 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

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

The Trust's overall appetite for risk was determined as part of a Board Workshop on risk which reviewed best practice and discussed the analysis of key risks as part of the Trust's overall strategic direction.

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

The Integrated Governance Committee has designated responsibility for risk management and is chaired by a Non-Executive Director of the Trust; the Chief Executive is a member of this committee. The Integrated Governance Committee provides a performance monitoring and scrutiny function on behalf of the Trust Board and oversees all aspects of integrated governance within the Trust including corporate governance. The Committee meets a minimum of 10 times per year and will review national risk management priorities and delegate responsibility for further analysis/ action and review the Corporate Risk Register.

Sub-Committees reporting to the Integrated Governance Committee also meet regularly and review the risks attributed to their respective committee, scrutinising and ensuring that appropriate ratings have been attributed and appropriate mitigation undertaken. This process includes the evaluation of mitigation actions that have taken place to understand and assess the outcomes of these actions.

Work to further develop the Corporate Risk Register in an electronic format is on-going; this should improve the ability for managers to review and update their risks and action plans on a regular basis. This is expected to be piloted during the summer of 2012.

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

The risk and control framework

A review of the risk management strategy was completed in July 2011, and updated in January 2012. The purpose of the risk management strategy is to:

- define the strategic direction for risk management in the Trust
- focus upon experiences and learning in order to improve patient care, clinical outcomes and the working environment,

- assess and where possible anticipate risk and also to eliminate or reduce risk of harm to patients, staff, visitors or contractors,
- describe the framework and the method that the Trust will use to identify, manage and reduce the risks (actual or potential) which exist within the organisation and its environment and provides the Trust with clear direction on which to base all future risk management initiatives.

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

The Trust recognises the importance of collecting meaningful and relevant data in a statistical format so that it can be analysed and trends can be monitored and appropriate action taken. Quarterly reports to the Integrated Governance Committee and the Trust Board highlight trends and pertinent risk issues. The quarterly Corporate Performance Report includes details of all red risks on the Board Assurance Framework and the Corporate Risk Register and tracks changes made during the last quarter.

Information on serious incidents is shared with key staff. Once completed serious incident investigation reports are anonymised and circulated to key stakeholders including the Virtual Serious Incident Review Investigation Group(VSIRI) for comments and feedback. The VSIRI Group is a multi-disciplinary co-opted group of senior staff who will review clinical reports and provide scrutiny of findings, recommendations and action plans. Meetings are arranged where necessary to discuss the findings of serious incident investigation reports.

Information on clinical and non-clinical incidents and claims is collated and incorporated in the Trust quality governance reports on a quarterly basis. Directorate quarterly quality governance reports are discussed at the Quality Committee and contribute to the Trust report. Actions and learning are detailed within the quarterly report which is reviewed and approved by the Integrated Governance Committee. Once approved the Trust report is submitted to the local commissioning bodies and scrutinised as part of the contract review process. The Quality Committee is also attended by members of the local commissioning body.

Monthly ward reports are developed into key performance indicators which cover workforce, training, safety, patient experience and effectiveness are reviewed on a monthly basis by the Senior Nurses Group. A RAG rating is produced which is circulated in order to share areas of good practice and encourage peer support with weaker areas. Improvement targets are set and monitored. This RAG rating is included in the Director of Nursing's monthly Patient Safety report to the Trust Board which is also sent to the commissioning body.

The Board Assurance Framework provides a framework for reporting key information to the Board. It identifies which of the Trust's objectives are at risk because of inadequacies in the

operation of controls and at the same time it provides structured assurances about where risks are being managed effectively and objectives are being delivered. The Board Assurance Framework draws together the key corporate risks from the Corporate Risk Register and is considered by the Integrated Governance and Audit Committees during the year to ensure a bottom up and top down approach to capturing key corporate 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 key on-going risks, as reported in the Board Assurance Framework are:

- Continued use of unfunded medical temporary/agency staffing
- Succession planning and future development of the general medical service to ensure a more comprehensive care for complex patients
- The Trust is unable to secure the use of third party specialist facilities creating long waiting times for spinal deformity cases

Red risks are managed through the Audit Committee and Integrated Governance Committee throughout the year and they will provide assurance to the Trust Board on status and progress.

The organisation has also highlighted a key risk around medical engagement for 2012/13, and work is on-going to review and develop the Trust's approach to service line management as a key vehicle for engaging the medical workforce. Changes in senior management positions, increasing the risk of reduced corporate memory, was highlighted as a major risk towards the end of 2011/12, and will require on-going risk management in 2012/13. This will be delivered by quarterly reviews undertaken by the Remuneration Committee to ensure the necessary leadership skill base is maintained and systems are put in place to allow detailed handovers between key postholders.

The Internal Auditors have undertaken audit work around the current risk management systems including the Trust Board Assurance Framework and risk management. They are able to give significant assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Internal Audit did highlight some weakness in the inconsistent application of controls in relation to compliance and record keeping in the Trust's complaints process. This was highlighted as a key risk in the 2010/11 Statement of Internal Control, which also outlined planned improvements in 2011/12.

A follow up audit relating to compliance with complaints processes identified, at the time of the audit, that "little progress" had been made in implementing the agreed management actions. However, evidence considered as part of the follow-up audit work demonstrated a much greater degree of compliance in more recent files and highlighted recent improvements and

on-going management actions to ensure adherence to the Trust's policies and procedures. A further assurance audit is planned for June 2012.

Data Security is monitored via the Information Governance Group, which is chaired by the Director of Strategic and Business Development who is also the Trust's Senior Information Risk Owner at Board level. This group maintains a Risk Register and an action list which addresses issues and an Incident Log all of which are reviewed and actioned bi-monthly. 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 bi-monthly meetings. Other specific controls include:

- Trust portable devices i.e. laptops, data sticks and PDAs, have encryption software installed and no personal devices can operate on the Trust network.
- Information flows containing personal/sensitive data in and out of the Trust have been identified, 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 and have appropriate access controls.
- All staff receive annual IG training via mandatory training supplemented by the e-learning IG Training Toolkit to ensure up to date knowledge about the importance of the confidentiality and security of information.

The Trust is committed to involving stakeholders as appropriate in all areas of the Trust's activities. This includes informing and consulting on the management of any significant risks. Key stakeholders include NHS Midlands and East, Birmingham and Solihull Cluster and newly developing Clinical Commissioning Groups, subcontractors, voluntary groups, the Members Council, patient groups (including the statutory LINKS), patients, the local community and the Local Authority Overview and Scrutiny Committee.

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

The Trust successfully passed a level 1 NHSLA Risk Management Standards Assessment in March 2012 with a maximum score of 50 out of 50.

Care Quality Commission Essential Standards of Quality and Safety - An audit of gathering, recording and quality of evidence was undertaken as part of the approved internal audit

periodic plan for 2011/12. It demonstrated that regular formal reviews of the evidence against the care standards are undertaken at the monthly CQC Essential Standards of Quality and Safety Evidence Review meetings, where outcomes are compared to the evidence collated by the appropriate lead. Prior to the formal CQC Essential Standards of Quality and Safety Evidence Review meeting, the attending directors undertake a walkabout in the area due for review, to observe the standards operating in practice. Summary reports are provided every quarter to the Integrated Governance Committee that is attended by both Executive and Non-executive Directors to provide assurance that the Trust is compliant with the Essential Standards. The audit found the frequency at which each outcome is formally reviewed by both Executive and Non-executive Directors demonstrates the importance that the Trust places on the CQC Essential Standards process. It found that the involvement of the Executive and Non-executive Directors in the walkabout process allows the Board to see the CQC essential standards operating in practice prior to the formal evidence review at the CQC Essential Standards of Quality and Safety Evidence Review Meetings. The report concluded that the Board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

The Trust was also subject to an unannounced risk based assessment by the Care Quality Commission which found that the Foundation Trust is fully compliant in respect of the requirements of registration with the Care Quality Commission.

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

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

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

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

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

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

The Trust has developed, within its Corporate Performance Report, a scorecard which monitors both national and local targets together with efficiency indicators which are reported on a monthly basis. More detailed monitoring, with a particular emphasis on financial controls, is reported on a quarterly basis.

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

The Trust regularly benchmarks its reference costs with national tariffs to highlight the areas of potential inefficiency and compares its use of resources with other specialist orthopaedic centres. As a member of the Specialist Orthopaedic Alliance both formal and informal reviews of services and their cost effectiveness are carried out.

The Trust benefits from the data produced by the Patient Level Information and Costing System, which has enabled the Trust to increase the understanding of where efficiencies can be targeted and has focused discussions with the Department of Health around issues with the national Payment by Results tariff system. Information from the Patient Level Information and Costing System has been used to develop Service Line Reporting, which is circulated to management and clinical directors on a quarterly basis. This has further developed the understanding of the link between income and costs and has provided clinical management with a greater depth of information to support their decision making. A staged roll-out to all key service users is being piloted in Quarter 1 2012/13.

The Management Team and the Trust Board have commissioned independent reviews of specific services during the year to ensure that they are fit for purpose and deliver economy, efficiency and effectiveness. Part of the Internal Audit programme during the year has been both to review core systems but also specific areas where there may be an opportunity to improve the use of resources.

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

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

The financial risk rating of 5 awarded by Monitor, the independent regulator represents a strong and robust financial performance in 2011/12.

The governance rating of Green awarded by the independent regulator represents full achievement of all Monitor governance indicators in 2011/12

Annual Quality Report

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

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

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

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

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and the executive managers 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 the Integrated Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- The Board regularly reviewing progress against a number of action plans including the red risks on the Board Assurance Framework to ensure that identified actions are implemented in a timely manner.
- The Audit Committee receiving regular reports on reviews undertaken by the Internal and External Auditors and monitoring the system of financial control.
- The Audit Committee receiving update reports on audit recommendation tracking to ensure that the management team are implementing the agreed improvements to internal control processes within the agreed timeframe or that there are reasonable explanations for variances.
- The Audit Committee receiving updates on prior year audit recommendations from the Trust's Internal Auditors.
- The Integrated Governance Committee monitoring progress and suggesting action to be taken as appropriate in relation to regular reports regarding complaints, incidents, legal claims and other risks identified.
- The Executive Management Team ensuring actions on lapses in the core standards are implemented.
- The Audit Committee reviewing its objectives annually and revising them in the knowledge of the Trust's objectives and the major risks identified on the Assurance

Framework. The Audit Committee objectives are designed to monitor the major organisational risks throughout the year as well as the systems of internal control.

- The Integrated Governance Committee having a programme for reviewing clinical audit and outcomes including the use of comparative benchmark data and the National Joint registry.
- Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems.
- Executive and Non-Executive Directors having been allocated specific areas within the Trust to visit and gain feedback on safety and experience issues.
- Staff listening events being hosted by the Chief Executive and the Director of Workforce and Occupational Development to gain direct feedback from staff on a wide variety of issues.
- The Clinical Outcomes and Effectiveness Committee (COEC) provides assurance to the Integrated Governance Committee on Clinical Audit, including agreeing the Clinical Audit Plan and monitoring progress against the plan in year.

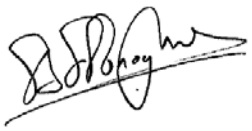
Conclusion

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

In addition to the process described above in arriving at my view as to the effectiveness of the control systems I have taken into account the following:

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

Signed



Donal O'Donoghue

Chief Executive

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

We have audited the financial statements of The Royal Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2012 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Cash Flow Statement and the related notes 1 to 27. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

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

Respective responsibilities of the accounting officer and auditor

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the Financial Statement

- give a true and fair view of the state of the Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor- Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements

Matters on which we are required to report by exception

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

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

Certificate

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

Fuis Miah (senior statutory auditor)
On behalf of Deloitte
LLP Chartered Accountants and Statutory Auditor
Birmingham,
United Kingdom
30 May 2012

Foreword to the Accounts

These accounts for the year ended 31 March 2012 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.

Donal O'Donoghue

Chief Executive

The Royal Orthopaedic Hospital NHS Foundation Trust

Accounts for the year ended 31 March 2012

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2012

	Notes	Year Ended 31 March 2012 £000	Year Ended 31 March 2011 £000
Operating Income	**3**	71,242	70,566
Operating Expenses	**4**	(68,812)	(69,543)
Operating Surplus		**2,430**	1,023
Finance Costs			
Finance income	**6**	142	131
Finance expense - financial liabilities	**6**	(46)	(30)
Finance expense - unwinding of discount on provisions	**16**	(13)	(9)
PDC Dividends payable		(1,268)	(1,275)
Net Finance Costs		**(1,185)**	(1,183)
SURPLUS / (DEFICIT) FOR THE YEAR		**1,245**	(160)
Other comprehensive income			
Impairments on property, plant and equipment		(624)	(405)
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**621**	(565)

There is no surplus for the year attributable to minority interests.

The notes on pages 110 to 148 form part of these accounts.

All income and expenditure is derived from continuing operations.

The Royal Orthopaedic Hospital NHS Foundation Trust

Accounts for the year ended 31 March 2012

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2012

	Notes	31 March 2012 £000	31 March 2011 £000
Non-current assets			
Intangible assets	8	120	137
Property, Plant and Equipment	9	39,046	39,624
Trade and other receivables	11	27	36
Total non-current assets		**39,193**	39,797
Current assets			
Inventories	10	2,927	3,155
Trade and other receivables	11	3,329	5,122
Other non-financial assets	11	456	286
Other current assets	11	681	1,119
Cash and cash equivalents	13	19,711	14,803
Total current assets		**27,104**	24,485
Current liabilities			
Trade and other payables	14	(8,306)	(7,310)
Borrowings	14.2	(164)	(166)
Provisions	16	(177)	(116)
Other liabilities	14.1	(1,122)	(621)
Total current liabilities		**(9,769)**	(8,213)
Total assets less current liabilities		**56,528**	56,069
Non-current liabilities			
Borrowings	14.2	(842)	(1,006)
Provisions	16	(240)	(239)
Total non-current liabilities		**(1,082)**	(1,245)
Total assets employed		**55,446**	54,824
Financed by taxpayers' equity			
Public Dividend Capital		38,905	38,905
Revaluation reserve		2,645	3,268
Other reserves		0	0
Income and expenditure reserve		13,896	12,651
Total taxpayers' equity		**55,446**	54,824

The financial statements were approved by the Audit Committee on behalf of the Board of Directors on 29 May 2012 and are signed on its behalf by:

Donal O'Donoghue – Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2012

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

	Total	Public Dividend Capital	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	**55,113**	38,905	3,156	2,416	10,636
Prior period adjustment	276	0	517	(2,416)	2,175
Taxpayers' Equity at 1 April 2010 - restated	**55,389**	38,905	3,673	0	12,811
Deficit for the year	(160)	0	0	0	(160)
Impairment losses on property, plant and equipment	(405)	0	(405)	0	0
Taxpayers' Equity at 31 March 2011	**54,824**	38,905	3,268	0	12,651

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2012

	Year Ended 31 March 2012 £000	Year Ended 31 March 2011 £000
Cash flows from operating activities		
Operating surplus	2,430	1,023
Non-cash income and expense		
Depreciation and amortisation	2,319	2,443
Impairments	922	1,913
Reversal of impairments	(6)	(284)
Amortisation of government grants	61	61
Decrease/(Increase) in Trade and Other Receivables	2,103	(1,060)
Decrease/(Increase) in Inventories	228	(572)
Increase/(Decrease) in Trade and Other Payables	1,620	(355)
(Decrease)/Increase in Other Liabilities	(166)	1,014
Increase in Provisions	49	13
Other movements in operating cash flows	1	1
NET CASH GENERATED FROM OPERATING ACTIVITIES	**9,561**	4,197
Cash flows from investing activities		
Interest received	143	130
Purchase of intangible assets	(61)	(124)
Purchase of Property, Plant and Equipment	(3,216)	(6,708)
NET CASH GENERATED USED IN INVESTING ACTIVITIES	**(3,134)**	(6,702)
Cash flows from financing activities		
Interest element of finance lease	(46)	(30)
Capital element of finance lease rental payments	(171)	(80)
PDC Dividend paid	(1,302)	(1,286)
NET CASH GENERATED USED IN FINANCING ACTIVITIES	**(1,519)**	(1,396)
Increase/(Decrease) in cash and cash equivalents	**4,908**	(3,901)
Cash and Cash equivalents at 1 April	**14,803**	18,704
Cash and Cash equivalents at 31 March	**19,711**	14,803

Notes to the accounts

1.1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual (FT ARM)* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2011/12* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual (FREM)* to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Significant accounting policies, judgments and sources of estimation uncertainty

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

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

Leases

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

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

Determination of useful lives for Property, Plant and Equipment

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

Partially completed spells

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

may be the expected or actual length of stay or may be based on the costs incurred over the length of the treatment.

Impaired receivables

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

Annual Leave provision

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

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

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

HM Treasury has granted dispensation to the application if IAS 27 by NHS Foundation Trusts in relation to the consolidation of NHS charitable funds until 31 March 2013.

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

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

An associate is an entity which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method.

1.3 Income

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

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

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

1.4 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension costs

NHS Pension Scheme

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

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

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and an IAS19 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay.

From 1 April 2008, employees' contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) IAS19 Accounting valuation

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

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.
The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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

Scheme provisions as at 31 March 2008

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

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

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

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

Scheme provisions from 1 April 2008

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

Local Government Superannuation Scheme

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

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

1.5 Expenditure on other goods and services

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

1.6 Property, Plant and equipment

Recognition

Property, Plant and Equipment is capitalised where:

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

Measurement

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

Property is measured at fair value. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last independent asset valuations were undertaken on 31 March 2012 by GVA Grimley international property advisers. The revaluation undertaken at that date has been accounted for in these accounts on 31 March 2012 as follows:

- Land £3,135,060
- Buildings and Dwellings £31,690,760

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

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

Assets in the course of construction are valued at cost and are valued on completion by professional valuers as part of the land and buildings revaluation required by IAS 16.

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

Subsequent expenditure

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

Depreciation

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

Property, Plant and Equipment which has been reclassified as ‘Held for Sale’ ceases to be depreciated upon reclassification. Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

- Buildings – as per Professional Valuer’s estimate
- Plant and Machinery:

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

- Transport Equipment – 7 years

- Information Technology – 3 years

- Furniture and Fittings:

    - Furniture – short life 3 years
    - Furniture – medium life 5 years
    - Furniture – long life 10 years

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

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

Impairments

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

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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, government grant and other grant funded assets

From 2011/12 the accounting treatment for donations has changed. The new policy should be applied retrospectively, through a prior period adjustment.

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.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

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

Intangible fixed assets are capitalised when:

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

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

Measurement

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

Subsequently intangible assets are measured at fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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

Amortisation

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

1.9 Revenue government and government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The accounting treatment for Government grants has changed; the new policy will be applied retrospectively through a prior period adjustment. 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. 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 90 days or less and bank overdrafts. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases bank overdrafts are shown within borrowings in 'current liabilities' on the Statement of Financial Position. In the Statement of Cash Flows, bank overdrafts which are repayable on demand and which form an integral part of an entity's cash management are also included as a component of cash and cash equivalents with the equivalent items reported in the Statement of Financial Position.

1.12 Finance income and costs

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

1.13 Financial instruments and financial liabilities

Recognition

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

The Trust holds a financial liability in respect of assets acquired or disposed of through a finance lease at 31 March 2012. The Trust has not entered into any regular way purchases or sales in the year to 31 March 2012. Public Dividend Capital is not considered to be a 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 revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS foundation trusts disclose the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

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

1.16 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% (2010/11: 2.9%) in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 16 on page 141 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 143 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 19 unless the probability of a

transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

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

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

1.19 Value Added Tax

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

1.20 Corporation Tax

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

1.21 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

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

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

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

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

1.22 Third party assets

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

1.23 Losses and special payments

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

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

1.24 Application of International Financial Reporting Standards

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

2012/13

IFRS 7 Financial Instruments: Disclosures – amendment

IAS 12 Income Taxes amendment

1.25 Charitable funds

The Trust is not required to apply IAS 27 in 2011/12 following dispensation obtained by Monitor. However, this only applies to the consolidation of NHS Charitable Funds. The Trust has therefore not consolidated 'The Royal Orthopaedic Hospital Charitable Fund' into the financial statements for the Trust for the year ending 31 March 2012.

1.26 Related Party Disclosures

The IASB issued a revised version of IAS 24 in November 2009 which supersedes the version which was amended in 2003. The re-issued version is applicable from 2011/12 onwards. The new standard 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:

	Year Ended 31 March 2012		Year Ended 31 March 2011	
	£000	%	£000	%
Income from whole HM Government	69,584	97.67%	67,354	95.45%
Income from non HM Government	1,658	2.33%	3,212	4.55%
	71,242	100.00%	70,566	100.00%

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

3 Income from Activities

3.1 Income by type

	Year Ended 31 March 2012 £000	Year Ended 31 March 2011 £000
Elective income	40,834	41,578
Non elective income	2,582	2,784
Outpatient income	8,008	7,470
Other NHS clinical income	14,737	12,959
Private patient income	775	825
Other non-protected clinical income	31	48
Total income from activities	**66,967**	65,664
Other operating income		
Research and development	416	369
Education and training	2,370	2,496
Charitable and other contributions to expenditure	0	279
Reversal of impairments of property, plant and equipment	6	284
Income in respect of staff costs where accounted on gross basis	1,067	1,076
Other	416	398
Total other operating income	**4,275**	4,902
TOTAL OPERATING INCOME	**71,242**	70,566

Other income includes £93,981 from onsite catering services (2010/11 - £156,453); staff accommodation rentals of £75,902 (2010/11 - £64,751); car park income of £37,551 (2010/11 - £12,160); clinical tests of £12,276 (2010/11 - £6,190); private guests accommodation rentals of £28,034 (2010/11 - £22,677).

Other NHS clinical income includes £6,152,534 (2010/11 - £6,190,947) for oncology block contract income from the National Specialist Commissioning Team, £2,474,745 (2010/11 - £1,761,170) for critical care bed days and £1,468,570 (2010/11 - £1,272,185) for physiotherapy services.

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

3.2 Income by Source

	Year Ended 31 March 2012 £000	Year Ended 31 March 2011 £000
NHS Foundation Trusts	268	174
NHS Trusts	20	138
Strategic Health Authorities	6,156	6,191
Primary Care Trusts	58,553	57,253
Non NHS Private Patients	638	720
Non NHS Overseas patients	137	105
NHS Injury scheme (RTA)	31	48
Non NHS Other	1,164	1,035
TOTAL INCOME FROM ACTIVITIES	**66,967**	65,664

3.3 Private Patient Income

	Year Ended 31 March 2012 £000	Year Ended 31 March 2011 £000	Base Year £'000
Private patient income	775	825	1,446
Total patient related Income	66,967	65,664	33,956
Proportion (as percentage)	**1.16%**	1.26%	4.26%

Section 44 of the 2006 Act requires that the proportion of the private patient income to the total patient related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03.

Private patient income is defined as patient related income arising from charges imposed by the NHS foundation trust, in respect of goods and services provided by the NHS foundation trust directly to patients other than for the purposes of the National Health Service.

4 Operating Expenditure

	Year Ended 31 March 2012 £000	Year Ended 31 March 2011 £000
Services from NHS Foundation Trusts	1	0
Services from other NHS Trusts	408	5
Purchase of healthcare from non NHS bodies	1,154	1,235
Employee Expenses - Executive directors	617	623
Employee Expenses - Non-executive directors	103	96
Employee Expenses - Staff	36,740	37,005
Drug costs	480	417
Supplies and services - clinical (excluding drug costs)	8,524	7,739
Supplies and services - general	443	476
Establishment	759	717
Transport	138	178
Premises	4,531	4,238
(Decrease)/Increase in bad debt provision	(229)	211
Inventories write down	9	13
Inventories consumed	9,208	9,852
Depreciation on property, plant and equipment	2,302	2,425
Amortisation on intangible assets	78	79
Impairments of property, plant and equipment	922	1,913
Audit services - statutory audit	41	40
Other auditor's remuneration - further assurance services	12	10
Clinical negligence	869	760
Loss on disposal of other property, plant and equipment	53	3
Legal fees	215	111
Consultancy costs	284	405
Training, courses and conferences	256	216
Patient travel	13	13
Redundancy	0	0
Hospitality	5	2
Insurance	80	86
Other services eg external payroll	204	242
Losses, ex gratia & special payments	65	69
Other	527	364
TOTAL OPERATING EXPENDITURE	**68,812**	**69,543**

Impairment of property, plant and equipment includes an amount of £405,412 (£1,765,623 - 2010/11) which relates to an impairment (due to market revaluation) of the New Outpatients building situated on the existing premises.

5 Operating leases

5.1 Payments recognised as an expense

	Year Ended 31 March 2012 £000	Year Ended 31 March 2011 £000
Minimum lease payments	2,379	2,234
TOTAL PAYMENTS	**2,379**	2,234

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

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

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

The lease with BMI Healthcare limited expires 31 March 2012.

5.2 Total future minimum lease payments

	Land £000	Buildings £000	Other £000	Year Ended 31 March 2012 £000	Year Ended 31 March 2011 £000
- not later than one year;	1	21	7	29	2,259
- later than one year and not later than five years;	0	0	12	12	4,464
TOTAL FUTURE PAYMENTS DUE	**1**	**21**	**19**	**41**	6,723

6 Finance income and costs

	31 March 2012 £000	31 March 2011 £000
Interest from deposit account investments	142	131
TOTAL FINANCE INCOME	**142**	131

	31 March 2012 £000	31 March 2011 £000
Finance lease interest	46	30
TOTAL FINANCE COSTS	**46**	30

7 Employee costs and numbers

	2011/12			2010/11		
		Permanently			Permanently	
	Total	Employed	Agency	Total	Employed	Agency
	£000	£000	£000	£000	£000	£000
Salaries and wages	29,503	29,503	0	29,657	29,657	0
Social security Costs	2,533	2,533	0	2,452	2,452	0
Employers contributions to NHS Pensions	3,047	3,047	0	3,070	3,070	0
Agency and contract staff	2,274	0	2,274	2,449	0	2,449
TOTAL EMPLOYEE COSTS	**37,357**	**35,083**	**2,274**	37,628	35,179	2,449

7.1 Employee costs

The total Employer Pension contribution payable for the period is £3,046,653 (31 March 2011: £3,069,687).

7.2 Average number of persons employed		Permanently			Permanently	
	Total	Employed	Agency	Total	Employed	Agency
	Number	Number	Number	Number	Number	Number
Medical and dental	102	98	4	105	97	8
Administration and estates	228	227	1	229	228	1
Healthcare assistants and other support staff	77	76	1	78	78	0
Nursing, midwifery and health visiting staff	321	310	11	315	308	7
Nursing, midwifery and health visiting learners	1	1	0	3	3	0
Scientific, therapeutic and technical staff	136	126	10	127	118	9
Other	7	7	0	6	6	0
TOTAL PERSONS EMPLOYED	**872**	845	27	863	838	25

The number of permanently employed staff has increased by 7 WTEs from 838 in 2010/11 to 845 in 2011/12. This movement includes a 7 WTE reduction in substantive staff, and a 14 WTE increase in bank staff.

The increase in bank staff relates to a change in the payment mechanism for additional hours worked by substantive post holders in 2011/12. In 2010-11, a full-time substantive post-holder who worked additional hours would have been paid these hours as overtime. Overtime is not included in WTE calculations, so is excluded from the WTE figures in note 7.2. In 2011-12, a full time substantive post-holder wishing to work additional hours requires a separate bank contract. Additional hours worked on a separate bank contract are included in WTE calculations. This change in the process for additional hour's payments has increased the WTE figures in 2011/12 by 14 WTE.

7.3 Highest paid director ratio

The HM Treasury FreM requires disclosure of the ratio between the highest paid director and the median remuneration of the reporting entity's staff. The calculation is based on the full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis.

The Trust ratio for this calculation is 6.1:1 for the year ending 31 March 2012.

7.4 Retirements due to ill health

During the year to 31 March 2012 there were no early retirements from the Trust agreed on the grounds of ill-health (31 March 2011 – £0).

8 Intangible assets

	Software licences (purchased) £000	Total £000
Gross cost at 1 April 2011	276	276
Additions - purchased	61	61
Gross cost at 31 March 2012	**337**	**337**
Amortisation at 1 April 2011	139	139
Provided during the year	78	78
Amortisation at 31 March 2012	**217**	217
Net book value		
NBV - Purchased at 31 March 2012	120	120
NBV - Donated at 31 March 2012	0	0
NBV total at 31 March 2012	**120**	120

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

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

9 Property, plant and equipment for year ended 31 March 2012

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2011	49,762	3,135	31,793	1,030	278	10,478	19	2,892	137
Additions - purchased	3,316	0	1,826	0	569	863	0	58	0
Additions - government granted	1	0	1	0	0	0	0	0	0
Impairments charged to revaluation reserve	(624)	0	(623)	(1)	0	0	0	0	0
Reclassifications	0	0	278	0	(278)	0	0	0	0
Revaluations	(2,367)	0	(2,327)	(40)	0	0	0	0	0
Disposals	(4,313)	0	0	0	0	(3,328)	0	(959)	(26)
Cost or Valuation at 31 March 2012	**45,775**	**3,135**	**30,948**	**989**	**569**	**8,013**	**19**	**1,991**	**111**
Accumulated depreciation at 1 April 2011	10,138	0	42	0	0	7,233	8	2,718	137
Provided during the year	2,302	0	1,404	40	0	759	3	96	0
Impairments charged to income and expenditure	922	0	922	0	0	0	0	0	0
Reversals of impairments	(6)	0	(6)	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	(2,367)	0	(2,327)	(40)	0	0	0	0	0
Disposals	(4,260)	0	0	0	0	(3,273)	0	(961)	(26)
Accumulated depreciation at 31 March 2012	**6,729**	**0**	**35**	**0**	**0**	**4,719**	**11**	**1,853**	**111**
Net book value									
NBV - Purchased at 31 March 2012	35,426	3,135	28,438	989	569	2,149	8	138	0
NBV - Finance lease at 31 March 2012	1,001	0	0	0	0	1,001	0	0	0
NBV - Donated at 31 March 2012	2,619	0	2,475	0	0	144	0	0	0
NBV total at 31 March 2012	**39,046**	**3,135**	**30,913**	**989**	**569**	**3,294**	**8**	**138**	**0**
Analysis of Property, plant and equipment									
NBV - Protected assets at 31 March 2012	35,037	3,135	30,913	989	0	0	0	0	0
NBV - Unprotected assets at 31 March 2012	4,009	0	0	0	569	3,294	8	138	0
Total at 31 March 2012	**39,046**	**3,135**	**30,913**	**989**	**569**	**3,294**	**8**	**138**	**0**

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

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings
Net book value									
NBV - Purchased at 31 March 2011	35,930	3,135	29,229	1,030	278	2,073	11	174	0
NBV - Finance lease at 31 March 2011	1,172	0	0	0	0	1,172	0	0	0
NBV - Donated at 31 March 2011	2,522	0	2,522	0	0	0	0	0	0
NBV total at 31 March 2011	**39,624**	3,135	31,751	1,030	278	3,245	11	174	0
Analysis of Property, plant and equipment									
NBV - Protected assets at 31 March 2011	35,916	3,135	31,751	1,030	0	0	0	0	0
NBV - Unprotected assets at 31 March 2011	3,708	0	0	0	278	3,245	11	174	0
Total at 31 March 2011	**39,624**	3,135	31,751	1,030	278	3,245	11	174	0

9.2 Impairments

	31 March 2012	Operating income	Operating expenses	Revaluation reserve
	£000	£000	£000	£000
Changes in market place	1,546	0	922	624
Reversal of impairments	(6)	(6)	0	0
TOTAL IMPAIRMENTS AT 31 MARCH 2012	**1,540**	**(6)**	**922**	**624**

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

10 Inventories

	31 March 2012	31 March 2011
	£000	£000
Consumables	2,927	3,155
TOTAL INVENTORIES	**2,927**	3,155

	31 March 2012	31 March 2011
	£000	£000
Inventories recognised in expenses	9,208	9,852
Write-down of inventories recognised as an expense	9	13
TOTAL	**9,217**	9,865

11 Trade receivables and other receivables

	Financial Assets		Non-Financial Assets	
	31 March 2012	31 March 2011	31 March 2012	31 March 2011
	£000	£000	£000	£000
Current financial assets				
NHS Receivables	3,206	5,229	0	0
Other receivables with related parties	145	144	0	0
Provision for impaired receivables	(22)	(251)	0	0
	3,329	5,122	**0**	0
Prepayments	0	0	303	212
Accrued income	91	50	0	0
Interest receivable	2	1	0	0
PDC receivable	45	11	0	0
VAT receivable	0	0	153	74
Other receivables	543	1,057	0	0
	681	1,119	**456**	286
Total Current Financial Assets	**4,010**	6,241	**456**	286
Non-Current financial Assets				
Trade and other receivables	27	36	0	0
TOTAL TRADE AND OTHER RECEIVABLES	**4,037**	6,277	**456**	286

11.1 Impairment of receivables

	31 March 2012 £000	31 March 2011 £000
Balance at 1 April	251	40
(Decrease)/Increase in provision	(8)	211
Unused amounts reversed	(221)	0
Balance at 31 March	**22**	251

The ageing analysis of NHS and Non NHS impaired debts is as follows:**Error! Not a valid link.**

The ageing analysis of NHS and Non NHS non-impaired debts is as follows:**Error! Not a valid link.**

12 Other current assets

12.1 Current and Non-Current asset investments

The Trust did not hold any current asset investments or non-current asset investments in the period to 31 March 2012 (£nil – 31 March 2011).

13 Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
Cash and cash equivalents at 1 April	14,803	18,704
Net change in year	4,908	(3,901)
Cash and cash equivalents at 31 March	19,711	14,803
Broken down into:		
Cash at commercial banks and in hand	116	(24)
Cash with the Government Banking Service	19,595	14,827
Cash and cash equivalents as in Statement of financial position and Statement of Cash Flows	**19,711**	**14,803**

14 Trade and other payables

	Financial liabilities		Non-financial liabilities	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
NHS Payables	3,312	1,637	0	0
Amounts due to other parties	15	15	0	0
Trade payables - capital	446	636	0	0
Social security costs	0	0	361	345
Taxes payable	0	0	447	464
Other trade payables	3,218	3,568	0	0
Accruals	507	645	0	0
TOTAL TRADE AND OTHER PAYABLES	**7,498**	6,501	**808**	809

Other Trade Payables include £385,914 outstanding pension contributions at 31 March 2012 (31 March 2011: £398,649). There are no payments due in future years under arrangements to buy out the liability for early retirements over five years.

14.1 Other liabilities

	Current		Non-Current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Deferred income	1,122	621	0	0
TOTAL OTHER LIABILITIES	**1,122**	621	**0**	0

14.2 Borrowings

	Current		Non-Current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Obligations under finance leases	164	166	842	1,006
TOTAL BORROWINGS	**164**	166	**842**	1,006

14.3 Finance lease obligations

	Net lease liabilities		Gross lease liabilities	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Within one year	164	166	200	283
Between one and five years	787	784	687	715
After five years	55	222	172	344
	1,006	1,172	**1,059**	1,342
Included in :				
Current borrowings	164	166	0	0
Non-Current borrowings	842	1006	0	0
	1,006	1,172	**0**	0

15 Prudential Borrowing Limit

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

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

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

As per Section 46 of the Act, the Trust has a Prudential Borrowing Limit of £17,900,000 in 2011/12 (£17,200,000 in 2010/11). The Trust borrowed/repaid a net £nil in 2011/12 (£nil in 2010/11) and at 31 March 2012 had £nil of outstanding borrowing (£nil at 31 March 2011).

The Prudential Borrowing Limit is the sum of the following:

(i) Maximum cumulative long term borrowing: £13.9m (£13.2m – 31 March 2011), and
(ii) Approved working capital facility of: not to exceed £4.0m

Financial Ratio	Actual 2011/12	Plan 2011/12	Actual 2010/11	Plan 2010/11
Minimum Dividend Cover	2x	2x	2x	2x
Minimum Interest Cover	0%	0%	0%	0%
Minimum Debt Service Cover	0%	0%	0%	0%
Maximum Debt Service to Revenue	0%	0%	0%	0%

The Trust has an approved working capital facility of £4.0m (£4.0m in 2010/11). The Trust had not utilised any of its working capital facility at 31 March 2012 (£0 at 31 March 2011).

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

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

16 Provisions for liabilities and charges

	Current		Non-Current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Legal claims	157	96	0	0
Other	20	20	240	239
TOTAL PROVISIONS	**177**	116	**240**	239

	Legal claims	Other	Total
	£'000	£'000	£'000
At 1 April 2011	96	259	355
Arising during the year	65	0	65
Utilised during the year	(4)	(12)	(16)
Unwinding of discount	0	13	13
At 31 March 2012	157	260	**417**
Expected timing of cash flows:			
not later than one year	157	20	177
later than one year and not later than five years	0	44	44
later than five years	0	196	196
Total expected timing of cash flows	157	260	**417**

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

Other claims relate to injury benefit provisions which are discounted using the real discount rate set by HM Treasury. From 1 April 2005 this rate is 2.2%. No uncertainty relates to this provision as it is being paid by the Trust on a quarterly basis.

The NHS Litigation Authority as at 31 March 2012 has £6,286,969 (£4,029,561 – 31 March 2011) in respect of clinical negligence liabilities of the Trust included in its accounts.

17 Contractual Capital Commitments

	31 March 2012	31 March 2011
	£000	£000
Property, plant and equipment	1,073	1,508
TOTAL CONTRACTUAL CAPITAL COMMITMENTS	**1,073**	1,508

Capital commitments include £341,489 for ambulatory care structural work to relocate the current day unit and admission wards, £176,377 for the new theatre scheme building work to create a new HDU department and £452,272 for kitchen building works.

18 Revaluation Reserve

	Total Revaluation Reserve	Revaluation Reserve - property, plant and equipment
	£'000	£'000
Revaluation reserve at 1 April 2011	3,268	3,268
Impairments	(624)	(624)
Other reserve movements	1	1
Revaluation reserve at 31 March 2012	**2,645**	2,645
	£'000	£'000
Revaluation reserve at 1 April 2010	3,156	3,156
Prior period adjustment	517	517
Revaluation reserve at 1 April 2010 - restated	3,673	3,673
Impairments	(405)	(405)
Revaluation reserve at 31 March 2011	**3,268**	3,268

The prior period adjustment relates to an accounting policy change for donated and government grant assets. Donated and grant funded property, plant and equipment assets are now capitalised at their fair value on receipt.

19 Contingent Liabilities

	31 March 2012	31 March 2011
	£000	£000
Gross value of contingent liabilities	0	8
NET VALUE OF CONTINGENT LIABILITIES	**0**	**8**

There are no contingent liabilities or contingent assets for the year ending 31 March 2012. The liability at 31 March 2011 related to two employee liability claims.

20 Post Balance Sheet Events

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

21 Related party Transactions

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

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

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

	Receivables	Payables	Revenue	Expenditure
	£000	£000	£000	£000
London Strategic Health Authority	128	0	6,141	0
Birmingham East and North PCT	381	13	6,107	0
Dudley PCT	48	894	3,658	0
Sandwell PCT	103	776	3,766	0
Solihull Care PCT	212	0	2,028	0
South Birmingham PCT	400	107	19,363	0
Coventry Teaching PCT	0	222	487	0
Walsall PCT	157	11	2,226	0
Worcestershire PCT	266	0	6,450	0
Herefordshire PCT	161	1	512	0
Heart of Birmingham PCT	168	9	3,345	8
Birmingham Community Health NHST	0	131	0	396
Birmingham Childrens Hospital NHS Foundation Trust	376	396	132	9
University Hospital Birmingham NHS Foundation Trust	197	228	320	3,312

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

	Receivables	Payables	Revenue	Expenditure
	£000	£000	£000	£000
NHS Litigation Authority	14	0	873	0
NHS Purchasing and Supply Agency	92	127	892	0

The Trust has also received revenue payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Trust Board. The Trust charged the Trust's charity for finance administration services totalling £13,603 during the year (£13,402 – 31 March 2011).

22 Private Finance Initiatives

The Trust did not have any Private Finance Initiative schemes as at 31 March 2012.

23 Financial Instruments

The Royal Orthopaedic Hospital NHS Foundation Trust seeks to minimize its financial risks and through its treasury management policy does not buy or sell financial instruments. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency Risk

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

Interest Rate Risk

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

Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

Liquidity Risk

The Trust's operating costs are incurred under contracts with NHS Primary Care Trusts who are financed annually from resources voted from Parliament. Such contract income is received in accordance with the NHS funding mechanism Payments by Results with regular twelfth payments made monthly and a quarterly adjustment made to bring payments in line with actual activity. This can generate a short-term cash flow impact which would be covered by the Trust's £4,000,000 working capital facility. The Trust aims to fund capital schemes by internally

generated funds. In addition the Trust can borrow from the Department of Health's financing facility or commercially. The Trust is therefore not exposed to significant liquidity risk.

Set out below is an analysis, by category, of the Trust's financial assets and liabilities as at 31 March 2012. Fair value approximates to the book value because of the short maturity of these instruments.

23.1 Financial Assets

	Carrying value 31 March 2012 £000	Fair value 31 March 2012 £000	Carrying value 31 March 2011 £000	Fair value 31 March 2011 £000
Current financial assets				
Trade and other receivables	3,329	3,329	5,122	5,122
Other current assets	681	681	1,119	1,119
Cash and cash equivalents	19,711	19,711	14,803	14,803
	23,721	23,721	21,044	21,044
Non-current financial assets				
Trade and other receivables	27	27	36	36
TOTAL FINANCIAL ASSETS	**23,748**	**23,748**	21,080	21,080

23.2 Financial Liabilities

	Carrying value 31 March 2012	Fair value 31 March 2012	Carrying value 31 March 2011	Fair value 31 March 2011
Current financial liabilities	£000	£000	£000	£000
Measured at amortised cost:				
Finance leases	1,006	1,006	1,172	1,172
Trade and other payables	7,498	7,498	6,501	6,501
Provisions under contract	177	177	116	116
	8,681	8,681	7,789	7,789
Non-current financial liabilities				
Provisions under contract	240	240	239	239
TOTAL FINANCIAL LIABILITIES	**8,921**	**8,921**	8,028	8,028

24 Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. In the year 2011/12 the Trust had 20 (31 March 2011: 23) separate losses and special payments, totaling £19,003 (31 March 2011: £46,484). These were in relation to cash losses and ex-gratia payments to patients.

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

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

25 Third Party Assets

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

26 Going Concern

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

27 Auditor's Liability

The auditors have a limitation of their liability in accordance with their engagement letter signed on the 10th May 2012 for the amount of £1 million.