Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Annual Report and Accounts 2018–2019

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Annual Report and Accounts for the period of 1 April 2018 to 31 March 2019

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ANNUAL REPORT

INTRODUCTION

Statement of Chairman and Chief Executive

At The Robert Jones and Agnes Hunt NHS FT we aspire to deliver world-class patient care. As a high quality specialist orthopaedic hospital our core purpose is to care for our patients, our staff and our finances. We are a leading orthopaedic centre of excellence with a reputation for innovation. Our staff pride themselves on the standards we achieve and in the feedback received from our patients on the quality of our services.

The following Annual Report details our performance for the 2018/19 financial year. The report outlines our key objectives and how we have progressed against these; it describes our governance arrangements, and provides detail on the important aspects of quality and finance which underpin our organisational achievements. The full performance report across all these areas is contained within this document.

There is plenty from the last year to look back on with pride – not least the hospital being rated as 'Good' overall, and 'Outstanding' for caring, in our latest inspection report from the Care Quality Commission, which was published in February 2019. We were also rated as 'Good' in a Well Led Review that formed part of that inspection process.

We were also thrilled with the fantastic feedback we received from our own patients over the past year. The annual Adult Inpatient Survey carried out by the CQC once again highlighted RJAH as one of the best hospitals in the country – and named one of just eight to be rated as performing "much better than expected". The same survey also saw food at RJAH rated as the best in the country. The Trust has come out top for the quality of its food in 12 out of the last 13 years.

Then there was the National NHS Staff Survey, which showed that our staff rated RJAH as the best specialist organisation to work for in the country – with 79% recommending it as a place to work. We would of course like that to be 100%, and we are certainly not complacent about these results. We have a cultural ambition to be a truly world-class place to work and will keep innovating to move in that direction.

Another key milestone from the last year was the launch of our latest Trust appeal , which has set the aim of raising £1.5 million to fund the country's first dedicated Veterans Orthopaedic Centre. Patrons of the appeal include Dame Vera Lynn and Dame Kelly Holmes. The appeal was launched with a reception at the House of Commons.

Linked to our support of the Armed Forces and our veterans, we were named as one of just 24 'Veteran Aware' NHS organisations. This mark of distinction means that patients who have served in the UK Armed Forces will be cared for by front-line staff who have received training and education on their specific needs, and can also signpost them to local support services.

We were proud to announce a £4 million capital programme, thanks to our strong financial performance in recent years. Projects funded from the programme included a refurbishment of Kenyon Ward and the lease of a new state-of-the-art CT scanner. The continuing financial stability set out in this annual report means that we have been able to set out plans for an even bigger programme worth £5 million in 2019/20.

It was particularly pleasing that our patient safety culture was recognised with certification as a Quality Data Provider by the National Joint Registry. This meant we go above and beyond what is legally required to make our processes safe – we did this by establishing a Procedures Committee, chaired by a senior clinician, which scrutinises all implants that have not been authorised before. No surgeon can use an implant not previously used at the hospital without the sign-off of this committee.

Our quality focus is essentially underpinned by robust business management, which is demonstrated in our delivery of a control total surplus of £1.1 million in 2018/19. This surplus was in line with our control total set by NHS Improvement and therefore made us eligible for additional provider sustainability funding worth a further £2.4 million. This will provide a basis for our future growth and development, enabling re-investment to improve care for patients. In the current financial climate across the NHS it was quite an achievement, and one of which we are very proud.

Over the next year, we will look to build on our recent successes, continue to grow and work towards our vision of aspiring to deliver world-class patient care. The current climate continues to be a difficult one, but we are confident that we are well equipped to meet those challenges and to flourish.

Frank Collins
Chairman

Mark Brandreth
Chief Executive

Highlights of the year

The Trust had plenty of reasons to celebrate in 2018/19. Here are just a few of our many highlights from the year:

- RJAH was rated 'Good' by the Care Quality Commission – and 'Outstanding' for Caring – in its latest inspection report.
- The Trust was able to announce a £4 million capital investment programme thanks to its strong financial performance in recent years. Projects funded from the programme included a refurbishment of Kenyon Ward and the purchase of a new state-of-the-art CT scanner.
- A new Trust appeal was launched, with the ambition of raising £1.5 million to fund the country's first dedicated Veterans Orthopaedic Centre. Patrons of the appeal include Dame Vera Lynn and Dame Kelly Holmes. The appeal was launched with a reception at the House of Commons.
- RJAH was named as one of just 24 'Veteran Aware' NHS bodies. This mark of distinction means that patients who have served in the UK Armed Forces will be cared for by front-line staff who have received training and education on their specific needs, and who can signpost them to local support services.
- The annual Adult Inpatient Survey once again highlighted RJAH as one of the best hospitals in the country – and one of just eight to be rated as performing "much better than expected".
- The same survey also saw food at RJAH rated as the best in the country for the third year running.
- Staff at RJAH rated it the best specialist organisation to work for in the country – with 79% recommending it as a place to work in the National Staff Survey.
- The Trust was a finalist in the Provider Trust of the Year category at the HSJ Awards for the second successive year.
- Staff Nurse Pip Page-Davies and Patient Admission Coordinator Paula Irving were named in healthcare's Top 70 Stars. The initiative from the NHS Confederation was part of the celebrations for the NHS's 70th birthday.
- The Swan Scheme, a national initiative to help improve end-of-life care for patients and their families, has been adopted by staff at RJAH.
- The patient safety culture at RJAH was recognised with certification as a Quality Data Provider by the National Joint Registry.
- Two members of our Spinal Injuries team – Consultant Nurse Alison Lamb and Service Manager Lynne Morris – were winners at the Spinal Injuries Association's prestigious Rebuilding Lives Awards.
- The career opportunities at RJAH were recognised, with the Trust being awarded the Talent Match Mark Youth Friendly Gold Award for supporting young people in their journey into work.
- Our Neuromuscular team, Biobank of the Study of Health and Disease, and Sarcoma team won a Meridian Award for embedding the 100,000 Genomes Project into clinics to improve patient care.
- We were full of admiration for a team of 25 runners who took part in the London Marathon to support the hospital's charity – raising an incredible £50,000 in the process.

PERFORMANCE REPORT

Overview of Performance

Statement from the Chief Executive

This section of the report provides an opportunity to highlight some of the considerable work that has been undertaken to enhance the Trust's services and to improve patient care and experience in the last year, centred on our key strategic themes. It also highlights the key risks to the achievement of the Trust's objectives.

We can be proud of the performance we have delivered in 2018/19. Below I have summarised some of our key items in terms of the impact on our patients, our staff and our finances.

There are some notable successes and I am proud of each and every one. Across them all, however, is the quality of care we deliver.

Over the last 12 months we have really placed an emphasis on patient safety. We want to be the safest specialist hospital in the world. We were rated as 'good' for safety by the Care Quality Commission, which was a notable achievement.

We want to be compared with the best of the world. We still have work to do to realise this ambition but we remain committed to our journey of improvement.

Caring for Patients

Our latest CQC Report was published in February 2019 and saw us rated as 'Good' overall and 'Outstanding' for care.

We have stepped up our work on care for veterans over the last year. Our campaign to raise £1.5 million for the UK's first dedicated Veterans Orthopaedic Centre was launched. We were also one of just 24 NHS bodies to be certified as Veterans Aware.

Caring for Staff

We have continued to place great emphasis on improving the culture of our organisation. We started this work almost three years ago with the launch of a Rebuilding Relationships programme. That has now evolved into Make The Difference, with an ambition to make this a truly extraordinary place to work.

The findings are seen in the results of the latest NHS Staff Survey which highlighted that we were rated as the best specialist Trust to work for in the country.

It is also great to see evidence from the Staff Survey that we are becoming an improvement-driven organisation. Over the last couple of years we have launched the Service Improvement Champions programme, and also the Ideas Scheme. These were all about empowering all of our people to make the changes they know are needed in their own areas. The survey shows that now is happening.

Caring for Finances

NHS organisations continue to experience pressure to reduce costs. Providers and commissioners alike have run up record-breaking deficits in recent years and the situation has got no better in the past 12 months.

However, in 2018/19, we generated a surplus of £1.1 million and in doing so delivered the control total set for us by NHS Improvement. This resulted in the Trust being eligible for a further £2.4 million of funding, money that will help us stay solvent in the medium and long-term, and help us continue to grow.

Looking ahead

We have to keep improving and keep growing. We must think about how we can continue to flourish in what is a difficult time for the NHS, both locally and nationally.

We continue to focus on our strategic aims, which are:

Operational Excellence

- getting a real grip on the operational things that will make a significant difference to our patients.

Local Musculoskeletal Services

- establishing RJAH as a central part of the local health system, rather than a fringe specialist provider.

Specialist Work

- being a national voice in our area of expertise, working in partnership with our specialist neighbours.

Underpinning the above outlined aims is one more important aim: **Culture and Leadership**. We must be a patient-focused, clinically-led organisation that is spoken of as an extraordinary place to work.

The Trust

Purpose and Activities

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is one of the UK's five Specialist Orthopaedic Centres. It is a leading orthopaedic centre of excellence with a reputation for innovation.

The Trust provides both specialist and routine orthopaedic care to its local catchment area and nationally. It is a specialist centre for the treatment of spinal injuries and disorders and also provides specialist treatment for children with musculoskeletal disorders.

The hospital has nine inpatient wards including a private patient ward; 12 operating theatres, including a day case surgery unit; and full outpatient and diagnostic facilities.

In addition to the above, the Trust works with partner organisations to provide specialist treatment for bone tumours and community-based rheumatology services.

The Trust is based on a single site in Oswestry, close to the border with Wales. The surrounding geographical area includes Shropshire, Wales, Cheshire and the Midlands. As such, we serve the people of both England and Wales, as well as a wider national catchment. We also host some local services which support the communities in and around Oswestry. We value our links with the local community, who are strong supporters of the hospital. The Trust has contracts with a number of commissioners.

The largest English commissioner is the Shropshire Clinical Commissioning Group (Shropshire CCG). The Betsi Cadwaladr University Hospital Board is the largest Welsh Commissioner followed by Powys Teaching Health Board. Commissioning for our specialised services is undertaken by NHS England, which is represented locally by the Birmingham and Black Country Local Area Team.

Brief History and Background

The orthopaedic hospital has been in existence as an independent hospital since 1900. It was taken into the NHS in 1948 and achieved NHS Trust status in 1994. In August 2011 the hospital was awarded NHS Foundation Trust status. This means that RJAH can better shape healthcare services around local needs and priorities and the requirements of commissioners of healthcare.

Sir Robert Jones

Dame Agnes Hunt

The Vision and Goals of the Trust

MISSION	Our core purpose	Caring for Patients, Caring for Staff, Caring for Finances
VISION	What we aspire to achieve	Aspiring to deliver World Class Patient Care
STRATEGY	Our strategic priorities	Operational Excellence; Local Musculoskeletal Services; Specialist Work; Culture and Leadership
ENABLING STRATEGIES	Strategies to support delivery of our priorities	Quality Strategy; Finance Strategy; IT Strategy; Patient Experience Strategy; Organisational Development Strategy; Risk Management Strategy; Communication Strategy
CORPORATE OBJECTIVES	How we organise and monitor our day-to-day activities	Delivering timely access to patient care; Delivering outstanding outcomes and experience; Achieving outstanding patient safety; Being an extraordinary place to work; Spending our money wisely; Delivering undertakings and not being in breach of our licence
VALUES and CULTURAL CHARACTERISICS	How we go about delivering our vision	Trust Values (Friendly · Caring · Excellence · Professional · Respect)

1. We respect people for their skills and devotion. Not their grade.
2. Patient need over rules process.
3. We choose positivity (we look for strength before weaknesses).
4. The person who knows most about something is able to get on with it.
5. Being humble is a sign of greatness, not weakness.
6. People are aware of – and manage – the impact they have on others.
7. We are honest and transparent in our dealings with each other.
8. If we see a problem we can fix it, if we see an opportunity we can grasp it.
9. We strive constantly to make things better for our patients, ourselves and the hospital.
10. We know that our differences are valuable – we don't believe that our differences make us superior or inferior.
11. We are do-ers not bystanders if we see something we *don't* like we say so (and do something about it), and if we see something we *do* like, we say so.

Key Issues and Risks

The Trust aims to deliver high quality healthcare services, however, it is recognised that there are inherent risks with providing these services.

The most significant risks are summarised in the Board Assurance Framework. The principal risks are collated into the following themes:

- Risks to Caring for Patients
- Risks to Caring for Staff
- Risks to Caring for Finances

During 2018/19 the key risks facing the Trust continued to be in relation to its ability to safely meet its activity requirements and the impact of this on its financial plan. There was also a focus on the Trust's compliance with the CQC standards; and with an inspection undertaken during the financial year with improvement demonstrated, this risk was downgraded in March 2019. Finally, the Trust continued to focus on its workforce risks with work on the sustainability and development of its workforce.

The key risks and issues facing the Trust for 2019/20 are as follows:

Caring for Patients

- Inadequate clinical engagement in work streams to reduce clinical variation
- Failure to implement national recognised evidence-based practice
- Limitations as a result of IT capabilities
- Inadequate operational processes
- Lack of clear national strategy for the commissioning of specialist services
- MSK service integration fails to deliver expected benefits

Caring for Staff

- Failure to improve staff engagement linked to communication between managers and the workforce
- Potential inability to have the right workforce in the right place at the right time

Caring for Finances

- Instability arising from fluctuations in the tariff
- Failure to achieve activity and income target within planned cost base

Risk Management

Risk management is an integral part of the Trust's approach to quality improvement and good governance and further it is a central part of the Trust's strategic and operational management. The Trust has in place a robust Risk Management Strategy which describes the systems that the Trust will use to embed risk management throughout the organisation in order to provide assurance that risks are managed and an effective internal control system is in place. The strategy is a Trust-wide document, and is applicable to employees, as well as seconded and sub-contracted staff at all levels of the organisation.

The Trust believes that effective risk management is imperative not only to provide a safe environment and improved quality of care for service users and staff, it is also significant in the business planning process. In light of this, the Trust is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities.

The Trust's Risk Management Strategy is subject to annual review via the Risk Management Committee and approval at Trust Board and it was last reviewed in September 2018.

Going concern disclosure

The Trust's cash balances are expected to remain sufficient to meet its working capital requirements for 12 months from the date of the financial statements. The Trust's Board monitors the financial performance using the monthly performance report. The key risks to the Trust's financial stability are included in the Board Assurance Framework and are monitored at the Finance, Planning and Digital Committee (formerly the Finance Planning and Investment Committee) and the Audit Committee.

The directors having taken assurance from this and, having reviewed future plans and financial forecasts for a period of at least one year from the date of the approval of the accounts, have agreed the following statement: "After making enquiries, the directors have a reasonable expectation that the 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".

Performance Analysis

Trust Performance

The Trust's overall performance in 2018/19 has been good and feedback from patients on services continues to be excellent. Performance is monitored through a broad range of both externally and internally driven Key Performance Indicators (KPIs) covering three domains:

- Caring for patients
- Caring for finances
- Caring for staff

These domains are detailed within the Trust's Integrated Performance Management report and reviewed monthly by the Trust Board. The KPIs used within the monthly performance report are reviewed annually to ensure that they give the Board the information required to oversee the delivery of the Trust's targets and objectives. Within the divisions and sub-specialty teams, monitoring is linked to overall Trust performance through the scorecard approach. Performance is confirmed by regulatory bodies, feedback from staff/patients and commissioners.

The Trust was inspected by the CQC in November 2018 with a report published in February 2019 which sees the Trust rated as 'good' overall and 'outstanding' for caring.

In March 2019, the Trust delivered 92.14% against the 92% 18 week Referral to Treatment open pathways target.

The Trust planned a control total surplus of £1.1 million for 2018/19 and delivered a surplus of £1.1 million excluding sustainability and transformation funding of £2.4 million.

Performance highlights across some of the key performance areas for the Trust during 2018/19 were as follows:

Caring for Patients

- 2018/19 was another year of improvements and new challenges in the continuing campaign to reduce avoidable Health Care Associated Infection (HCAI) at RJAH Orthopaedic NHS Foundation Trust.

- Successes include meeting our MRSA bacteraemia target of zero for the 13th year running and seeing a reduction in E.coli bacteraemia associated with health care. However, our numbers of C. *difficile* cases rose and at three cases we were over our target of two cases.

- The Trust continues to work towards the delivery of its Quality Improvement strategy which sets out the Trust's Quality aims for the next five years. Further good progress has been made with delivering the Patient Experience strategy, ensuring that we continue to be the best that we can be in relation to the experience of our patients

- The National Inpatient Survey 2018 results published by Picker Institute shows that the Trust achieved a response rate of 58.5% against a national average of 38.3% and the respondents' scores indicate the Trust is significantly better than average in 56 out of the 60 applicable questions. The final benchmarked report is due for publication in May 2019. The

last benchmarked report received by the Trust was in May 2018 and this confirmed that 824 patients had responded with 97% saying their care was seven out of ten or higher. Further, the Trust was noted to have performed better than most other Trusts in 9 out of the 10 applicable sections of the survey. Other highlights from the survey were that 97% of patients had complete faith in their doctors and 95% said they were treated with respect and dignity. Cleanliness also scored well with 100% saying their room or ward was very or fairly clean.

- The Trust has continued to score highly on the % of patients who would recommend the Trust through the Friends and Family Test, which asks patients 'would you recommend the Trust to family and friends'. The Trust's average monthly score was 99% of inpatients who would recommend the Trust to friends and family, which is higher than the average score of all NHS Trusts in England which was 96%. The Trust is one of the top performing NHS Trusts in the country for the Family and Friends Test.

- At March 2019, the Trust had one 52-week waiter[1] and RTT (referral to treatment time) performance stood at 92.14% compared to 90.05% in March 2018.

- The Quality Report, which is included within this Annual Report, gives an analysis of the Trust's performance against all of the national and locally agreed Quality and Safety indicators and further explanation of the Trust's work to continually improve the patient experience.

Caring for Finances

- The Trust overachieved against the baseline control total surplus by £28k giving a year-end surplus of £1.132 million. This rises to a surplus of £3.482 million when Provider Sustainability Funding (PSF) worth £2.350m is included. The PSF income is made up of £0.833m core income earned in full through delivery of the control total and £1.517m bonus/incentive STF earned as part of a national allocation of unearned PSF from other Trusts notified at the year-end. This position was supported by an efficiency programme which realised £3.7 million efficiencies in year.

- The Trust was allocated a 'core' agency ceiling target of £1,560k in **2018/19**. Agency spend was closely monitored and managed across the year and the Trust delivered a favourable variance to the target of £81k with expenditure totalling £1,479k.

Caring for Staff

- The Trust achieved a Staff Survey response rate of 41.5% (575 members of staff) and results were benchmarked against other Acute Specialist Trusts. Results were considerably better than 2017/18 with key headlines as follows:
    - Friends and Family test scores showed 75% would recommend the Trust as a place to work and 93% would recommend it for treatment and care
    - Engagement scores are slightly above average when compared with other acute specialist trusts

[1] this patient has subsequently requested to be removed from the waiting list.

- Work continues on developing an open culture, improving communication particularly between managers and staff and improving our leadership capacity and capability
- Key areas of improvement relate to learning from our mistakes up by 11% and communications between senior managers and staff with improvements up to 10%

Activity Analysis

The number of patients treated has increased during 2018/19. The data for GP referrals and activity has been refreshed retrospectively to align with that reported in the Trust's integrated performance report to ensure consistency both in reporting throughout the year and the Annual Report.

The decrease in surgical referrals and subsequent surgical planned inpatient stays is driven by the county-wide roll out of the Shropshire Orthopaedic Outreach Service which focuses on managing Musculoskeletal conditions outside hospital where possible.

	Division	15/16	16/17	17/18	18/19
Outpatients	Surgical	81,808	84,759	60,104	60,335
	Medical	24,419	27,641	48,946	55,327
	Total	**106,227**	**112,400**	**109,050**	**115,662**
Planned Inpatient Stays	Surgical	12,765	12,484	11,767	11,545
	Medical	2,087	2,387	3,067	3,453
	Total	**14,852**	**14,871**	**14,834**	**14,998**
Non Elective Stays	Surgical	289	298	302	345
	Medical	422	359	362	406
	Total	**711**	**657**	**664**	**751**
GP Referrals	Surgical	14,456	13,996	14,498	12,746
	Medical	8,072	8,225	8,488	9,141
	Total	**22,528**	**22,221**	**22,986**	**21,887**

Financial Analysis

The Trust consolidates its charity accounts into the Trust accounts, so to aid clarity, financial narrative and figures in this report show both the Group (including the charity) and the Trust on its own.

The Trust was set a control total surplus by NHS Improvement of £1,104k for 2018/19. Despite a number of in-year operational pressures the Trust achieved this target and therefore became eligible for additional provider sustainability funding (PSF) from NHS Improvement. This contained a core element of £833k and a further unplanned bonus element of £1,517k, which was a share of the unclaimed national sustainability fund. The final control total surplus for the year including sustainability funding was £3,482k.

The control total adjusts the accounting surplus for non-performance related elements such as the effects of charitable capital donations. A reconciliation between the two is included below:

	2018/19 £'000
Accounting surplus for the year	3,194
Add back capital donations/grants impact	288
Control total surplus (including PSF)	**3,482**
Less PSF	-2,350
Control total surplus (excluding PSF)	**1,132**
Control total target	-1,104
Over-achievement against control total	**28**

This strong financial performance has improved our financial resilience and will enable future investments back into services. It was supported by a programme of cost improvements which realised £3.7 million savings in-year from operating more efficiently (2017/18 £4.1 million).

In addition to the Trust's financial performance, the charity made a surplus of £327k, mainly due to increased donations as the new appeal for the Veterans Orthopaedic Centre was launched.

The accounting surplus of the Group and the Trust from the 2018/19 Annual Accounts is shown below. This differs for the Trust from the control total by the value of non-performance related adjustments (£288k) which relate to charitable capital donations:

	Group 2018/19 £'000	Trust 2018/19 £'000
Operating income	113,490	112,914
Operating expenses	-108,200	-107,946
Net finance costs	-1,769	-1,774
Surplus	**3,521**	**3,194**

Year-end cash balances totalled £6.7 million (£5.7 million for the Trust and £1m for the charity) which is an increase on the previous year's balance of £5.1 million (£4.2m for the Trust and £0.9m for the charity).

A full set of the Annual Accounts is included at the end of the Annual Report and further analysis of the Trust's financial performance is included in the Directors' report.

Capital Programme

The Trust invested £4.1 million in the capital programme for 2018/19, compared to £2.4 million in 2017/18 and includes donations of £320k from the RJAH Charity and the League of Friends.

The Trust invested in areas to improve services and resilience including:

- Building infrastructure works to enable the new leased CT scanner to be installed, the old one having reached the end of its useful life.
- Refurbishment of an existing area to create a co-ordination centre allowing staff to respond more effectively to real-time information to manage service demand.

- Refurbishment of wards and equipping of those areas to increase bed capacity.
- Fire risk reduction work to reduce the likelihood of a fire and improve safety in the event of a fire.
- Early stages of implementing a new Electronic Patient Record (EPR) system and upgrading of the Trust's physical network infrastructure.

The Trust has continued to invest in routine areas to ensure that quality and service continuity are maintained; these include:

- Estates backlog maintenance – this includes maintenance of areas such as roofing, car parks, cosmetic improvements and replacement of ageing infrastructure.
- Medical equipment – this includes replacement of ageing medical equipment and investment in additional equipment to support service improvement. Significant purchases include a bone density scanner, endoscopic spinal equipment, and a mobile image intensifier.
- Information Technology (I/T) – this includes investment in new technologies and ways of working as well as routine replacement of hardware and software.

Capital Scheme	2018/19 £'000
I/T investment/replacement	893
Backlog maintenance & site improvements	765
CT Scanner replacement (infrastructure works)	653
Medical equipment	628
Fire safety work	439
Bed capacity solution	360
Project management & fees for future capital schemes	161
Co-ordination centre	128
Other	75
Total capital expenditure	**4,102**

The Environment and Sustainability

In January 2014, the Sustainable Development Unit (SDU) launched a new Sustainable Development Strategy for the NHS, Public Health and Social Care System 2014-2020 – this replaced the previous NHS Carbon Reduction Strategy 2009. The Strategy describes the vision for a sustainable healthcare system which reduces carbon emissions, minimises waste and pollution, makes the best use of scarce resources, builds resilience to a changing climate and nurtures community strengths and assets.

The Board of Directors is unanimous in its continued commitment to work towards a low carbon NHS which is good for health. It is an opportunity not only to help the NHS to become a sustainable, high-quality healthcare service but also to save the Trust money.

In 2014/15 the Trust exceeded the Carbon Reduction Commitment (CRC) threshold, which meant it became a participant in Phase 2 of the CRC Energy Efficiency Scheme. The Trust has to purchase Carbon Credits annually to offset energy use at a current cost of c£90k per annum through to 2019.

In response to this, through the Trust's Sustainability Working Group, the Trust revisited and refreshed its own Sustainable Development Strategy ensuring that whilst delivering outstanding

patient care remains the Trust's primary focus, it is committed to embedding sustainability across the organisation, understanding that it must play its part and tackle the challenges of sustainability because of the longer-term impact on the health and wellbeing of service users, employees, visitors and the wider community.

The strategy focuses on five key areas of commitment:

These areas have been chosen to reflect both the national trend of areas requiring the most improvement and those themes upon which this Trust can make the greatest measurable impact.

The Trust's development and oversight of the delivery of this Sustainability Strategy agenda will be reported through the Annual Report. The Trust has both a named executive and non-executive director for sustainability.

The targets set for the Trust are:

The introduction, in 2016, of a combined heat and power (CHP) unit at the Trust has had a step change effect on the way the Trust consumes energy. The CHP unit uses gas to generate electricity at the Trust site; as a by-product of the generation process heat is captured and utilised to heat the Trust, thus creating a highly efficient process. Utilising the CHP to its greatest potential has had the effect of increasing the Trust's gas consumption from the grid. The Carbon Trust recognises that grid gas generation is far less harmful to the environment, generating 2.5 times less CO_2 per kWh; as such the deviation from 2020 target is less of a concern. Because of the efficiencies created by the CHP unit the Trust is likely to remain above the original target, a target it had met through conventional, but less efficient, processes; as such the target will be reviewed to recognise the efficiencies whilst still demonstrating a commitment to minimise the impact the Trust has on the environment.

The Trust continues to prioritise water safety compliance, undertaking a high number of water flushing exercises; flushing reduces the likelihood of issues related to water-borne bacteria but increases the volume of water used. Water per patient has improved from 2017/18 and remains on target to achieve the National 2020 target, but the improvement is not sufficient enough to suggest the Trust will achieve the most stringent target that it set itself.

Waste created at the Trust is increasingly avoiding landfill as the Facilities Department raises awareness of the most appropriate, greenest, waste streams and is making more recycling bins available. There is pleasingly a general interest throughout the Trust to reduce landfill waste, particularly plastics.

The below table demonstrates the progress made against the National 2015 and 2020 Sustainability target, plus the Trust's own Sustainability Strategy target. It should be noted that due to the use of CHP the Trust's gas usage has increased but its electric usage has decreased, therefore whilst the mix of gas and electric no longer fall into line with predicted improvements, overall energy consumption is well within the strictest target.

	National / Trust Targets			Progress					
Metrics	*National 2015*	*National 2020*	Trust 2020	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total Energy (Kilowatt Hrs per patient)	*218*	*182*	NA	145	135	131	135	154	136
Gas (Kilowatt Hrs per patient)	*112*	*94*	NA	102	94	92	105	130	111
Electric (Kilowatt Hrs per patient)	*57*	*47*	35	42	40	38	30	24	25
Water (Litres per patient)	*816*	*680*	560	658	595	698	617	665	632
Waste (% Landfill avoidance)	*NA*	*75%*	90%	78%	83%	82%	84%	87%	Xx

Key:

On course to achieve strictest target - Slipping from strictest target - Likely to fail strictest target

Social, Community and Human Rights

The Trust continues to have strong links with the local community, which are enhanced by its public governors. It has an active apprentice scheme and in 2018-19, 33 staff commenced an apprenticeship qualification with the Trust.

The Trust also provided work experience placements for 147 local young people and held an "Operating Theatre Live" event for 16-18 year-olds.

We have played an active role in our local community working with 25 members of staff acting as health ambassadors supporting careers fairs, training programmes and other community events.

The Trust takes its social responsibilities seriously; patients' rights are enshrined in the NHS Constitution and the Trust's policies and procedures promote those rights. Adherence to such rights as privacy and dignity, confidentiality and involvement in treatment decisions are reviewed by the Trust's monitoring bodies, including the CQC and commissioners. Further assurance on these areas is gained from the inpatients' survey.

Conclusion of the Performance Report

I have presented this report in my capacity as the Accounting Officer and confirm that the Trust's auditors have reviewed the Performance Report for consistency with the financial statements.

Mark Brandreth

Chief Executive Officer

23 May 2019

ACCOUNTABILITY REPORT

Directors' Report

The report includes the following:

- Meet the Board
- Delivery of the 2018/19 strategic plan
- Looking ahead: vision for the Trust for 2019/20
- The strategic priorities for 2019/20
- Better payment practice code
- Quality governance
- Section 43(2A) NHS Act 2006 statement regarding income disclosures
- Statement of disclosure to auditors

Meet the Board

The directors present their annual report together with the audited financial statements for the year 1 April 2018 to 31 March 2019. The directors' report incorporates an analysis of the delivery of the 2018/19 strategic plan during that period and the vision for 2019/20.

As can be seen from the directors' biographies below and from our compliance with the requirements of the Foundation Trust Code of Governance, the Board has an appropriate composition, balance of skills and depth of experience to lead the Trust for the good of patients, staff and the communities it serves.

Details of the directors who currently hold office are listed below and unless specified have held office for the full financial year. Any directors who held office during the financial year but have since left the Trust are cited in the section entitled 'Changes to the Board':

Frank Collins Chairman

Frank was appointed as the Trust's Chairman in February 2015 and has extensive experience in healthcare leadership.

He spent his early career in the NHS culminating in Chief Executive posts at both Kettering General Hospital and Heatherwood and Wexham Park NHS Trust. Frank later moved into the private sector where he held Chief Executive posts at a private hospital, Hydron Ltd, (a manufacturer / supplier of contact lenses), and The Summit Medical Group (an international medical devices company), where he subsequently became Chairman.

Frank currently serves as non-executive director/chairman to a range of healthcare related companies and is a trustee of a local charity.

Mark Brandreth – Chief Executive

Mark was appointed Chief Executive in April 2016. He joined the Trust from the Countess of Chester NHS Foundation Trust where he was Deputy Chief Executive and Director of Operations and Planning. Prior to this he has worked in a number of senior NHS management posts. Mark has also worked in Wales and was invited to work for a period in a national role at the Department of Health.

Mark has a particular interest in improving services for patients and improving organisational culture.

Alastair Findlay Non-Executive Director

Alastair is the Trust's Deputy Chairman and the Chair of the Finance, Planning and Investment Committee (formerly the Business Risk and Investment Committee)

He has significant experience of working at board level in both the public and private sector, with direct experience of NHS board work as a board member for eight years at the Countess of Chester Hospital NHS Foundation Trust until March 2013.

As a chartered accountant, Alastair's early career was in the investment banking sector and his final full-time role was Finance Director for the Mersey Docks and Harbour Company. He was on the board of the Skipton Building Society for five years, latterly as Chairman, and is also a non-executive director at the Trafford Housing Trust.

David Gilburt
Non-Executive Director

David is the Chair of the Trust's Audit Committee and a member of the Finance, Planning and Investment Committee and Quality and Safety Committee.

He is a qualified accountant and has worked as Director of Finance in roles across the NHS at Health Authority, Trust and Regional level.

More recently, David has worked as an independent consultant specialising in financial turnaround for NHS organisations in financial difficulty. In this capacity he worked at the Trust from June 2007 to July 2008 as interim Director of Finance & Turnaround.

Paul Kingston
Non-Executive Director

Paul joined the Trust in January 2019 and is the Chair of the Trust's newly founded People Committee. He is also a member of the Trust's Audit and Quality and Safety Committees.

Paul is a Professor of Ageing and Mental Health and the Director of the Centre for Ageing and Mental Health at the University of Chester. He has been one of the academic leads of the RAID evaluation team since its inception at City Hospital in Birmingham. Since 1986, Paul has presented over 150 conference papers in a number of different countries.

Chris Beacock
Non-Executive Director

Mr Christopher Beacock lives in Shropshire and is a Foundation Trust member and takes a keen interest in the hospital.

He has 27 years clinical experience as a Consultant Urological Surgeon at the Shrewsbury and Telford Hospital NHS Trust. He formally retired in 2014 and has been re-employed on a part time contract since then.

He has worked across a wide range of acute trusts, integrated care organisations and community service providers. He has had a long standing interest in medical management and held various posts up to and including that of Deputy Medical Director. He has also served as Chairman of the Clinical Governance and Clinical Audit Committees and has sat on Quality and Safety Committees.

Harry Turner
Non-Executive Director

Between 2008 and 2016 Harry served as a Non-Executive Director and subsequently as the Chairman for the Worcestershire Acute NHS Trust before joining the Trust in January 2017. He therefore brings with him extensive relevant experience.

Harry also took up the position of Chairman of the John Taylor Hospice in Birmingham in October 2016 and is also the Chairman of Dudley and Walsall Mental Health NHS Trust.

Harry has also been a Justice of the Peace in Worcestershire Courts for more than a decade and previously worked as an Operations Director in the hotel industry for businesses including Travel Inn and Marriott International.

Steve White
Medical Director

Mr Steve White has been a Consultant Orthopaedic Surgeon for 24 years.

Steve was appointed as Medical Director in 2012, having previously been the Clinical Lead of Knee and Sports Surgery at the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) and Surgical director.

His research in the field of his special interest, the knee, has involved regular auditing of the quality of outcomes for knee replacement surgery with published papers on the outcome of new procedures and techniques.

Steve has experience in medico-legal reporting and the investigation of complaints on behalf of other Trusts; he is committed to continuous improvement of the quality of care for patients.

Bev Tabernacle
Director of Nursing/ Deputy Chief Executive

Bev joined the Trust in January 2016 from Bolton NHS Foundation Trust where she had been Acting Director of Nursing and Director of Infection Prevention and Control at Bolton NHS.

Bev has wide experience and has worked clinically and operationally across hospital, community and social care. She was one of the first Nurse Consultants in the country for Older People and is passionate about ensuring the delivery of care to patients is responsive and person-centred.

In 2009 Bev won the Chief Nursing officer award from the Nursing Times for work undertaken with A/E departments relating to Domestic Violence.

Craig Macbeth
Finance Director

Craig joined the Trust in 2008 as Deputy Director of Finance having previously worked at Shrewsbury and Telford Hospitals.

He was instrumental in supporting the Trust's sustainable services programme taking the lead on the contracting and commissioning elements. He subsequently led the finance team through the Foundation Trust application process and has more recently been leading the business planning for the Trust.

He became Acting Director of Finance in October 2015. He was later named Associate Director of Finance, before becoming Director of Finance on 1 April 2017.

Nia Jones
Director of Operations

Nia joined the Trust in January 2016 as Deputy Director of Operations, having previously worked at Betsi Cadwaladr University Health Board.

Nia has worked as Performance Manager for North Wales Regional Office, working with Policy Divisions, Trusts and Commissioners to provide a Performance Framework for North Wales NHS organisations and implementation of referral to treatment in Wales. She has also worked as Service Manager for Orthopaedics at North East Wales Trust before becoming Lead Manager for Operational Improvement for Surgery and Anaesthetics, working across the three District General Hospitals in North Wales.

Nia became Director of Operations in August 2017.

Changes to the Board of Directors

During 2018/19 the following changes have been made to the Board of Directors:

Starters

Director	Date of Change
Paul Kingston, Non Executive Director	1 January 2019

Leavers

Director	Date of Change
Hilary Pepler, Non Executive Director	30 November 2018

Declarations of Interest of the Board of Directors

The Board undertakes an annual review of its Register of Declared Interests. At each meeting of the Board a standing agenda item also requires all directors to make known any interests in relation to the agenda.

The Register is available for inspection during normal office hours in the Trust Secretary's office and is are also published on the Trust's website.

Independence of Non-Executive Directors

The Trust assesses the independence of it's Non-Executive Directors against the FT Code of Governance.

Cost allocation and charging guidance

The Trust has complied with the above guidance issued by HM Treasury.

Modern Slavery Act 2015

In accordance with the Act, the Trust has agreed and published its statement.

Delivery of the 2018/19 Strategic Plan

During 2018/19 the Trust Board agreed six key aims under the four headings Caring for Patients, Caring for Staff, Caring for Finances and Regulatory Action. These were translated into 18 objectives with a clearly defined measurable target for each. The table below provides a position statement against each of the objectives (as at 31 March 2019).

Annual Objective		Delivered by	Q4 Progress	Q 1	Q 2	Q 3	Q 4
1. Achieving outstanding patient safety.							
1.1	100% delivery of WHO checklist.	This will be measured through the Trust WHO audit compliance process, which considers both quantitative and qualitative measures.	Human Factors training continues to be rolled out which highlights the behaviours that need to change. Away days of the multi-disciplinary teams took place in October, supported by our Human Factors trainers to debate and discuss to ensure an owned new process. The new process was launched in January and embedding well. As the IPR shows compliance is at 100%	G	G	G	G
1.2	Improved learning from incidents.	As measured through the staff survey question “we are given feedback about changes made in response to reported errors, near misses and incidents”.	The improvement and delivery of this objective is shown through the results of the staff survey question ““we are given feedback about changes made in response to reported errors, near misses and incidents” which has improved by 4.3 percentage points in the last 12 months to 62.6% from 58.3% and is now above the average response rates for specialist Trusts which is 62.4%	G	G	G	G
1.3	Provision of a continuously improving paediatric service.	Refresh our service model to ensure it continues to meet the relevant standards.	As signalled through our recent CQC report the new directorate has embedded well with Rob Freeman as the lead clinician directly reporting to the Medical Director. The service review continues to develop well.	A	G	G	G
2. Delivering outstanding outcomes and experiences.							
2.1	Increased capture and use of patient reported outcome measures (PROMs).	Delivery of an improved, standardised method to capture PROMs with incorporated reporting for improving service delivery.	As previously reported the Trust has increased the capture and use of PROMs with standardised published individual reports for all arthroplasty, knee and sport surgeons utilised for reflection and improvement through appraisal and, as planned, is expanding to further specialities. The Trust have now reviewed the initial reports from MSK-HQ data for both SOOS and physiotherapy which had never previously been collected. Expansion to partner sites continues.	G	G	G	G
2.2	Utilising real time patient experience data.	Implementation of a method to capture real time patient experience, with evidenced use to improve services.	Use of Meridian commenced in November for data collection, in a phased approach. Further tablets have been purchased to enable the next phase of real time collection to commence. Paper comment cards are now being removed following embedding of the system.	G	G	G	G

2.3	Reduce the number of rescheduled episodes.	As measured through the Picker Inpatient survey question “planned admission: admission date changed by hospital” and to be determined measure for outpatients.	As highlighted at Q3 this was an at risk objective as signalled and monitored through the Board Integrated Performance Report. The Picker Inpatient survey is not released until later in the year to monitor our measurement. Reportable cancellations have been 0.17% above plan year to date this year. However, progress has been made with non- reportable cancellations have improved against our plan this year being 0.20% below the plan.	**A**	**A**	**A**	**A**
3. Delivering timely access to patient care							
3.1	Sustain the delivery of our access and waiting times	Deliver the commissioner standards as per agreed 2018/19 contractual arrangements.	Our targets were met for the financial year end.	**G**	**G**	**A**	**G**
3.2	Deliver an outpatient capacity model	Design and delivery of an outpatient capacity model to provide a method of outpatient planning.	The outpatient capacity model has been designed and delivered with the operational team now at implementation.	**A**	**A**	**A**	**G**
3.3	Generate greater understanding within our workforce of MSK self-management and non-surgical pathways.	As measured through the difference in results of a perception survey delivered in April 2018 and March 2019.	Changes in 2019/20 contract in regards to risks shares and MSK models, together with much greater partnerships, now all partners attend and are involved in the MSK delivery board.	**G**	**G**	**G**	**G**
4. Being an extraordinary place to work.							
4.1	Implement the behavioural standards framework	Improvement in 2018 staff survey scores for harassment, bullying and discrimination.	Signature behaviours have been launched and are in the process of embedding. Specific focused pieces of work have commenced with Research, Theatres and SOOS. The theme scores in the staff survey for Safe environment – bullying and harassment shows a change from 8.4 in 2017 to 8.1 in 2018.	**G**	**G**	**G**	**G**
4.2	Develop a strategic workforce plan	Delivery of a three to five year workforce plan.	The workforce plan has been developed and will be presented through the People Committee in Q1 of 2019/20 for approval.	**G**	**A**	**A**	**G**
4.3	Improve the level of communication and engagement between managers and our workforce.	Continued improvement in 2018 staff survey scores for questions in relation to ‘your managers’.	The theme scores in the staff survey trends for immediate managers shows an improvement from 6.7 in 2017 to 6.9 in 2018. More detailed analysis from the staff survey shows the following; • Support from immediate managers has improved from 66.7% to 71.4% • Clear feedback on work from managers has improved from 57.8% to 63.3% • Managers asking opinion before making decisions that	**G**	**A**	**G**	**G**

			affect my work has improved from 51.1% to 56.1% • Managers taking interest in health & wellbeing has improved from 65.8% to 71.3% • Managers valuing work improved from 70.3% to 73.2%				
5. Spending our money wisely.							
5.1	Deliver our financial control total for 2018/19.	Deliver the planned financial control total for financial year 2018/19.	Control total has been achieved as per report in Board papers.	**G**	**G**	**A**	**G**
5.2	Understand and reduce clinical variation.	Utilising GIRFT measurements provide the range of areas of clinical variation; produce an action plan for reducing variation evidenced through the GIRFT measurements.	Recent clinical engagement in the GIRFT visit in March with Prof. Tim Briggs which was well attended, good discussion and presentations from all involved. Followed by continued actions.	**G**	**G**	**G**	**G**
5.3	Develop and implement an operational transparency model.	Evidence the implementation of real time data use to drive operational management and decision making.	The co-ordination centre has been implemented with daily meets and information utilised in multi-displinary teams to make operational decisions.	**G**	**A**	**A**	**G**
6. Meeting the requirements of our regulators							
6.1	Continue to improve performance in relation to the CQC core standards.	An audited CQC action plan incorporating both response to past inspections together with preparation for 2018.	CQC inspection resulted in an overall rating of 'good' evidencing the improvement in performance from the last inspection.	**G**	**G**	**G**	**G**
6.2	Maintain our Single Oversight Framework (SOF) score.	As demonstrated by the March 2019 score in comparison with March 2018.	We over achieved our anticipated our SoF reaching the highest level of 1, due to greater cash balances.	**G**	**G**	**G**	**G**
6.3	Develop a register of accreditations.	Maintenance of accreditations, e.g. HTA licences, fire safety, etc.	The register is now in place and will continue to be added to as appropriate.	**G**	**G**	**G**	**G**

Looking ahead for 2019/20

Looking ahead the strategic priorities will continue to be based on the Trust's ambition to be the leading centre for high quality, sustainable orthopaedic and related care, achieving excellence in both experience and outcomes for our patients. The Trust aspires to deliver world-class patient care.

The next fiscal year will focus on building on the great work of 2017/18 and 2018/19. It will involve looking at those performance targets that have not been achieved in 2018/19 and what actions need to be taken to achieve these. The Trust will ensure that patient safety and quality standards are maintained and at the fore of its business.

In summary our strategy is;

1. We will become the local system integrator for MSK services.
2. We will develop a specialist orthopaedic chain.
3. We will deliver operational excellence.

Operational Excellence	Culture and Leadership
• Focus on the operational detail, using good data. • Embed and standardise safe processes. • Define data enabled transformation schemes. • Focus on unwarranted variation and waste, drive efficiency and value to ensure sustainability. • Be as safe as we can be – CQC Outstanding.	• Clinically-led organisation. • Rebuilding Relationships. • Structured team development. • Investing in leaders and aspiring leaders. • Focused support for first line managers. • Refine service improvement method and capability.
Specialist Orthopaedic	**Local MSK Services**
• Explore new markets. • Leading work to develop a 'chain' • National voice on our area of expertise. • Maintain and secure our position as an excellent educator.	• Relevant. • Part of the system. • Management of Demand • Underwriter of quality of care in the system. • Long-term contractual model. • Long-term expert and partner. • MSK and orthopaedic services. • Innovative and creative.

The Corporate Objectives for 2019/20

Caring for patients	
1. Achieving outstanding patient safety	
Annual Objective	**Measure**
Reduce unwarranted variation with a focus in 19/20 upon reducing avoidable harm A focus on GIRFT principles, falls, UTIs and managing deteriorating patients	• Lower UTIs in older people are diagnosed and treated in line with NICE guidance for 90% of cases by year end • All new devices across all disciplines are reviewed and approved through the New Devices and Procedures Committee • Older people have recognised falls prevention measures in place. 80% compliance by year end • Implement quarterly audits of compliance with patient observations including NEWS • Ensure correct level of patient deterioration training available to reach Trust wide compliance of 80% by year end
2. Delivering outstanding outcomes and experiences	
Increased focus on MSK population health A focus on transition from volume based to value based, reactive to proactive and illness to health and wellness	• Alternative contract model in place for 2020/21 more focused upon value than volume • Roll out of Q Lab improvement programme • Stabilisation of SOOS to be measured through improved KPI performance

3. Delivering timely access to patient care	
Improving systems and processes for best care A focus on job planning, booking and scheduling and outpatient protocols	• Implementation of the internal audit recommendations linked to job planning • Implementation of 6-4-2 working • Overarching protocol in place with rollout of sub specialty

Caring for staff

4. Being an extraordinary place to work	
Focus on providing an environment for our workforce to 'flourish at work' A particular focus on bullying and harassment, progress in the areas identified as cultural hotspots and inclusion	• Staff survey results • Sickness absence and voluntary turnover in hotspots • WRES/Staff survey results

Caring for finances

5. Spending our money wisely	
Develop a more clinically led infrastructure and meeting architecture	• Demonstrable increase in clinically-led decisions • Reduction in non-value added meetings • Committee effectiveness

A focus on increasing clinical involvement in the leadership and management and review and rationalisation of organisational meetings to ensure they are effective and fit for purpose	
Achieve and maintain the Single Oversight Framework score of 2 and seek to improve underlying measures	• Deliver control total trajectory for Income and Expenditure • Deliver agency control total for core agency • Maintain cash balances at trajectory and enable repayment of financing commitments
A focus on the use of resources score	

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay invoices within 30 days of receipt of the goods or receipt of the invoice, whichever is later, with performance being measured in terms of both number and value of invoices.

During 2018/19 the Trust paid 93% of the number of invoices and 95% of the value of invoices within the target and no interest was due in respect of any of these invoices.

	2018/19		2017/18	
	Number of invoices	Value in £000s	Number of invoices	Value in £000s
Total invoices paid	38,235	79,251	33,546	62,128
Invoices paid within target	35,420	75,226	31,031	59,088
Percentage paid within target	93%	95%	93%	95%

Quality Governance

Quality in the NHS encompasses three domains – Patient Safety, Patient Experience and Clinical Outcomes. The Trust's work in this area embraces a number of strands of work including complaints, clinical effectiveness and risk. All these elements are critical in ensuring our patients and their carers receive excellent care, and the Trust continues to meet its core values.

All staff have responsibility for safety and quality. There are, however, designated roles within the Trust who lead or are directly involved in these activities under the executive lead of the Director of Nursing, the Medical Director, with the Chief Executive being ultimately responsible.

The Trust has produced its Annual Quality Account which sets out its priorities and objectives in relation to quality improvements for the year and is currently in the process of reviewing its Quality Strategy to ensure continued alignment to the Trust's priorities and overall strategy going forward.

The Trust has in place a robust governance framework to underpin the delivery of enhanced quality and further detail on this framework is contained within the Trust's Annual Governance Statement which can be found at page 71 of the Annual Report.

Quality Governance Framework

The Quality Governance framework has been further assessed and is part of the Quality account declaration. The Trust remains compliant with this framework and this is supported by internal audit reviews during 2018/19.

Patient Care Activities

We are aligned to the requirements of national strategy in that quality is at the core of all we do. Our aim is to continue delivering outstanding patient care to every patient every day. We pride ourselves in the standards we achieve and in the feedback from our patients on the quality of our services.

We aim to safeguard our patients, both adults and children, at all times. This is achieved through clear policies and procedures that protect and support patients and their families during their stay

and beyond. This also means working in partnership with other agencies to get the right outcome for our patients.

For quality to flourish we need to recognise the need to change and to improve where systems and processes are hindering our staff to deliver high quality care to patients every day. We need to set a clear vision so staff and patients understand what our aims and goals in delivering that high quality service look like and how they can contribute to enhancing our services.

There needs to be clear lines of responsibility for safety and quality from board to ward/departments with each person including those using our services understanding their roles and responsibilities in ensuring improvements are made. Even the smallest change can make a difference to the patient, carer or staff experience.

The quality of the services we provide to patients is routinely reviewed by our Commissioners as part of monthly performance reviews that consider summary dashboard reporting on Trust wide quality issues. These provide opportunity for any areas of concern to be discussed and reviewed.

Quality risks are identified from the Trust's risk management processes and are monitored, managed and mitigated at local, divisional and corporate levels. Each risk is clearly defined and includes clear action plans to control and mitigate the risk.

The corporate risk register and Board Assurance Framework are reviewed quarterly by the Board and identify the key quality risks for the organisation with clear mitigations and action plans.

Performance Against Key Health Care Targets

The Trust has continued to make excellent progress in improving the quality of care for our patients; this is measured through the production of our integrated performance reports.

In September 2017 the Trust agreed its Quality Improvement Strategy. In this we set out our Quality aims for the next five Years and throughout 2018/19 the Trust has continued to work towards the delivery of these aims.

Our Quality Aims

Aim 1 - Reducing Patient Harm
- *Prevent avoidable deaths*
- *Managing the deteriorating patient*
- *Ensuring the safe transfer of patients to and from the hospital*

Aim 3 - Improving Documentation
- *Audit Process*
- *Review of Pathways*
- *Improving consistency*

Aim 2 - Reviewing Leadership roles and accountability
- *Divisional structures*
- *Performance review process*
- *Cultural Behaviour Characteristics*

Aim 4 - Providing effective and reliable care
- *100% Delivery of WHO checklist*
- *Implementation of the Sepsis care bundle*
- *Continued development of the STAR accreditation process*

In addition the Trust has in place a Patient Experience Strategy. The Strategy outlines a number of Always events and also starts our journey on co-production with our patients.

Always Events

Always Event 1: Improve the patient Journey
We will improve the experience of our patients and carers from their first contact with the Trust, through to their safe discharge from our care.

Always Event 2: Improve communication
We will improve the information we provide to enhance communication between our staff, patients and carers.

Always Event 3: Meet care needs
We will meet our patients' physical, emotional and spiritual needs while they are using our services, recognising that every patient is unique.

This strategy will underpin our efforts to achieve our Always Events with our staff, patients and the public, commissioners and partner organisations. An annual evaluation of progress towards our ambitions will be undertaken and published on the Trust's website.

Listening to Patients and Carers

Collecting Patient experience data is an important part of monitoring the quality of care provided at the RJAH and helps promote an open learning culture by identifying and sharing examples of good complaints practice and learning that was identified through patient feedback.

The table below shows overall patient feedback in 2018/19 compared to 2017/18:

Feedback	2018/19	2017/18	Diff from 2018/19 to 2017/18
Complaints	105	78	27
Local resolution	46	32	14
PALS concerns	558	433	125
PALS info requests	856	862	-6
Compliments	4721	4979	-258

Key Highlights

CQC Action Plan

During December 2018, the CQC carried out an inspection of the Trust and the outcome of this inspection was published in February 2019. This showed the Trust to be 'Good' overall with 'Outstanding' achieved for caring. The breakdown of ratings is shown in the table below:

Ratings for The Robert Jones and Agnes Hunt Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Surgery	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Critical care	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019
Services for children and young people	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Outpatients	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Diagnostic imaging	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Overall*	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019

In response to the inspection report the Trust has put in place a robust action plan to address the areas for improvement highlighted by the CQC. Completion of this action plan will be monitored via the Quality and Safety Committee. The general themes for the actions can be categorised as follows:

- Ensuring robust policy management
- Monitoring of staff training compliance down to departmental level
- Review of the High Dependency Unit against the Critical Care Standards
- Continued addressing of staff bullying and harassment in known pockets of the organisation

Patient Feedback

The Trust offers patients many mediums to feedback including email, Twitter and Facebook accounts and via the NHS Choices website. All feedback is shared with the clinical areas and is responded to by the Communications Team.

In addition the Trust has in place a robust complaints process which enables patients to raise concerns formally. These are all investigated in line with the Trust's complaints policy and action plans put in place, where applicable, to ensure learning and improvement.

Friends and Family Question

Patients are asked to answer the national Friends and Family Test (FFT) question: "How likely are you to recommend our ward/clinic to friends and family if they needed similar care or treatment" on the day of discharge or after they have attended a clinic appointment. They are invited to rate the Trust against options ranging from "extremely likely" to "extremely unlikely".

In 2017 as part of the implementation of the Patient Experience Strategy the Trust has invested in a 'Real time' patients experience system and this was implemented during 2018/19. The Trust has been collecting FFT data using iPads to reduce the reliance on paper cards and in March 19, 72% of surveys were collected electronically. Staff have also had training to view patient feedback in real time as they come in and provide a response.
Further developments are planned for July 2019, as part of the project where some patients will be invited to leave their feedback after being sent a SMS text.

For April 18–March 2019, Trust results continue to be very high with 99% of the 10303 patients asked would recommend the Trust.

The RJAH achieved an average monthly rank of 3th out of 147 NHS Trusts in England, making the Trust one of the top performing NHS Trusts in the country.

- This is higher than the national score in England of 96%
- 47% of inpatients provided a response

	FFT score	Promoters - Extremely Likely	Passive – Likely	Detractors – Not at All	Detractors – Neither Likely nor Unlikely	Detractors – Unlikely	Don't Know
Inpatients	99.47%	6644	263	10	16	7	5
Outpatients	98.60%	3112	205	4	21	7	9

The Trust is committed to improving the percentage of patients who would recommend the Trust and recognise that there is always room to improve our patient's perception of their experience. The comments that are received from the patients are shared with the relevant clinical areas to ensure that any areas for improvement can be addressed.

The results for the Trust over the last three years are as follows based on the average percentage of patient's who would recommend the Trust to friends and family as a place to receive treatment and care:

	2015/16	2016/17	2017/18	2018/19
National Average	96%	96%	96%	96%(to Feb 19)
Highest Score	100%	100%	100%	100%(to Feb19)
Lowest Score	75%	75%	64%	76%(to Feb 19)
Robert Jones and Agnes Hunt	99%	100%	99%	99%

Stakeholder Relations

Stakeholder relationships have continued to be supportive and positive during 2018/19. We meet with commissioners from the various commissioning parties throughout the year and Shropshire CCG has undertaken a number of visits to the Trust in their role as the commissioning body.

We have an excellent relationship with our local Health Watch and have regular meetings in place to share intelligence regarding their consultation events. Further one of our Stakeholder Governors is the Chair of the Health and Adult Social Care Overview and Scrutiny Committee.

Sit and See Observations

The Sit and See observation tool captures and records the smallest things that can make the biggest difference to patient care.

Since April 2018-March 2019 there have been 83 observations across wards and departments of which 99% were positive.

There are 12 active Sit & See Observers, of which eight are Patient panel volunteers or Trust Governors.

15 actions have been taken following observations. Staff are encouraged to share positive results at ward or department meetings. Themes on any poor or passive observation have been about:

- Staff attitude and behaviour, i.e. chewing gum and being abrupt while explain/answering patient questions
- Clutter and equipment in the corridors/bays

The Trust is looking to review the metrics that are observed in line with the Quality Strategy.

Some examples of Positive practice identified from 'Sit and See' during 2018-19:

Powys: You said… We did posters on display.

MOPD: All staff noted to welcome patients into OP room

Sheldon: Water on all bed tables and also in corridor for all to use.

HDU: Staff welcoming to a visitor and reassured her of husband's progress

Examples of Passive and Poor themes across the wards:

Observation: Ludlow: Physiotherapist quite blunt when answering a patients question about how she was managing walking

Observation: Pre-op: Patient did not understand abbreviations and stats board

Observation: X-ray: HCA chewing gum when calling out patients name

Observation: Sheldon: 2 trollies and some equipment left around

Section 43 (2A) NHS Act 2006 Statements Regarding Income Disclosures

The Trust has fulfilled its principal purpose as its total income from the provision of goods and services for the purposes of the health service in England has been greater than its total income for the provision of goods and services for any other purposes.

Private practice complements the NHS services provided by the Trust and makes up a very small amount of our overall activity. Private patients only use facilities when they are not required for the NHS and this generates extra income which is used to enhance services and, in turn, benefits NHS patients every year.

Statement as to disclosure to auditors

For each individual director who was a director at the time this report was approved:

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

A director is regarded as having taken all these steps that they ought reasonably to have taken as a director in order to do the things mentioned above and:

- Made such enquiries of his/her fellow directors and of the Trust's auditors for that purpose; and
- Taken such steps (if any) for that purpose, as are required by his/her duty as a director of the Trust to exercise reasonable care, skill and diligence.

Mark Brandreth
Chief Executive Officer

23 May 2019

Remuneration Report

This report includes details regarding “senior manager’s” remuneration in accordance with the following:

- Sections 420 to 422 of the Companies Act 2006 as they apply to foundation trusts;
- Regulation 11 and Parts 3 and 5 of Schedule 87 of Large and Medium-Sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI2008/410);
- Parts 2 and 4 of Schedule 8 of the Regulations as adopted by Monitor and
- Elements of the NHS Foundation Trust Code of Governance.

The Trust considers that disclosures in this report and the staff report meet the requirements of the NHS Act 2006 on the work of the Trust’s Remuneration Committee.

Annual Statement on Remuneration by the Chairman of the Nomination and Remuneration Committee (Trust Chairman, Mr Frank Collins)

The membership of the Nomination and Remuneration Committee is as follows:

- Frank Collins, Chairman
- Chris Beacock, Non-Executive Director
- Alastair Findlay, Non-Executive Director
- David Gilburt, Non-Executive Director
- Harry Turner, Non-Executive Director
- Paul Kingston, Non-Executive Director

In addition the Chief Executive and Director of People have been in attendance as requested by the Committee.

The Nomination and Remuneration Committee met four times during the year (April, September, October and February 2019), and approved changes to the senior management structure to strengthen the Board of Directors as follows:

- Change in role of the Director of Finance to incorporate strategy and planning
- Ceasing of the role of Director of Strategy and Planning
- Development of the role of Director of Improvement, Organisational Development and Performance

The Nomination and Remuneration Committee also approved the redundancy of the post of Direction of Strategy and Transformation.

The Nomination and Remuneration Committee recommended that the Chief Executive, Director of Nursing/Deputy Chief Executive and former Director of Operations to receive a non-consolidated performance related pay award of 2%. All Directors were awarded an uplift of 1% in line with the national pay award.

All of the members of the Committee attended all meetings with the exception of the following:

- Mr Harry Turner gave apologies for the April, September and October meetings
- Alastair Findlay gave apologies for the September meeting
- David Gilburt gave apologies for the February meeting.

Senior Managers' Remuneration Policy

The remuneration of the Chief Executive and Executives directly accountable to the Chief Executive is determined by the Remuneration Committee. Details of the membership of this Committee and attendance at its meetings are set out above and in the Foundation Trust Governance section of the report.

The Executive and Associate Directors' Remuneration framework, which was not subject to formal consultation, is agreed by the Committee and determines remuneration of the Chief Executive and

Executives directly accountable to the Chief Executive. This Framework was last reviewed and updated at the Remuneration Committee of August 2017.

National Context

The Committee will take into consideration any guidance given from the Department of Health regarding public sector pay including the inflation uplifts.

Pay Comparators

Salaries are benchmarked against the NHS Chief Executives and Directors Salary Surveys and NHS Improvement Pay Comparators.

Ranges for each post are agreed based on this information.

Performance-Related Pay and Assessment Process

The Executive and Associate Directors Remuneration Framework policy states that Directors may earn a maximum of 3% Performance-Related Pay annually.

Directors will be set annual objectives which address the following six areas:

- Annual Corporate Objectives
- Corporate Risks
- Supporting Strategies
- Other e.g. legislative
- Standards of Business Conduct & Trust Values
- Personal Development

Performance-related pay will not be consolidated for a period of 12 months, and is not therefore pensionable for this period. After 12 months, performance-related pay will be consolidated into the director's salary subject to sustained full-year financial performance and subject to upper salary limits based on benchmarking information.

There is no provision for the recovery of sums paid to a Director following confirmation of sustained performance.

The directors all hold permanent contracts, which include a six months' notice period.

None of the directors' contracts include any provision for compensation for early termination of employment.

The full Council of Governors determined the remuneration for Non-Executive Directors in 2011 and review remuneration levels periodically via the Council of Governors Remuneration Committee.

During 2018/19 the Council of Governors re-appointed the Chairman, Frank Collins, to serve a further three years. Further the Council of Governors appointed a new Non-Executive Director, Paul Kingston, following the end of Hilary Pepler's term as Non-Executive Director. Finally, the Council of Governors extended David Gilburt's term for a further 3 years.

Future Policy

The Trust's future policy is as outlined in the table below:

Item	Salary/Fees	Taxable Benefits	Annual Performance Related Bonus	Long Term Related Bonus	Pension Related Benefits
Support for the short and long term objectives of the Foundation Trust	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives	All payments made relate to car lease or car allowance for staff with significant travel requirements for their role	As per the Performance Related Pay and Assessment Process section above	None paid	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Paid in even twelfths	Paid in even twelfths	As per the Performance Related Pay and Assessment Process section above	None paid	Employee and employer contributions
Maximum payment	As set out in Senior Managers' Remuneration Table	As set out in Senior Managers' Remuneration Table	As per the Performance Related Pay and Assessment Process section above	None paid	As set out in Senior Managers' Remuneration Table
Framework used to assess performance	Trust appraisal system	Not applicable	As per the Performance Related Pay and Assessment Process section above	None paid	Not applicable
Performance measures	Tailored to individual posts	Not applicable	As per the Performance Related Pay and Assessment Process section above	None paid	Not applicable

Item	Salary/Fees	Taxable Benefits	Annual Performance Related Bonus	Long Term Related Bonus	Pension Related Benefits
Amount paid for minimum level of performance and any further level of performance	Salaries are agreed on appointment and set out in the contract of employment	Not applicable	As per the Performance Related Pay and Assessment Process section above	None paid	Not applicable
Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments	Any overpayments may be recovered	Any overpayments may be recovered	Any overpayments may be recovered	None paid	Any overpayments may be recovered

Non-executive Directors are appointed on fixed terms contracts, normally three or four years in length, and they do not gain access to the Pension Scheme as a result of this engagement. The fee payable to Non-executive Directors is set out in the tables on the next pages. They do not receive any other payments from the Trust.

Any changes to the future policy will be discussed by the Remuneration Committee taking account of national arrangements.

Service Contract Obligations

There are no obligations on the Trust which could give rise to, or impact on, remuneration payments or payments for loss of office but which are not disclosed elsewhere in the remuneration report.

Policy on Payment for Loss of Office

Notice periods for all Executive Directors are set at six months. Any payments for loss of office will be made in accordance with NHS Terms and Conditions of Service and HM Treasury guidance 'Managing Public Money' where appropriate.

Statement of Consideration of Employment Conditions

Employment conditions for Senior Managers mirrors those set out in Agenda for Change. The remuneration policy takes account of national pay comparators provided by NHS Improvement and the scale of any inflationary pay award.

Annual Report on Remuneration

Service Contracts

For each senior manager who has served during the year, the date of their service contract, the unexpired term and details of the notice period are set out below:

Officer	Start date	Unexpired term	Notice period
Collins, F Chairman	1 February 2015	31 January 2021	N/A
Beacock, C Non-executive Director	4 July 2016	3 July 2019	N/A
Findlay, A Non-executive Director	1 November 2013	31 October 2019	N/A
Gilburt, D Non-executive Director	1 December 2015	30 November 2018	N/A
Pepler, H Non-executive Director	30 November 2012	28 November 2018	N/A
Turner, H Non-executive Director	1 January 2017	31 December 2019	N/A
Kingston, P Non-executive Director	1 January 2019	31 December 2021	N/A
Brandreth, M Chief Executive	1 April 2016	N/A	6 months
Tabernacle, B Director of Nursing/ Deputy Chief Executive	1 January 2016	N/A	6 months
White, S Medical Director	1 June 2012	N/A	6 months
Macbeth, C Finance Director	1 April 2017	N/A	6 months
Jones, N Director of Operations	1 April 2017 (Interim) 1 August 2017 (Substantive)	N/A	6 months
Bloomfield, S Interim Director of Nursing	11 March 2019	N/A	1 month

Disclosures Required by Health and Social Care Act

The following information is required by section 156 (1) of the Health and Social Care Act 2012, which amended paragraph 26 of Schedule 7 to the NHS Act 2006

Senior Managers' Remuneration

For the purposes of this report 'senior managers' are defined as 'those persons in senior positions having authority or responsibility for directing the major activity of the Trust. The Trust's Chief Executive has agreed the definition.

Senior Managers Remuneration 2018/19							
Name and Job Title	**Salary & fees (bands of £5,000)** **£'000**	**Taxable benefits (to nearest £100)** ***Note 1*** **£**	**Annual performance related bonuses (bands of £5,000)** **£'000**	**Sub total of remuneration paid by the Trust (bands of £5,000)** **£'000**		**All pension-related benefits (bands of £2,500)** ***Note 2*** **£'000**	**Total (bands of £5,000)** **£'000**
Frank Collins Chairman	35 - 40			35 - 40			35 - 40

Chris Beacock Non Executive Director	10 - 15			10 - 15			10 - 15
Alastair Findlay Non Executive Director	10 - 15			10 - 15			10 - 15
David Gilburt Non Executive Director	10 - 15			10 - 15			10 - 15
Paul Kingston Non Executive Director *(from Jan 19)*	0 - 5			0 - 5			0 - 5
Hilary Pepler Non Executive Director *(to Nov 18)*	5 - 10			5 - 10			5 - 10
Harry Turner Non Executive Director	10 - 15			10 - 15			10 - 15
Mark Brandreth Chief Executive	150 - 155	6,100	5 - 10	160 - 165		62.5 - 65	225 - 230
Craig Macbeth Director of Finance	95 - 100	6,300	0 - 5	100 - 105		10 - 12.5	115 - 120
Bev Tabernacle Director of Nursing	100 - 105	5,900	0 - 5	110 - 115		0	100 - 105
Nia Jones Director of Operations	85 - 90	4,600	0 - 5	90 - 95		65 -67.5	155 - 160
Steve White Medical Director *Note 3*	160 - 165	0	25 - 30	190 - 195		0	35 - 40

Senior Managers Remuneration 2017/18

Name and Job Title	**Salary & fees (bands of £5,000) £'000**	**Taxable benefits (to nearest £100) *Note 1* £**	**Annual performance related bonuses (bands of £5,000) £'000**	**Sub total of remuneration paid by the Trust (bands of £5,000) £'000**		**All pension-related benefits (bands of £2,500) *Note 2* £'000**	**Total (bands of £5,000) £'000**
Frank Collins Chairman	35 - 40			35 - 40			35 - 40
Chris Beacock Non Executive Director	10 - 15			10 - 15			10 - 15
Alastair Findlay Non Executive Director	10 - 15			10 - 15			10 - 15
David Gilburt Non Executive Director	10 - 15			10 - 15			10 - 15
Hilary Pepler Non Executive Director	10 - 15			10 - 15			10 - 15

Harry Turner Non Executive Director	10 - 15			10 - 15			10 - 15
Mark Brandreth Chief Executive	140 - 145	6,100	5 - 10	155 - 160		22.5 - 25	180 - 185
Craig Macbeth Director of Finance	95 - 100	6,800	0	100 - 105		52.5 - 55	155 - 160
Bev Tabernacle Director of Nursing	95 - 100	5,500	0	100 - 105		42.5 - 45	145 - 150
Nia Jones Director of Operations	80 - 85	3,100	0	80 - 85		40 -42.5	120 - 125
Steve White Medical Director *Note 3*	170 - 175	0	30 - 35	200 - 205		37.5 - 40	235 - 240

Notes

1. Taxable benefits relate to either a lease car or a car allowance.
2. Pension related benefits are based on the HMRC approved calculation and assume a pension will be drawn for 20 years from retirement. This excludes employee contributions.
3. The Medical Director's salary includes £100 - £105k relating to clinical duties. A clinical excellence award of £30 - £35k is included in the annual performance related bonus column.

Governor and Director Expenses

The following table provides details of expenses claimed by either Directors or Governors during the reporting period and provides comparative data for the previous year. The majority of the expenses relate to travel.

Name	Role	2018/19	2017/18
Directors			
Frank Collins	Chairman	£4,173	£2,271
Chris Beacock	Non Executive Director	£587	£596
Alastair Findlay	Non Executive Director	£955	£1,236
David Gilburt	Non Executive Director	£1,578	£1,621
Harry Turner	Non Executive Director	£1,676	£3,568
Mark Brandreth	Chief Executive	£2,143	£880
Craig Macbeth	Director of Finance	£105	£202
Bev Tabernacle	Director of Nursing	£265	£1,816
Steve White	Medical Director	£285	£270
Governors			
Martin Coggon	Governor (Public) North Wales	£0	£64
Peter David	Governor (Appointed) Voluntary Services Committee	£0	£34
Jan Greasley	Governor (Public) North Wales	£146	£138
Katrina Morphet	Governor (Public) Cheshire & Merseyside	£610	£175
Gareth Pritchard	Governor (Public) North Wales	£0	£17
Linda Ward	Governor (Public) Powys	£497	£1,551
Total		**£13,020**	**£14,439**

Fair Pay Multiple

The HM Treasury FReM requires disclosure of the median remuneration of the Trust's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director (including that paid for work as other than a director). Directors are those defined as senior managers earlier in this report.
The calculation is based on full-time equivalent staff of the Trust at the reporting period end date on an annualised basis.

No employees received remuneration in excess of the highest paid director.

	2018/19	2017/18
Mid point of banded remuneration of highest paid director	192,500	202,500
Median remuneration of all staff	23,951	23,597
Ratio	8.0	8.6

Pension Entitlement

The CETV in the table below is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The disclosures include accrued benefits derived from the member's purchase of added years of service and any "transferred-in" service.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Senior Managers Pension Entitlement 2018/19							
Name and Job Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real increase in Cash Equivalent Transfer Value
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mark Brandreth Chief Executive	2.5 - 5.0	2.5 - 5.0	50 - 55	120 - 125	882	701	160
Craig Macbeth Director of Finance	0.0 - 2.5	0	30 - 35	75 - 80	598	501	83
Bev Tabernacle Director of Nursing	0	0	35 - 40	110 - 115	762	661	81
Nia Jones Director of Operations	2.5 - 5.0	0	15 - 20	0	156	96	58

Steve White Medical Director	0	0	60 - 65	185 - 190	N/A	N/A	N/A

Information provided by the NHS Pensions Agency

Note : Steve White is over normal retirement age in the existing scheme so a CETV calculation is not applicable.

Senior Managers Pension Entitlement 2017/18							
Name and Job Title	**Real increase in pension at pension age (bands of £2,500)**	**Real increase in pension lump sum at pension age (bands of £2,500)**	**Total accrued pension at pension age at 31 March 2018 (bands of £5,000)**	**Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)**	**Cash Equivalent Transfer Value at 31 March 2018**	**Cash Equivalent Transfer Value at 31 March 2017**	**Real increase in Cash Equivalent Transfer Value**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mark Brandreth Chief Executive	0.0 - 2.5	0	45 - 50	110 - 115	701	631	63
Craig Macbeth Director of Finance	2.5 - 5.0	2.5 - 5.0	30 - 35	75 - 80	501	426	70
Bev Tabernacle Director of Nursing	0.0 - 2.5	5.0 - 7.5	35 - 40	110 - 115	661	574	81
Nia Jones Director of Operations	2.5 - 5.0	0	10 - 15	0	96	74	21
Steve White Medical Director	2.5 - 5.0	7.5 - 10.0	65 - 70	200 - 205	N/A	1,479	N/A

Information provided by the NHS Pensions Agency

Note : Steve White is over normal retirement age in the existing scheme so a CETV calculation for 2017/18 is not applicable.

Payments for Loss of Office

One compulsory redundancy of the Director of Strategy and Transformation was enacted in 2018 and all payments were in line with contractual entitlements.

Payments to Past Senior Managers

No payments have been made to past senior managers during 2018/19.

Staff Report

Staff Costs

Staff costs are shown in the table below. Costs have increased mainly due to pay awards and incremental drift. In addition there has been an increase in staff establishment.

	2018/19			2017/18
	Permanent £'000	Other £'000	Total £'000	Total £'000
Salaries & wages	49,883	495	50,378	46,650
Social security costs	4,690	-	4,690	4,387
Apprenticeship levy	227	-	227	213
Employer's contributions to NHS pensions	5,880	-	5,880	5,474
Pension cost - other	7	-	7	3
Termination benefits	106	-	106	24
Temporary staff		4,419	4,419	4,403
Total gross staff costs	**60,793**	**4,914**	**65,707**	**61,154**
Recoveries in respect of seconded staff	-752	-	-752	-941
Total staff costs	**60,041**	**4,914**	**64,955**	**60,213**
Of which:				
Costs capitalised as part of assets	*156*		*156*	*112*

Average number of employees

The average number of employees on a whole time equivalent basis (WTE) is shown in the table below, analysed over professional groupings.

	2018/19			2017/18
	Permanent Number	Other Number	Total Number	Total Number
Medical & dental	125	3	128	123
Administration & estates	462	18	480	495
Healthcare assistants & other support staff	228	26	254	192
Nursing, midwifery & health visiting staff	275	19	294	287
Scientific, therapeutic & technical staff	182	4	186	173
Healthcare science staff	12	0	12	10
Total average numbers	**1,284**	**70**	**1,354**	**1,280**

Exit packages

All exit packages agreed in 2018/19 and 2017/18 are shown in the table below.

	2018/19			2017/18		
Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	3	3	-	5	5
£10,001 - £25,000	-	-	-	-	1	1
£50,001 - £100,000	1	-	1	-	-	-

Total number	**0**	**3**	**3**	**0**	**6**	**6**
Total cost	**£100,000**	**£10,000**	**£110,000**	**-**	**£24,000**	**£24,000**

Analysis of the non-compulsory payments:

	2018/19		2017/18	
Exit package cost band	**Number of agreements**	**Value of agreements**	**Number of agreements**	**Value of agreements**
Contractual payments in lieu of notice	2	£6,000	6	£24,000
Non-contractual severance payments requiring HMT approval	1	£4,000	-	-
Total number of exit packages	**3**	**£10,000**	**6**	**£24,000**

Trade Union Facility

Through our Recognition Agreement, we recognise a number of Trade Unions and Professional Associations for the purpose of collective bargaining on behalf of **all employees** who are directly employed by the Trust, whether full time or part time, permanent or temporary.

The members of each of these organisations elect representatives who work with us to represent their members. They can be carrying out union duties, which means that under legislation, employers are obliged to pay elected representatives to carry it out. They can also be carrying out union activities – which means that employers are not legislatively obliged to provide paid time to elected representatives. The overarching term 'facility time' covers both union duties and activities.

Where facility time is paid, payment is made at the amount the representative would otherwise have received had they been at work. Where union duties are in addition to the normal contracted hours of the individual accredited representative, payment is made at single time or the equivalent time off given – no overtime pay is applicable.

It is our statutory duty to publish this information for the previous financial year by the end of July each year and our publications can be found via the following link: https://www.rjah.nhs.uk/About-Us/Publications/Corporate-Documents/Facility-Time.aspx

Staff gender distribution

A breakdown of the number of persons who were directors of the Trust, senior managers and other employees during 2018/19 is shown below:

	Male	Female
Executive Directors	2	5
Non-executive Directors	5	1
Other senior managers	10	17
Other employees	394	1304

Total	411	1327

Staff sickness absence

The sickness absence figures in the table below are provided to the Trust, calculated from statistics published by NHS Digital. They are for calendar years, due to timing difficulties with financial year data. The Department of Health & Social Care considers the figures to be a reasonable proxy for the financial year.

2018/19			2017/18		
Average FTE 2018	FTE Days Lost 2018	Average Sick Days per FTE 2018	Average FTE 2017	FTE Days Lost 2017	Average Sick Days per FTE 2017
1,271	10,985	8.7	1,214	9,339	7.7

Note: FTE = Full Time Equivalent

Staff Equality and Diversity

The age, ethnic breakdown, staff gender distribution and number of staff with recorded disabilities is shown below:

The trust employed 1738 staff at 31st March 2019.

The demographic profiles of our staff are shown below:

Age Range	Headcount	% Headcount
19 and below	29	2%
20 - 29 Years	246	14%
30 - 39 Years	374	22%
40 - 49 Years	437	25%
50 - 59 Years	467	27%
60 and above	185	11%
Total	1738	

Gender	Headcount	% Headcount
Female	1324	76%
Male	411	24%
Total	1738	

Ethnicity	Headcount	% Headcount

Any Other Ethnic Group	11	0.6%
Asian or Asian British	57	3.3%
Black or Black British	8	0.5%
Chinese	2	0.1%
Mixed - Any mixed background	8	0.5%
Not stated	106	6.1%
White - British	1457	83.8%
White - Other	89	5.1%
Total	1738	

Part Time/Full Time	Full Time	Part Time	% Full Time	Total
Female	538	789	41%	1327
Male	303	108	74%	411
Total	841	897		1738

The Trust has a multi-disciplinary Equality & Diversity Steering Committee which considers equality, diversity and inclusion matters for patients and staff. The group reviews the Trust's EDS2 submission and annual report prior to publication.

In addition, implementation of the Five Year People Plan (further detail in the next section) will include a focus on equality, diversity and inclusion with some initial ideas around the following:

- Review of diversity training
- Holding a masterclass on equality, diversity and inclusion
- Exploring the differences between the treatment and experiences of white and BMS workforce.

Supporting Staff with Disabilities

The Trust's policies ensure full and fair consideration is given to all job applications from people with a disability and ensures adaptations and support are available to facilitate the continued employment and training of staff with a disability.

Recruitment data is collected and analysed to ensure applicants to the Trust are free from any form of discrimination. Candidates who declare themselves as having a disability and who meet the essential requirements of the job description and person specification are guaranteed an interview by the Trust.

In the event that a staff member becomes disabled while employed by the Trust, the Trust's policies ensure support, reasonable adjustments to the role or alternative roles are offered to enable them to remain in employment.

Health and Safety

Health and Safety incidents are monitored on an ongoing basis throughout the year. All incidents are investigated and remedial actions taken to prevent or reduce the likelihood of reoccurrence. Those incidents reported that involve specified injuries, dangerous occurrences or result in a member of staff taking more than seven days off work as a result of a work-related accident are also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

During 2018-19 there were 3 incidents reported to the HSE under the requirement of the RIDDOR regulations. This is compared to 3 in 2017-18, 2 in 2016-17 and 1 in 2015/16.

The Trust has a pro-active programme of safety inspections which are carried out by Staffside union accredited safety representatives in conjunction with the Health and Safety Advisor. The Governance department has instigated a 'Safety Champions' initiative in order to raise the profile of safety throughout the Trust.

The Health and Safety Committee meets on a bi-monthly basis and a Chair's report is presented to the Trust Risk Management Committee.

Key health and safety actions in 2018-19 include:

- The appointment of a Health and Safety Advisor to undertake the roles of Competent Person for safety, Medical Devices Safety Officer and Central Alerting System Liaison Officer.
- Reviews of the Trust Health and Safety Policy and Estates & Facilities safety policies and procedures.
- Completion of the NHS Premises Assurance Model (PAM) for Estates and Facilities which gave assurance that the department's governance and safety activities were effective.

Staff Engagement

Culture and Leadership is one of the four strategic themes and its workstreams underpin the five year People Plan: Make the Difference which has the objective: "To continuously improve our performance through consistently bettering our employee experience" and ambition: "to be an extraordinary place to work" and cultural aim: "to move from 'Rebuilding Relationships' to everyone wanting to 'Make the Difference'".

Culture and Leadership - 12 months in pictures

Countering fraud and corruption

The Trust has in place a Local Counter Fraud Specialist who oversees any investigations of potential fraud. On an annual basis the Trust assesses the effectiveness of its counter fraud service and this is reported to the Audit Committee.

The Trust has in place security and counter fraud policies to ensure compliance with NHS Counter Fraud Authority guidance. The Trust has an established Counter Fraud Protocol which outlines the role of the Local Counter Fraud Specialist and the cross over and interaction with the Trust's Local Security Management Specialist.

In line with national guidance the Trust introduced a Managing Conflicts of Interest Policy during 2017 in order to provide a clear outline of the Trust's position on issues where there is the potential for conflict to arise such as through the acceptance of gifts and hospitality. The policy also outlines the requirements on senior staff, consultants and approvers on the Trust's procurement system with regard to the declaration of interests.

The Trust was subject to an NHS Counter Fraud Authority inspection in August 2018 and this highlighted three key areas for improvement:

- Improved risk assessment to inform the counter fraud work plan
- Review of the way the effectiveness of counter fraud training is measured
- Clarity of roles to ensure appropriate LCFS oversight of the key elements of counter fraud work

An action plan has been developed and its completion is overseen by the Audit Committee.

Staff Survey results

Further improvements were seen within the 2018 NHS Staff Survey. 94% of respondents would be happy with the standard of care provided if a friend or relative needed treatment and 79.5% of respondents would recommend the Trust as a place to work.

	2017		2018		Trust Change
Response Rate	Trust	Trust	Trust	Comparator Average	
	41.5%	41.5%	44.9%	52.8%	+3.4%

Our survey results have been shared, with our staff and divisional and corporate teams. Key areas from this year's results are set out below.

We are improvement-driven

Question	2016	2017	2018	2018 Comparator average
I am able to make suggestions to improve the work of my team/dept	76%	76.4%	78.6%	77.3%
I am able to make improvements happen in my area of work	50.4%	55.2%	63.3%	62.5%
Feedback from patients/service users is used to make informed decisions within my directorate/department	57.5%	60.3%	66.4%	62%

The Trust has made continued progress in this area over the last three years and is above the national average for each question. The Trust has achieved this through a number of improvement initiatives involving staff, in particular the introduction of Improvement Champions.

Job satisfaction (recognition)

Question	2016	2017	2018	2018 Comparator average
(I am satisfied with) The recognition I get for good work	51.1%	51.2%	59.9%	60%
(I am satisfied with) The extent to which the organisation values my work	40.6%	43.3%	55%	54.6%

The Trust has made continued progress in this area over the last three years with events such as the annual staff awards and the monthly health hero nominations aimed at recognising and valuing staff contributions.

We listen

Question	2016	2017	2018	2018 Comparator average
I know who the senior managers are here	71.6%	78.6%	85.5%	84.6%

Communication between senior managers and staff is effective	31.4%	39.4%	45.1%	46.2%

The Trust has made continued progress in this area over the last three years and is above the national average for each question. The Trust has achieved this through ongoing staff engagement. The Trust's monthly staff forum with the Chief Executive is well attended and provides opportunity for two way engagement with the senior leadership team.

We're getting better at learning from errors and incidents

Question	2016	2017	2018	2018 Comparator average
My organisation treats staff who are involved in an error, near miss or incident fairly	48.3%	55.7%	64.6%	63.3%
My organisation encourages us to report error, near misses or incidents	86.6%	90%	93.2%	91.5%
When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again	63.5%	71.8%	77.3%	76.4%
We are given feedback about changes made in response to reported errors, near misses and incidents	47.8%	58.3%	62.6%	62.4%

The Trust has improved year on year over the last three years and is above national average for each question. The Trust has strengthened its governance team with a new structure and has improved its incident management processes. This year the Trust has introduced Safety Champions who undertake regular walks around the hospital to speak with staff about safety and learning from incidents.

We have effective appraisals

Question	2016	2017	2018	2018 Comparator average
My appraisal - helped me improve how I do my job	12.8%	18.1%	22.3%	24.4%

My appraisal - helped me agree clear objectives	25%	33.4%	36.4%	37.8%
My appraisal - left me feeling my work is valued by my organisation	22.4%	27.9%	35.8%	36.1%
The Values of my organisation were discussed as part of the appraisal process	29.1%	34.6%	42.7%	40.4%

Although the Trust has continued to improve in this area and is aligned with the national average, its work on the appraisal process is ongoing in order to further improve responses.

Local level results have also been shared with divisional and corporate teams to inform further improvements at local level. The survey is one element of our ongoing work to continue to develop our leadership capacity and capability and support our cultural change programmes.

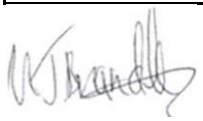
Through the survey and other engagement methods with staff, the Trust has identified bullying and harassment as an area to improve on and this is reflected in one of the Trust's annual objectives for 2018/19 aimed at enabling staff to 'flourish at work'.

Expenditure on consultancy - Off-payroll arrangements

The table below provides details of the Trust's off payroll engagements during 2018/19 and comparator data for 2017/18.

Off- payroll engagements as at 31 March 2019, for more than £220 per day and lasting more than six months	**2018-19**	**2017-18**
Number of existing engagements as at 31 March 2018	13	11
Of which		
have existed for less than one year at the time of reporting	7	4
have existed for between one and two years at the time of reporting	4	5
have existed for between two and three years at the time of reporting	2	1
have existed for between three and four years at the time of reporting	0	1
have existed for four or more years at the time of reporting	0	0
Assurance has been sought and received from all of the individuals above that they have made appropriate arrangements for the payment of their tax liabilities		
New Off- payroll engagements or those that reached six months duration between 1 April and 31 March 2019, for more than £220 per day and lasting more than six months	**2018-19**	**2017-18**
New Off- payroll engagements or those that reached six months duration between 1 April and 31 March 2017	7	6
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to Income tax and National Insurance obligations	5	6
Number of whom assurance has been requested	0	2

Of which		
Assurance has been received		2
Assurance has not been received		0
have been terminated as a result of assurance not being received		0
Off- payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April and 31 March 2019	**2018-19**	**2017-18**
Off- payroll engagements of board members, and/or senior officials with significant financial responsibility during the financial year		0
Number of individuals that have been deemed board members, and/or senior officials with significant financial responsibility during the financial year. NB includes both off-payroll and on-payroll engagements	1	0



Mark Brandreth
Chief Executive Officer
23 May 2019

NHS Foundation Trust Code of Governance Disclosures

Statement of compliance with the NHS Foundation Trust Code of Governance

Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust is a public benefit corporation established under Section 35 of the National Health Service Act 2006. The Board attaches great importance to ensuring that the Trust operates to high ethical and compliance standards. In addition it seeks to observe the principles set out in the NHS Foundation Trust Code of Governance.

The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the hospital and consults on its future strategy with its members through the Council of Governors.

The Council of Governors' role is to influence the strategic direction of the Trust to take into account the needs and views of the members, local community and key stakeholders, to hold the Board to account for its performance, to develop a representative, diverse and well-involved membership and to make a noticeable improvement to the patient experience. It also has to undertake other statutory and formal duties, including the appointment of the Chairman and Non-Executive Directors of the Trust and appointment of the external auditors.

In the event of a dispute between the Board and the Council a disputes procedure is described in the Constitution.

In accordance with its Licence, the Trust has in place mechanisms in its Constitution to ensure that no person who is an unfit person may become or continue as a governor, except with the approval in writing of NHS Improvement.

The Board has established governance policies that reflect the principles of the NHS Foundation Trust Code of Governance; these include:

- Corporate Governance Framework incorporating the Standing Orders of the Board of Directors, Standing Orders of the Council of Governors, Scheme of Reservation and Delegation of Powers, and Standing Financial Instructions.
- Established role of Senior Independent Director.
- Regular private meetings between the Chair and the Non-Executive Directors.
- Performance Appraisal Process for all Non-Executive Directors, including the Chairman, developed and approved by the Council of Governors.
- Attendance records for directors and governors at key meetings.
- Register of Interests – directors, governors and senior staff.
- Established role of Lead Governor.
- Regular communication between the Chair and governors to advise matters reviewed at Board meetings.

- Effective Council of Governors' sub-committee structure with quarterly meetings of the Council of Governors
- Council of Governors' agenda-setting process.
- Board Review and Remuneration Committee of the Board.
- Nominations Committee of the Council of Governors.
- Agreed recruitment process for Non-Executive Directors.
- High quality reports to the Board and Council of Governors.
- Council of Governors' presentation of performance and achievement at Annual Members Meeting.
- Code of conduct for governors.
- Quarterly review of the Trust's membership
- Robust Audit Committee arrangements.
- Ensuring robust governance arrangements are in place supported by an effective assurance framework that supports sound systems of internal control.
- Ensuring rigorous performance management which ensures that the Trust continues to achieve all local
- and national targets.
- Seeking continuous improvement and innovation.
- Measure and monitor the Trust's effectiveness and efficiency.
- Ensuring that the Trust, at all times, is compliant with its Licence, as issued by the sector regulator NHS Improvement.
- Exercising the powers of the Trust established under statute, as described within the Trust's Constitution

Meet the Trust's Council of Governors

The Council of Governors consists of nine Public Governors, three Staff Governors and three Stakeholder Governors. The Trust's Governor can be contacted via the following email address: rjah.governors@nhs.net

Katrina Morphet
Public Governor – Cheshire and Merseyside

Jan Greasley
Public Governor - North Wales - Lead Governor

Julie Santy-Tomlinson
Public Governor - Rest of England & Wales

Allen Edwards
Staff Governor

Kate Chaffey
Staff Governor

Peter David
Stakeholder Governor

Russell Luckock
Public Governor - West Midlands

Sue Nassar
Public Governor - Shropshire

Gill Pitcher
Public Governor - Shropshire

Colin Chapman
Public Governor - Shropshire

William Greenwood
Public Governor - Powys

Martin Coggon
Public Governor – North Wales

Karen Calder
Stakeholder Governor

Karina Wright
Stakeholder Governor

Kate Betts
Staff Governor

Council of Governors Terms of Office

Type of Governor	Constituency	Term of Office Yrs	Appointed / Elected	Date Term in Office Ends
Stakeholder Governors (Appointed)				
Karen Calder	Shropshire Council	-	-	-
Karina Wright	Keele University	-	-	-
Peter David	Voluntary Services Committee	-	-	-
Staff Governors (Elected)				
Kate Chaffey	Staff	3	26 Oct 17	25 Oct 20
Allen Edwards	Staff	3	1 Aug 16	31 Jul 19
Kate Betts	Staff	3	11 Apr 19	10 Apr 22
Public Governors (Elected)				
Colin Chapman	Shropshire	3	26 Oct 17	25 Oct 20
Jan Greasley	North Wales	3	1 Aug 16	31 Jul 19
Russell Luckock	West Midlands	3	26 Oct 17	25 Oct 20
Sue Nasser	Shropshire	3	1 Aug 16	31 Jul 19
Gill Pitcher	Shropshire	3	1 Aug 16	31 Jul 19
Julie Santy-Tomlinson	Rest of England and Wales	3	1 Aug 16	31 Jul 19
Martin Coggon	North Wales	3	26 Oct 17	25 Oct 20
William Greenwood	Powys	3	11 Apr 19	10 Apr 22
Katrina Morphet	Cheshire and Merseyside	3	26 Oct 17	25 Oct 20

During 2019 the Trust held Governor elections in order to fill vacancies. The following table sets out the vacancies and the recruitment that took place.

Governor Elections

Elections commenced in January and concluded in April 2019, the results of which were as follows:

Results of the Governor Elections		
Constituency	Number of vacant posts	Elected Governor
Staff Governors		
Staff	1	Kate Betts
Public Governors		
Powys	1	William Greenwood

Council of Governor Meetings

During 2018/19 the Trust held four meeting of the Council of Governors. The Trust recognises the importance of these meetings in ensuring that the members of the Board of Directors, and in particular the Non-Executive Directors, develop an understanding of the views of the Governors and it's members.

Attendance at the Council of Governors meetings by the Executive and Non-Executive Directors is outlined below:

Name	Council of Governors
Total 2018/19	**4**
Frank Collins, Chairman	4
Hilary Pepler, Non-Executive Director (Until 31 October and Board Advisor thereafter)	4
Harry Turner, Non-Executive Director	3
Alastair Findlay, Non-Executive Director	4
Chris Beacock, Non-Executive Director	1
David Gilburt, Non-Executive Director	4

Paul Kingston, Non-Executive Director(from 1 January 2019)	1
Mark Brandreth, Chief Executive	4
Craig Macbeth, Director of Finance	4
Shelley Ramtuhul, Trust Secretary	4
Bev Tabernacle, Director of Nursing	3
Sarah Bloomfield, Interim Director of Nursing	1
Nia Jones, Director of Operations	3
Steve White, Medical Director	1

Membership

The Trust reviews its membership on a quarterly basis at the Council of Governors meeting. This review looks at the number of members and analyses the demographic information to ensure that, as far as possible, the membership remains representative of the community the Trust serves. The table below provides a breakdown of the membership by constituency for the financial year 2018/19. In addition there were 1171 staff members at the end of March 2019.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cheshire & Merseyside	323	324	326	326	328	328	328	329	330	331	332	333
North Wales	878	877	879	876	881	893	892	892	894	891	893	893
Powys	509	509	512	513	516	519	521	524	524	524	526	525
Shropshire	2,490	2,497	2,509	2,513	2,530	2,561	2,575	2,580	2,590	2,597	2,612	2,618
West Midlands	474	474	476	474	475	475	485	488	489	489	490	490
Rest of England & Wales	224	223	222	221	220	222	224	226	225	225	226	226
Out of Trust Area	37	37	39	39	39	38	38	38	38	38	39	40
Total	**4,935**	**4,941**	**4,963**	**4,962**	**4,989**	**5,036**	**5,063**	**5,077**	**5,090**	**5,095**	**5,118**	**5,125**

In 2015 the Trust set its Membership Strategy which aimed to achieve a 5% increase year on year. For 2018/19 this represented a total membership target of 6447 against which an actual membership of 6296 was achieved. For 2017/18 there were 6140 members and therefore there has been an increase in membership of 2.5%

The Trust has continued to hold members surgeries during 2018/19, held in the hospital's main foyer as a way of drawing attention to membership. In November 2018 the Trust refreshed it's Membership Strategy with a focus on recruiting members from underrepresented groups. In January 2019 the Council of Governors held a workshop focused on the Membership Strategy and its implementation.

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

As at April 2019 the Trust is in segment 1 (highest). Latest segmentation information for all NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

As at April 2019 the Trust overall use of resources score was a 1 (the highest possible score)

Area	Metric	2018/19 Plan	2018/19 Outturn
Financial sustainability	Capital service cover	2	1
	Liquidity	2	1
Financial efficiency	Income & expenditure margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	2	2
Overall scoring			**1**

Governance using the Well-Led Framework

The Board of Directors ensures that the principles set out in the Well-Led Framework not only inform their work, but are also embedded across the organisation. For example, the Board receives regular reports on all aspects Trust performance, and ensures that these address each of the eight Key Lines of Enquiry as set out in the Framework. Further detail about the Trust's approach to ensure that its services are Well-Led is set out in the Annual Governance Statement later on in this report.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require the Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the 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 Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Foundation Trust's performance, business model and strategy, 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 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 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 the *NHS Foundation Trust Accounting Officer Memorandum*.

Signature: 

Name: Mark Brandreth, Chief Executive

Date: 23rd May 2019

ANNUAL GOVERNANCE STATEMENT 2018/19

Scope of responsibility

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

The purpose of the system of internal control

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

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust "(the Trust)", to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust considers that risk management is everyone's business ranging from staff taking individual responsibility for the safety of themselves, their colleagues or patients to Executive Director responsibility for strategic risks or the Non-Executive responsibilities for robust challenge of effective risk management and assurance of adequate control.

The Trust has in place a robust Risk Management Strategy which outlines its vision for risk management and defines the Trust's approach, as endorsed by the Board of Directors. This strategy has been distributed through the Trust and is available to staff on the Trust intranet.

The Risk Management Strategy delegates leadership and responsibilities for risk management to the following senior managers and Executive Directors:

Chief Executive

- Accounting Officer
- Maintain a sound system of internal control
- Prudent and economic administration of the organisation
- Strategic leadership for the Trust's Information Management and Technology infrastructure and services

Director of Finance and Planning

- Advise Board on Financial Strategy and Management
- Ensure sound financial management, including compliance with SFIs
- Ensure that external financial reporting complies with the relevant standards

- Ensure that there are systems in place to meet the Trust's operational targets and objectives
- Ensure sound financial management of the Capital Programme

Director of Nursing and Quality

- Board lead for Quality and Safety (in conjunction with the Medical Director)
- Sound Clinical Governance
- Professional Leadership of Nursing Staff and Allied Health Professionals
- Patient and Public involvement
- DIPC (Director of Infection Prevention and Control)
- Information Governance, Caldicott Guardian
- Oversight of risk management process
- Accountable Officer for controlled drugs
- Health and Safety management and compliance with statutory requirements

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Medical Director

- Responsible Officer including the appraisal, revalidation and performance management of medical staff
- Professional Leadership of Medical Staff
- Ensure that medical staff have the requisite skills to provide high quality medical care
- Lead on clinical governance, accountability and quality (in conjunction with the Director of Nursing)
- Lead for the Clinical Services Strategy (in conjunction with the Director of Strategy and Planning)
- Leading the Trust's relationships with General Practitioners and Medical Schools
- Lead medical input into litigation and claims management
- Ensure that sound governance arrangements are in place for research

Director of People

- Effective matching of workforce to activity
- Leading and facilitating continuous professional development
- Develop the leadership capacity and capability

Director of Operations

- Efficient delivery of operational and clinical support services
- Implementation of national policy on waiting list targets
- Lead service redesign to improve the patients' pathway and operational effectiveness
- Ensure that there are systems in place to meet the Trust's operational targets and objectives

Director of Improvement, Organisational Development and Performance

- Ensuring the Trust has adequate oversight of its performance.
- Strategic leadership for the Trust's service improvement framework and agenda
- Ensuring the development and implementation of the Organisational Development Strategy
- As Senior Information Risk Owner (SIRO) ensuring that risks to data security are recognised and managed
- Design and ensure the effective operation of the Trust's process of continuous improvement

Trust Secretary

- Provide central support and advice to the Board regarding the establishment of an effective system of internal control
- Develop and maintain the Trust's Board Assurance Framework
- Senior lead for risk management, patient experience, health and safety and clinical audit and reporting to the Director of Nursing for these aspects of the role
- The Trust's Data Protection Officer in accordance with the General Data Protection Regulation (GDPR)

Clinical Leads / Senior Managers

- Manage risks at a local level and developing an environment where staff are encouraged to identify and report risk issues proactively
- Maintain a risk register and presenting key risks to the Risk Management Committee on a bi-monthly basis
- Ensure that their staff report immediately any near-miss incidents, adverse incidents and serious incidents, using the Trust's incident reporting procedure
- Provide appropriate feedback regarding specific incidents reported and implement recommendations following investigations to reduce the likelihood of recurrence

Risk awareness is promoted throughout the organisation with all staff expected to have an understanding of the Trust's incident reporting procedure and knowledge of the process for escalating risks. Staff are trained in risk management awareness both at induction for new starters and as refresher training; in addition drop-in sessions are held every month for staff.

The Risk and Control Framework

Risk Management Strategy

The Trust's Risk Management Strategy sets out the framework and systems for implementation of risk management and governance in the Trust. This strategy was reviewed and updated by the Board of Directors in September 2018.

The strategy clearly defines how risks are identified, reviewed, managed and, where appropriate, escalated. Further, it sets out individual and committee roles and responsibilities and defines the levels of authority for the management of identified levels of risk. It also describes the Trust's interpretation and definition of 'acceptable risk'.

The Trust's approach to risk management is one of proactive identification, mitigation and monitoring with oversight at divisional level through governance meetings, at a corporate level through the Risk Management Committee and at Board level through use of the Board Assurance Framework.

The Trust utilises an online risk management database to escalate risks up and down through the organisation in accordance with the matrix outlined in the Risk Management Strategy.

The strategy includes the following key elements:

- It describes what is meant by 'risk management'

- It identifies the roles and responsibilities of all staff within the Trust
- It clearly describes the roles and responsibilities of the key accountable officers
- The training requirements for staff
- It sets out the process of risk management as follows:

i. Risk identification
ii. Risk evaluation
iii. Risk recording
iv. Risk treatment and escalation

The Board of Directors is responsible for setting the Trust's risk appetite on an annual basis according to its present position and anticipated direction of travel for the financial year ahead. The defined appetite is then applied through implementation of the Trust's Risk Management Strategy.

The Board Assurance Framework is the key tool used by the Board of Directors to assure itself of the efficacy of the control framework. This sets out the principal risks to delivery of the Trust's strategic objectives. An Executive Director is identified as the lead for each risk and attends the monthly Risk Management Committee which reports to the Board of Directors. This Committee has oversight of the effectiveness of the operational management of risk with the Audit Committee overseeing the effectiveness of the governance framework and controls.

In addition there are several internal and external assurances gained throughout the year through sources such as:

Internal
•Strategic and business planning •Adverse incident analysis •Complaints •Claims •Analysis of compliance with statutory duties and guidance •Intelligence from internal health and safety, fire or security inspections •Internal Audit

External
•Safety alerts or hazard warnings •External body recommendations •New legislation •External inspections or assessments •External Audit •Regulatory reviews

The Trust utilises a risk assessment matrix to ensure a consistent approach is taken to assessing the potential consequences and likelihoods of risks and furthermore that appropriate action is taken to address each risk based on the resulting risk score. This process of assessment is conducted via the online risk management system referenced previously.

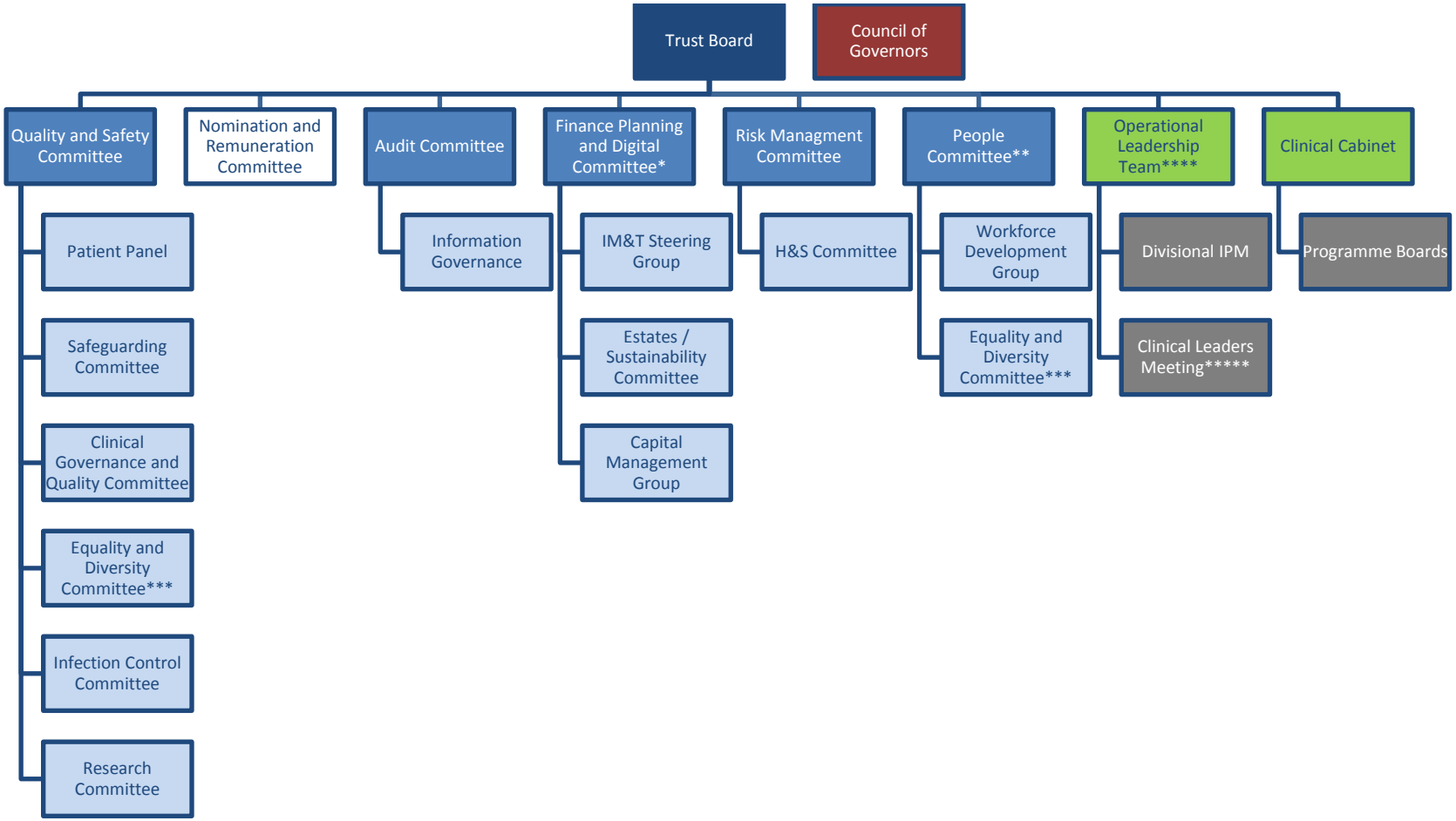
The Trust is committed to ensuring that any potential risks are mitigated to the lowest possible level and where possible negated altogether and uses both internal and external expertise, as required, to decide on the most appropriate treatment of identified risks.

Governance Framework of the Organisation

The Trust has continued to develop its governance structures over the last 12 months in line with internal and external audit recommendations. The structures in place are aimed at delivering an integrated governance agenda. Integrated governance is the combination of systems, processes and behaviours which the Trust uses to lead, direct and control its functions in order to achieve its organisational objectives.

Board Assurance Structure

The Board of Directors leads on integrated governance and delegates key duties and functions to its committees whilst retaining certain decision making powers on strategy and aspects of financial management. The diagram below sets out the committee structure for 2019/20 with the changes since the 2018/19 structure highlighted where relevant:



** Previously Finance Planning and Investment Committee*
***Established from 1 April 2019*
****Reporting to both Quality and Safety Committee and People Committee*
***** Formerly Executive Team*
******Formerly Clinical Cabinet*

The roles and responsibilities of these committees are described more fully below and performance of these committees is evaluated on an annual basis:

Board of Directors

The Board meets regularly to discuss an agenda based on three key elements:

- Strategy and Policy
- Performance and Governance
- Quality and Safety

The Board is responsible for setting the organisation's strategy and for ensuring that the Trust meets its statutory duties and effectively manages risk. The Board gains assurance through the Board Assurance Framework. The Board holds prime responsibility for corporate governance and the development of systems and processes for internal control, including risk management, the Board Assurance Framework and compliance with Care Quality Commission (CQC) regulations.

The Board maintains responsibility for setting and approving work plans and monitoring the delivery of planned objectives. The Board of Directors regularly receives reports from its committees on the business covered, risks identified and action taken as well as regular performance related reports.

The Board is responsible for ensuring the financial viability through the establishment of effective financial stewardship.

Membership of the Board comprises the Trust Chairman, Chief Executive, Non-Executive and Executive Directors with attendance from non-voting Directors and the Trust Secretary.

Audit Committee

The Audit Committee is accountable to the Board and is responsible for ensuring there is an effective system of risk management and internal control across the Trust. The operational management of risk is delegated to the Risk Management Committee with oversight and assurance of the processes and systems established via the Audit Committee. The Audit Committee provides an oversight of the activities of internal audit, external audit, the local counter fraud service and the assurance on internal control, including compliance with the law and regulations governing the Trust's activities.

The Audit Committee is chaired by a Non-Executive Director and membership consists solely of Non-Executive Directors with Board Executives invited to attend.

The Audit Committee oversees the annual audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal controls with respect to risk management in place. An annual Head of Internal Audit Report is presented to the Audit Committee.

Quality and Safety Committee

The Quality and Safety Committee is accountable to the Board and is responsible for ensuring effective clinical governance throughout the Trust. It assists the Board in obtaining

assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. It works with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes and controls in place throughout the Trust to:

- promote safety and excellence in patient care
- identify, prioritise and manage risk arising from clinical care
- ensure efficient and effective use of resources through evidence-based clinical practice

The Quality and Safety Committee is chaired by a Non-Executive Director and is attended by a further two Non-Executive Directors and members of the Executive Team.

Finance Planning and Digital Committee

The Finance Planning and Digital Committee is accountable to the Board and responsible for advising the Board on all aspects of the Trust's Annual and Long Term Financial Plans and recommending adoption of the plans to the Board of Directors.

The Committee is responsible for the following aspect of Risk Management:

- To oversee Financial Risk Assessment and Financial Risk Management
- To oversee the business and performance risk
- To oversee the Trust's digital risks
- To oversee the Trust's operational performance delivery

This Committee is chaired by a Non-Executive Director and attended by a further Non-Executive Director and members of the Executive Team.

Risk Management Committee

The Risk Management Committee is accountable to the Board and has overall responsibility for establishing a strategic approach to risk management across the organisation, ensuring there is a proactive approach. In addition to reporting to the Board, the committee provides reports to the Audit Committee on assurances relating to the effective operation of controls.

The committee is responsible for the following aspects of Risk Management:

- Championing and promoting highly effective risk management practices and ensuring that the risk management process and culture are embedded throughout the organisation
- Maximising the delivery of objectives through an effective control system
- Improving the standard of decision making on risk management
- Receiving and reviewing the BAF and making recommendations regarding this to the Board
- Reviewing risk management practices at divisional level and the effectiveness of risk mitigation action plans
- Developing and embedding and effective reporting mechanism to allow for the escalation of risk and governance issues from divisional level to the appropriate level.

- Providing the Executive Team and ultimately the Board of Directors with assurance that effective governance processes are in place across the organisation
- Providing the Audit Committee with assurance around the Trust's risk assurance framework and the controls in place.
- Overseeing the Trust's strategy for clinical risk management.

People Committee (Effective from 1 April 2019)

The People Committee is accountable to the Board and has overall responsibility for establishing a strategic approach to the management and development of the Trust's workforce. In addition to reporting to the Board, the committee provides reports to the Audit Committee on assurances relating to the effective operation of controls.

The committee is responsible for the following aspects of Risk Management:

- Maximising the delivery of workforce objectives through an effective control system
- Overseeing the management of risks relating to the workforce and its development and sustainability

Council of Governors

The Trust's governors are elected representatives of the local communities the Trust serves and together they form the Council of Governors (CoG) which is an integral part of the Trust's governance framework. They are not responsible for the operational management of the Trust but rather are responsible for challenging and holding to account the Board of Directors.

They plan an active role in the development of the Trust and its activities and are included in the initiatives and collaborative committees run throughout the year. The statutory powers and duties of the COG include:

- To appoint, remove and decide upon the terms of office of the Chair and Non-Executive Directors of the Trust
- To determine the remuneration of the Chair and Non-Executive Directors
- To appoint or remove the Trust's auditor
- To approve or not approve the appointment of the Trust's Chief Executive
- To receive the annual report and accounts and auditor's report at a general meeting
- To hold the Non-Executive Directors to account for the performance of the Board
- To represent the interests of members and the public
- To approve or not approve increases to non-NHS income of more than 5% of total income
- To approve or not approve acquisitions, mergers, separations and dissolutions
- To jointly approve changes to the Trust's constitution with the Board
- To express a view on the Board's plans for the Trust in advance of the Trust's submission to NHS Improvement
- To consider a report from the Board each year on the use of income from the provision of goods and services from sources other than the NHS in England.

The Trust has a duty to ensure that governors are equipped with the skills to perform this role. As required by the Health and Social Care Act 2012, during the year workshop sessions were provided for all governors in respect of their duties and responsibilities.

The Board works closely with the CoG. The Chairman is also the Chairman of the CoG and is supported at every meeting by other members of the Board. The Chairman works closely with the nominated Lead and Co-ordinating Governors. Governors meet prior to each meeting of the Council of Governors to agree items to be discussed and review key issues.

Attendance at the Trust's Board of Directors and Board level committees is monitored on a monthly basis and the table below outlines the attendance for the year:

Name	Board of Directors	Council of Governors	Quality and Safety Committee	Risk Management Committee	Audit Committee	Finance Planning and Digital Committee
Total 2018/19	**10**	**4**	**10**	**10**	**4**	**6**
Frank Collins, Chairman	9	4	-	-	-	-
Hilary Pepler						
Non-Executive Director (until 31 Oct 19 thereafter in capacity as Board Advisor)	10	4	7	-	2	-
Harry Turner, Non-Executive Director	8	3	1	6	2	
Alastair Findlay, Non-Executive Director	5	4	-	-	-	6
Chris Beacock, Non-Executive Director	8	1	6	10	-	
David Gilburt, Non-Executive Director	10	4	6	-	4	5
Paul Kingston, Non-Executive Director (From 1 Jan 2019)	4	1	2	-	1	-
Mark Brandreth, Chief Executive	10	4	7	7	-	6

Sarah Sheppard, Director of People	9	-	1	1	-	
Kerry Robinson, Director of Improvement, Organisational Development and Performance	9	2	-	7	2	4
Craig Macbeth, Finance Director	9	4	-	5	3	6
Bev Tabernacle, Director of Nursing	8	3	9	4	-	1
Sarah Bloomfield, Interim Director of Nursing	1	1	1	-	-	-
Nia Jones, Director of Operations	10	3	6	7	4	5
Steve White, Medical Director	7	1	6	-	-	-

Note: Non-membership is indicated by a '-'

Internal Audit

During 2018/19 the Trust appointed BDO as its internal auditors who met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committee, Chief Executive and Board. They primarily provide an independent and objective opinion to the Trust on the degree to which risk management, control and governance processes support the achievement of the Trust's objectives.

External Audit

The Trust's external auditors are Deloitte LLP. External audit is an essential element of corporate governance, contributing to the stewardship and process of accountability for use of resources. The scope of audits is extended to cover not just financial statements but the arrangements to secure value for money. The Trust's external auditors report into the Audit Committee.

Quality Governance

The Board is responsible for ensuring that the Trust has sound Quality Governance arrangements in place. It is supported in this by the Quality and Safety Committee which reviews evidence from a number of sources including, specialist committees, clinical audit reports and patients stories. It receives reports and reviews in full all serious incident root-cause analysis reports and any actions taken in response to them.

The Trust updated its Quality Strategy in 2017 following consultation with key stakeholders on the priorities to be included and the Board is regularly updated on progress against the key quality initiatives.

Staff are required to report all untoward incidents through a formal system and these are reviewed by the Clinical Governance Team who are responsible for ensuring that all learning is shared and actions agreed and implemented as per the Trust's Incident Management and Serious Incident Management Policies.

The Trust reviews all of the complaints it receives and the results of this review are reported to the Quality and Safety Committee and the Board.

The Trust has a well-established openness policy, which includes whistle-blowing. Whistle-blowing is included on the staff induction training which all staff are required to attend. In addition, that Trust has in place three Freedom to Speak Up Guardians.

A rigorous process is in place for doctors appraisals, supported by the production of a comprehensive data set for each doctor. In addition, the Trust is compliant with the doctors revalidation programme.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC)

The Trust was subject to a planned inspection by the CQC in December 2018 following which it received an overall rating of 'Good' with findings of 'Good' for well led and 'Outstanding' for caring. Notwithstanding the significantly improved ratings, the Trust has devised an action plan to address the CQC recommendations and observations. Completion of this action plan will be overseen by the Quality and Safety Committee on a monthly basis with quarterly updates to the Board of Directors.

Use of the Well-Led Framework

In October 2017 the Board of Directors completed a well-led developmental review of leadership and governance using the Well-Led Framework. This was a full a thorough review conducted by an external consultancy and informed a development plan.

In December 2018 the Trust underwent a well led assessment as part of a CQC inspection. The outcome of this was a 'good' rating for well-led. An action plan has been developed to address all recommendations made by the CQC. The well-led elements are particularly focusing on policy management and staff training.

Corporate Governance Statement

The Trust confirms compliance with the Corporate Governance Statement on an annual basis. It gains assurance on compliance in a number of ways:

- Consideration of governance risks as set out above.
- The maintenance of a Board governance pack detailing the key governance structures and their inter-relationships. This was reviewed by the Board in March 2019.

- The Internal Auditors have undertaken the following specific reviews linked to governance:

Summary of Key Findings / Recommendations
Data Quality

There is an agreed framework in place which sets out a robust process of how data is identified, validated and reported. This is supported by clear arrangements and documented. However:

- Across the sample of nine audits tested, there was inconsistent application of the new data quality approach with regards to representative sample testing and recording of recommendations after audit completion

There was one instance of the IPR not being updated to show that a KPI had been through the data quality approach

Booking System

Good practice included a clear system and procedures in place to manage arrangements and the process documents were largely clear, updated and approved. However:

- Our testing identified the following design issues, which cause issues for consultants using the system:
  - The appointments within Bluespier were not consistent with PAS
  - Admission cancellations are not always visible within Bluespier
- Of the sample of 15 patient records we found the following:
  - Date of referral was not available within the system view
  - One out of 15 patient admission dates were inconsistent between Bluespier and PAS.
- Neither Bluespier or PAS are subject to an interface process. As a result there are a number of duplication of duties within the bookings team, as the bookings team are having to key in data within the Bluespier system, increasing the risk of inaccuracies on the system

We found that the patient waiting list view in Bluespier contained a number of inaccuracies, which prevented consultants from booking their own admissions and reviewing their current utilisation.

Paediatrics

Good practice included a clear structure diagram and arrangement for new processes and positive action on the majority of most previous CQC findings. However:

- Strategy for the Directorate needs to be decided in order to address the fact that CQC out of hours paediatrician staffing requirement is not met
- Some pathways are not defined in a SOP and subject to audit

Evidence of two actions from the CQC action plan was not provided.

Recruitment

There are arrangements to support recruitment activity in terms of the central HR team and process documents from identification through to hire. However:

- At present there is no long term recruitment strategy in place. Whilst this is being worked on, key dates have not been defined and there is a risk of delay (High)
- There are no recruitment KPIs in place and the paper-based system impedes development in this area
- There were variances in the time taken for various stages of the recruitment process. Delays found during testing reflect the necessity of the TRAC online system in order to improve the consistency of record keeping and efficiencies within the recruitment system
- There is no process for exit interviews in place at the Trust

At present there is no assurance on the consistency of interview technique and process at the Trust or around equality and diversity

Consultant Job Planning

All consultant job plans were in place and approved however:

- The systems and resources available to Trust management do not facilitate effective monitoring of consultant activity and how this compares with expectations set out within their job plans, potentially leading to operational inefficiencies (see Detailed Finding 1). On average across our sample, actual consultant clinic activity was 14% below expected activity, with the performance ranging from 50% below expected activity to 21% above expected activity. Actual consultant theatre activity was 27% below expected activity, with the performance ranging from 39% below expected activity to 8% below expected activity

Trust data appears to indicate consultants are undertaking out of job plan sessions during periods where their job plans indicate they should be completing normal scheduled activity, potentially resulting in consultants receiving double payments for the same periods of time (see Detailed Finding 2). The number of apparent conflicts during 17/18 per consultant ranged from one to 13.

Main Financial Systems and Budgets Management and Financial Planning
None. Strong controls operating throughout those tested with no exceptions identified from our testing.
GDPR
Corporate documents were in place and approved which are supported by regular communication to staff and high levels of training – 95%. However: • Delays in responding to subject access requests were recorded in December 2018 (11%) and these were not reported to the Information Governance Committee • Data breach procedures and user guidance for reporting are in place but the timeliness of the end-to-end process has not been tested
Post Market Surveillance
There are arrangements in place to identify post market surveillance cases and then processes to follow and document how action is taken however: • There is no Trust-wide central database of all post-market surveillance research studies, and during the review it became apparent that studies had been started outside of the Research Department (High) • Whilst the post SI Report Action Plan is in progress, the Trust at present is still unable to provide a definitive answer on the number of patients affected by the breach that have now consented • There is no Research and Post-Market Surveillance Policy • Research Standard Operating Procedures (SOPs) require updating • Three of the seven patient information forms did not explicitly state that data may be shared outside of Europe. The studies had HRA approval, so this is not a higher priority finding, but it highlights that where there are inconsistencies in the documents provided to the Trust by the Sponsor, there is no clear policy in place to guide Research staff as to how to challenge them Clarity in a SOP is required with regard to the storing of patient identifiable data with the Case Report Forms (CRFs) and locked cabinets would provide greater assurance over security of physical CRFs than just the locked room

Principal Risks

The principal risks to the Trust's objectives are included on the Board Assurance Framework and are allocated to a Board Committee for scrutiny. In addition the Risk Management Committee reviews these risks on a monthly basis and the Board reviews them on a quarterly basis.

Other corporate risks are included on the corporate risk register and allocated to a board committee and reviewed by the Executive team. The Risk Management Committee has oversight of the corporate risks with input sought from the appropriate board committee as required.

During 2017/18 the NHS Improvement removed the licence breach previously put in place in January 2016 by Monitor. This was in relation to a breach of licence for RTT performance and governance breaches. In order to address the breach of licence, the Trust put in place a recovery programme for its RTT performance with a Recovery Board chaired by a Non Executive Director. Further, an Integrated Governance Action Plan (IGAP) was devised to ensure delivery of the undertakings that had been agreed between the Trust and Monitor. These interventions had the desired effect with both the Recovery Board and the (IGAP) being brought to a close during April 2017 and an announcement by NHS Improvement in June 2017 that the licence breach had been removed.

Risks 2018/19

During 2018/19 the following risks were identified and cited on the Board Assurance Framework:

- Inadequate or unsuccessful implementation of learning from incidents
- Limitations as a result of IT capabilities
- Failure to achieve activity and income target within planned cost base
- Failure to improve performance in relation to the CQC core standards

- Instability arising from fluctuations in the tariff from 2019/20 onwards
- Inadequate operational processes
- Inability to sustain the delivery of our access and waiting times
- Lack of clear national strategy for the commissioning of our specialist services
- Local health partners do not see the benefit of specialist orthopaedic services within the system

In addition, during the year the Trust added a risk to the Board Assurance Framework relating to the potential for EU Exit to impact on service delivery.

Risks 2019/20

The Trust has established its strategy for 2019/20 to support its desired direction of travel over the next five years. The four key strategic aims for 2019/20 remain as follows:

- Musculo-Skeletal (MSK)
- Specialist Services
- Operational Excellence
- Culture and Leadership

The Board has reviewed the key risks facing the Trust's ability to achieve these strategic aims and has agreed that these are as follows:

Caring for Patients

- Inadequate clinical engagement in work streams to reduce clinical variation
- Failure to implement national recognised evidence-based practice
- Limitations as a result of IT capabilities
- Inadequate operational processes
- Lack of clear national strategy for the commissioning of specialist services
- MSK service integration fails to deliver expected benefits

Caring for Staff

- Failure to improve staff engagement linked to communication between managers and the workforce
- Potential inability to have the right workforce in the right place at the right time

Caring for Finances

- Instability arising from fluctuations in the tariff
- Failure to achieve activity and income target within planned cost base

The sub-set of risks linked to the above will be detailed on the Trust's Board Assurance Framework and Trust-wide Risk Register for ongoing review and management through the year.

As described in the sections above, the Trust has in place effective governance structures with clear responsibilities delegated to each Executive Director and Board Committee. Furthermore, within the Risk Management Strategy and the Terms of Reference for each

Board Committee, the Trust has clear reporting lines between the Board, its sub committees and the Executive Team to ensure an integrated approach is maintained.

The Trust's Board of Directors sets key performance indicators against a range of areas under the headings; Caring for Patients, Caring for Staff and Caring for Finances. Performance against these indicators is tracked and reported to the Board on a monthly basis. In addition to this, the Trust sets annual corporate objectives and progress against these is tracked and reported to the Board. During 2017/18 the Trust established a Strategy Oversight Group (Executive Team Meeting – once a month) and a Strategy Board (Board of Directors' Meeting – three times per year) to oversee the delivery of its corporate objectives and strategy more closely.

NHS Pension Scheme

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

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Emergency Preparedness and Civil Contingency

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Workforce Strategies and Safeguards

The Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective. This assurance is obtained in a number of ways:

- The development and implementation of a People Plan
- Regular reporting on safe staffing and junior doctor working to the Quality and Safety Committee and Board of Directors
- Staff survey results
- Internal audit

During 2019/20 the Trust is introducing a People Committee to increase oversight and assurance of the Trust's workforce strategy.

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 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.

The Trust has published an up-to-date register of interests for decision-making staff within the 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

In carrying out the above, the Trust ensures compliance with the 'Developing Workforce Safeguards'.

Sustainable Development Management

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptations Reporting requirements are complied with.

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

The Trust sets targets for improvements of economy, efficiency and effectiveness in its Operational Plan and these are reflected in its Quality, Innovation, Productivity and Prevention (QIPP) and Cost Improvement Programmes (CIPs). All targets are agreed by Divisional Managers and monitored as part of the Board performance report and the system of divisional performance reviews. These programmes are also approved by the Medical and Nursing Directors to ensure that they have no adverse effect on quality. The Trust's CIP process has been benchmarked against national guidance on sustainable CIPs and the principles of the Carter Review recommendations.

During 2018/19 the Trust tracked its financial performance, including the economic, efficient and effective use of resources via the Finance Planning and Investment Committee and further the Board receives a monthly update on the Trust's financial performance.

Overview of Financial Performance

The Trust's annual accounts provide full detail of the Trust's financial performance but to summarise, the Trust was set a control total surplus by NHS Improvement of £1,104k for 2018/19. Despite a number of in-year operational pressures the Trust exceed this target by £28k and therefore became eligible for additional provider sustainability funding (PSF) from NHS Improvement. This contained a core element of £833k and a further unplanned bonus element of £1,517k, which was a share of the unclaimed national sustainability fund. The final control total surplus for the year including sustainability funding was £3,482k.

This position was supported by a programme of cost improvements which realised £3.7 million savings in-year compared to £4.1 million in the previous year.

The Trust's financial performance for 2018/19 provides assurance of the financial controls it has in place and the economic, efficient and effective use of its resources.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by a

data security and protection toolkit and the annual submission process provides assurances to the Trust, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The Trust has an established information governance management framework and continues to develop information governance processes and procedures in line with the information governance toolkit. The Trust`s Information Governance status is the subject of ongoing review by the Information Governance Committee which is responsible for reviewing policy and monitoring compliance with Department of Health Guidelines. This process is overseen by the Audit Committee which also has a role in ensuring that all serious data governance risks or incidents are brought to the attention of the appropriate Board Committee. Two directors have complementary roles in assuring data governance; the Director of Nursing as the Caldicott Guardian, and the Director of Strategy and Planning as the Senior Information Risk Officer (SIRO). Further, the Trust is the Data Protection Officer.

The requirements of the new Data Security and Protection Toolkit (DSPT) are designed to encompass the National Data Guardian review's 10 data security standards.

The revised DSPT supports key requirements under the General Data Protection Regulation (GDPR), identified in the NHS GDPR checklist.

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance DSPT score overall for 2018/19 was **STANDARDS MET*.***

During 2018/19 the Trust identified and reported one serious incident relating to a historical information governance breach. This involved four post-marketing surveillance studies established over ten years ago which had not appropriately obtained patient consent for the use of their limited medical data for this purpose. The information was pseudonymised before being shared with third parties and therefore the risk of the breach was considered relatively low. The studies had, however, involved a large number of patients and each patient was contacted to advise them of the breach and the extent to which it affected them. The incident was reported to the ICO who, following review of the Trust's internal investigation, decided to take no action.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on 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 Annual Quality Report 2018/19 has been developed in line with relevant national guidance and is supported internally through the Board Assurance Framework. The majority of the content of the Quality Report is subject to the various foundation trust policies and procedures which ensure the quality of care provided.

As outlined earlier in this statement, the Trust has a dedicated Quality and Safety Committee whose role is to oversee quality improvement and development within the organisation. The

Quality and Safety Committee is chaired by a Non-Executive Director of the Board and attended by the Chief Executive, Director of Nursing, Medical Director and a minimum of one other Non-Executive Director. All data and information within the Quality Report is reviewed through this committee. The Trust has a detailed data quality audit programme which reviews all of its data quality KPIs on an annual basis. This programme is overseen by the Audit Committee.

The Board of Directors reviews the quality key performance indicators monthly within an integrated performance report and includes progress against high level improvement goals within three identified themes: Patient Experience, Effectiveness and Patient Safety. Comments on the content of information included within the Quality Report have been provided by local stakeholders including commissioners, patients and the local authority.

Deloitte LLP provides external assurance on the Quality Account by issuing a limited assurance report (limited in scope) on compliance with the Regulations and this is included in the Quality Account itself. Also data quality and accuracy in the Quality Account is subject to both external and internal audit.

The Quality Account is subject to detailed review by the Medical Director, Director of Nursing and Director of Operations and is approved by the Board of Directors.

The Trust regularly reviews systems and processes as part of its commitment to ensure data quality and has a programme of internal and external audits to assess data quality.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and other Board Committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust's Head of Internal Audit provides an annual opinion on the assurance framework and for the financial year to 31 March 2019 this can be summarised as follows:

'Overall, we are able to provide ***moderate assurance*** that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently'.

In addition to this, the Trust has in place a robust governance structure with clear responsibilities delegated to Board Committees and Executive Directors. There is a process in place to assess the effectiveness of the Board Committees and this is overseen by the Audit Committee and reported to the Board for assurance.

During 2018/19 all the Executive Directors have completed appraisals which have included reflections on the discharging of their duties as Directors.

Conclusion

There are have been no significant internal control issues identified and my review confirms that the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. To the best of my knowledge and belief I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed

Chief Executive
Date: 23 May 2019

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Quality Account 1 April 2018 – 31 March 2019

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INTRODUCTION

The safety and quality of the care that we deliver at Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is our utmost priority. We therefore value the opportunity to review the quality of our services each year and outline the progress we have made against our set quality priorities. This is as well as acknowledging the challenges that we have faced in some areas in delivering care to the standard that we aspire.

Each NHS Trust is required to produce an annual report on quality as outlined in the National Health Service (Quality Account) Regulations 2010. The quality account is the vehicle by which we, as providers, inform the public about the quality of the services we provide. The quality account enables us to explain our progress to the public and allows leaders, clinicians, governors and staff to demonstrate their commitment to continuous, evidence based quality improvement.

Through increased patient choice and scrutiny of healthcare service, patients have rightfully come to expect a higher standard of care and accountability from the providers of NHS services. Therefore a key part of the scrutiny process is the involvement of relevant stakeholders. To that end, one of the requirements for inclusion with the quality account is a statement of assurance from these key stakeholders and evidence of how the stakeholders have been engaged.

In addition, NHS Foundation Trusts are required to follow the guidance set out by NHS Improvement with regard to the quality account and there are a number of national targets set each year by the Department of Health against which we monitor the quality of the services we provide.

Through this quality account, we aim to show how we have performed against these national targets. We will also report on a number of locally set targets and describe how we intend to improve the quality and safety of our services going forward.

Foreword from the Director of Nursing and Medical Director

The Trust's aspiration is to provide world class care and quality sits firmly at the core of this. During 2017 we revised our Quality Strategy to strengthen our aim to continue delivering outstanding patient care to every patient, every day and the focus for 2018-19 has been the delivery of this in practice.

We pride ourselves in the high quality of the services we deliver and during 2018-19 this has been reflected in the feedback received from our patients. Further it cannot go unmentioned that the Trust's recent CQC inspection found the Trust's care to be 'outstanding'.

As we move into 2019-20 our focus will be to build on the significant improvements already seen and to ensure that providing quality care remains at the heart of everything we do, every day.

Bev Tabernacle
Director of Nursing

Mr Steve White
Medical Director

PART 1

Statement on Quality from the Chief Executive

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has a clear vision statement – that we aspire to deliver world class patient care. This is an ambitious goal, but also an achievable one. It is supported by our Quality Strategy, which ensures that quality and patient safety are at the heart of everything we do.

These Quality Accounts set out our key achievements in 2018-19, as well as sharing our priorities for 2019-20. We hope this will provide patients, their families and carers with confidence in the quality of their services.

During 2018-19, we were inspected by the Care Quality Commission, who rated the Trust as 'Good' overall and 'Outstanding' for care. We were also rated as 'Good' for safety. This was an exceptional report which really reflected the hard work that everyone at RJAH has put in over the last three years to make the improvements we knew we needed to make.

The inspectors saw several examples of outstanding practice across the domains they inspect, related to medical care and services for children and young people, as well as our diagnostic imaging team.

We will not rest on our laurels – we are heading in the right direction but know there is still more to do if we are to deliver on our world class vision.

The Trust has maintained low infection rates, with no MRSA bacteraemia since 2006 and low surgical site infection rates. We ensure ongoing monitoring and surveillance of all infections, as well as regular monitoring of ward and department level practices.

Learning from all patient safety incidents is promoted throughout the Trust with examples of good practice shared at a variety of meetings. The Staff Survey 2018 provided clear evidence that we are taking action to ensure errors and incidents do not happen again, and that staff are getting feedback on that action.

The staff survey also found that 94% of staff would recommend the hospital to their family and friends – a score that ranked us in the top two in the country against this measure. Staff are very proud of the service that they deliver, giving patients even more confidence in the care and treatment provided by the hospital.

The Trust has continued to use a ward based nursing assessment process, 'STAR' (Sustaining quality Through Assessment and Review) to provide assurances with regard to 14 standards based upon national recommendations. This has been developed to be more team and multidisciplinary focused through the development of 5 STAR. We had three 5-STAR wards at the end of the last financial year, and all three of those retained their status in the past 12 months.

Feedback from our patients also shows we have been getting it right. Last June we saw Adult Inpatient Survey results that showed us to be one of the leading Trusts in the country in terms of overall patient experience. The results of the latest Inpatient Survey also look

very impressive, and whilst we do not at the time of writing have the benchmarking data to see where we sit against our peers, I think we can be confident that we will be close to the top once again.

Quality is at the heart of every decision we take and, with the significant contribution of staff from across the hospital, we will strive to keep improving in 2019/20 to deliver ever higher levels of patient experience.

I confirm that to the best of my knowledge the information outlined in this document is true.

Mark Brandreth
Chief Executive

PART 2

Priorities for improvement

Our Quality Priorities for 2019/20

Deciding on our quality priorities for the coming year

This part of the report describes the areas for improvement that the Trust has identified for the forthcoming year 2019-20. The quality priorities have been derived from a range of information sources consulting with key staff and including our Council of Governors. We have also been guided by our performance in the previous year and the areas of performance that did not meet the quality standard to which we aspire.

In choosing our priorities, we considered the quality issues raised about the Trust through the various feedback mechanisms available to our staff and patients and our commissioners. We have also taken account of the national landscape and shaped our priorities to align with emerging national quality priorities.

Each of the quality priorities outlined below will be monitored throughout the year via existing governance structures which will be described in more detail below. In addition we will facilitate stakeholder engagement workshops where we will chart our progress and discuss any challenges to implementing the quality improvement priorities as agreed.

Patient Safety

1. Ensuring the safe transfer both in and out of the hospital through the implementation of the Patient Passport.

Objective: To improve the quality of handover information for patients being transferred into and out of the hospital through the use of a patient passport.

Rationale: During 2017-18 a number of reviews were undertaken following the transfer of patients from other hospitals. This identified that in order to maintain the delivery of safe care improvements in the process of transfer were needed and the introduction of a Transfer Passport has been established as the solution for this. This was a priority for 2018-19 and whilst the patient passport has been successfully implemented for some patients it is recognised that there is more to do to ensure that every patient benefits from this.

Measures:

- 100% implementation of the Transfer Passport for patients transferred from another hospital for care at RJAH. with auditable data to support this.

Board Sponsor: Sarah Bloomfield, Director of Nursing.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also

be presented to the Council of Governors on a Quarterly basis. In addition, stakeholder engagement workshops will be planned to chart progress and discuss any challenges to implementing this priority.

Clinical Effectiveness

2. Improved management in the recognition of deteriorating patients (to include implementation of the deteriorating patient education package)

Objective: To ensure that all clinical staff are trained to recognise deterioration and institute appropriate clinical management in order minimise the risk of an adverse event for the patient

Rationale: Clinical deterioration can occur at any stage of a patient's treatment or illness, but patients are more vulnerable during medical or surgical interventions. Patients who are at risk of deteriorating may be identified before a serious adverse event occurs by monitoring changes in physiological observations recorded by healthcare staff. The interpretation of these changes and timely institution of appropriate clinical management once physiological deterioration is identified is of crucial importance to minimise the likelihood of serious adverse events, including cardiac arrest and death. This is an extension of the priority from 2018-19 linked to the training of staff in managing deteriorating patients as it is recognised that there is still further work to do. Data on the performance against the 2018-19 priority can be found in Part 3 of this report.

Measures:

1. 90% with NEWS compliance
2. 80% clinical staff have undertaken Managing the deteriorating patient training
3. 10% reduction in unplanned admissions to HDU

Board Sponsor: Sarah Bloomfield, Director of Nursing.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis. In addition, stakeholder engagement workshops will be planned to chart progress and discuss any challenges to implementing this priority.

Patient Experience

3. Implementation of the SWAN end of life framework

Objective: To ensure that all patients and staff receive the support they require during an end of life pathway

Rationale: The Trust recognises the importance of promoting dignity, respect & compassion at the end of life as there is only one chance to get this right for our patients and their families. It is further generally acknowledged that for patient's loved ones, their experience of end of life care can have a significant impact on their grieving process. Finally, it is important that staff feel confident in providing care and support to patients and their families at the end of life.

Measures:

1. Trust Policies aligned to the SWAN end of life framework

2. Continued roll out of end of life care training and have developed a suite of e learning training to complement the facilitated learning
3. Refurbishment of the Mortuary to align with the SWAN principles

Board Sponsor: Sarah Bloomfield, Director of Nursing.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis. In addition, stakeholder engagement workshops will be planned to chart progress and discuss any challenges to implementing this priority.

4. Monitoring and learning from complaints

Objective: To evidence effective learning from complaints

Rationale: The Trust welcomes all patient feedback on its services and recognises the opportunity these present in terms of improving services and preventing recurring themes of patient discontent. The Trust does not receive a high volume of complaints but should still actively seek to implement improvements based on the feedback.

Measures:

- Introduction of dashboards linked to the new Meridian patient feedback system
- Introduction of a public display of 'You Said, We Did' relating to complaints
- Introduction of a triangulated PICC report on patient experience (**P**ALS, **I**ncidents, **C**omplaints and **C**laims)
- Implementation of a robust action tracker via Datix Web

Board Sponsor: Sarah Bloomfield, Director of Nursing.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis. In addition, stakeholder engagement workshops will be planned to chart progress and discuss any challenges to implementing this priority.

Statements of Assurance from the Board

In this section we report on matters relating to the quality of NHS services provided as stipulated in regulations. The content is common to all providers so that as can be compared across NHS Trusts.

Review of Services

During 2018-19, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provided three NHS services, in musculo-skeletal surgery, medicine and rehabilitation.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these health services.

The income generated by the relevant health services reviewed in 2018-19 represents 100% of the total income generated from the provision of NHS services by The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for 2018-19

Participation in Clinical Audit

During 2018/19, 3 National clinical audits and 2 national confidential enquiries covered NHS services that the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provides.

During that period, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in during 2017/18 are as follows:

- National Audit of Rheumatoid Arthritis
- National Joint Registry
- Elective Surgery (National PROMS Programme)
- National Confidential enquiry-Chronic Neurodisability
- National Confidential enquiry-Perioperative Diabetes

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was eligible to participate in during 2018/19 are as follows:

- National Joint Registry
- Elective Surgery (National PROMS Programme)
- National Confidential enquiry-Pulmonary Embolism
- National Confidential enquiry-Perioperative Diabetes
- National Audit of Rheumatoid Arthritis

The national clinical audits and national confidential enquiry that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was eligible to participate in and for which data collection was completed during 2018/19 are listed below alongside that 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:

	Eligible to participate	% cases submitted
National Joint Registry	Yes	Ongoing – 3 year audit
Elective Surgery (National PROMS Programme)	Yes	Ongoing – 3 year audit
National Confidential enquiry-Pulmonary Embolism	Yes	100%
National Confidential enquiry-Perioperative Diabetes	Yes	100%

The reports of **0** national clinical audits were reviewed by the provider in 2018/19 as these audits are ongoing.

The reports of **13** local clinical audits were reviewed by the provider in 2018/19 and the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the actions set out in below to improve the quality of healthcare provided.

	Audit Number	Title of Audit	Action Points
1	17/18_041	An audit of the communication of the decision to prescribe antimicrobials in orthopaedic infections	1. Education of Start Smart then Focus at registrars induction and on the ward 2. Disseminate results of quarterly point prevalence studies to antimicrobial stewardship committee 3. Look into adapting the drug card to prompt this information being recorded and at other Trusts cards
2	17/18_045	Reaudit of day case 1st ray surgery	1. Present audit findings at departmental meeting and all team members to be reminded of need for adequate documentation 2. Adequate minimum data set in EPR-To include in ward note and on discharge summary identified cause for inpatient stay 3. Disseminate through departmental presentation, letters to wards and registrars 4. Liaise with inpatients booking to try and avoid evening lists (allowing for requirement of Trust RTT targets)
3	17/18_034	Reaudit of reviewing the condition of personal radioactive equipment in theatre	1. Awareness of looking after and storing lead gowns-signs in theatre 2. Order more storage racks for taking into theatre
4	17/18_007	Level of compliance with antibiotic guidelines for surgical antibiotic	1. Inclusion of detailed reaction when documenting penicillin allergy to allow the reaction to be defined as severe or non-severe

		prophylaxis in patients who have undergone primary total hip or knee joint replacement surgery within RJAH	2. Pharmacists and pharmacy technicians to record history of penicillin allergy when taking medication histories. For example in the case of rash was this immediate following administration or a delayed reaction 3. Report to be presented to the RJAH pharmacy department 4. Seek clarification for appropriate dosing for 24 hours of antibiotic prophylaxis in arthroplasty in order to avoid misinterpretation 5. Review of antibiotic guidelines to consider addition of vancomycin 1g IV as the recommended choice for surgical prophylaxis in primary total joint replacement surgery for patients with severe penicillin allergy 6. Discussion of audit results at relevant multi-disciplinary team audit meetings 7. Engagement of the antimicrobial team, anaesthetists and surgeons where possible to improve adherence to standards
5	17/18_058	Reaudit of Urinary Incontinence in women	None as all criteria was met-100% compliance
6	17/18_066	Reaudit of outcome data collection for upper limb	1. Obtain data collection from all patients within the criteria 2. Record data on outcomes database following introduction of new process 3. Report data to all upper limb consultants 4. Look into systems to undertake electronic data collection
7	17/18_028	Reaudit of Compliance with DoH Guidelines on Vitamin D prescribing in Children	1. Increase awareness of NICE Guidelines among general practitioners via GP study Day and written letters 2. Advice to parents at child birth by including in the new-born protocol via information leaflet 3. Present findings at Multi-Disciplinary Clinical Audit Meeting
8	16/17_017	Re-audit of Are we adhering to the Data protection Act	1. Completion of information flows and understanding of databases/spreadsheets held containing personal data. 2. Discussion being held to have this completed by a project team/outside source 3. Currently there is a template available to capture assets/systems and flows. Suggest Mr White encourage completion of this along with a ‘champion’ of his choosing to help promote the project 4. Promote the different ways/methods of understanding learning-Online via ESR E-learning or via completion of the work book. 5. Look to secure a training slot on Divisional Boards alongside cyber awareness with IT representative-Present to divisional leads 6. Promote good practice via newsletters, bulletins, emails, posters

9	CARMS 0492	NEWS and PEWS Audit	1. News score modification ability-Upgrade of e-observation software to v3.4
10	17/18_026	Reaudit of the accuracy/completeness of data on submitted histopathology request forms	1. Redesign and issue of histopathology request forms 2. Presentation at Junior Doctor Induction 3. Presentation at Theatre Audit Training day 4. Presentation at MCSI Ward meeting
11	18/19_008	Reaudit of National Joint Registry Data Capture at RJAH	1. Junior Doctors in the hand team to be reminded of the importance of completing these forms and where to submit them to 2. Surgical teams to double check the form has been completed when assessing the patient preoperatively on Baschurch 3. Registrars, nurses and physios to ensure that OSS performed in pre-op, NJR consent collected and forms completed
12	18/19_020	Reaudit of Date of surgery following referral of a patient with an ACL tear	1. To continue the current practice of arranging bi-annual meetings between the local GP's and Physiotherapists so they are continuously updated to the current practice for ACL reconstructions.
13	17/18_060	Reaudit of EPR Handover	1. All medical doctors to be reminded about the importance of handover during lunchtime meeting 2. All medical doctors to be reminded about the importance of handover via email

13 Service Evaluation projects reports were reviewed by the provider in 2018/19 as follows:

	Project Number	Project Title	Action Plans
1	17/18_009	Reaudit of Orthotics footwear service evaluation	No action plan needed due to high compliance and implementation of original evaluation action plan
2	17/18_071	Space blanket V Bair Hugger-An evaluation of temperature management in spine surgery	1. Present report findings to Anaesthetic team meeting 2. Present findings to the wider consultant team at next Multi-Disciplinary Clinical Audit Meeting
3	17/18_071	New device for temperature management in spine surgery	1. Present report findings to Anaesthetic team meeting 2. Present findings to the wider consultant team at next Multi-Disciplinary Clinical Audit Meeting
4	17/18_056	Reaudit of Outpatient Letters to GP's	No action plan required due to high compliance and implementation of original evaluation action plan
5	17/18_044	Effectiveness of Fluoroscopic guided Ankle and Foot Joint Injections	1. Spread awareness among radiologists, foot and ankle orthopaedic surgeons, GPs and other healthcare providers performing injections 2. Produce and send a letter to foot and ankle orthopaedic surgeons 3. Produce and send a letter to radiologists at RJAH
6	17/18_024	Reaudit of the patient experience in the	No action plan required due to high compliance and implementation of original evaluation action plan

		pre-operative assessment unit service evaluation	
7	CARMS 00310	Evaluation of introduction of a symptom control clinic for patients with Neuromuscular conditions	1. To determine a more suitable measure for assessing quality of life in this clinic group 2. Ensure all patients are informed via letter of clinic arrangements
8	17/18_046	Survey of children with DMD and Paediatric Hospices in the UK	1. Obtain a list of all the neuromuscular care advisors in the UK from our neuromuscular care advisor at RJAH to ascertain which hospices are used by their patients 2. Paediatric neuromuscular registrar to contact the neuromuscular care advisors and ask them to complete the survey proforma if not already done so by their hospices and also check the responses from the hospices replied 3. Once above has been completed to update this survey report 4. Contact the 2 hospices with large amounts of patients to see if they included other DMD patients or have a large catchment area
9	17/18_012	Use of anterior hip props for patients in lateral position during surgery	1. Promote use of Granuflex dressing beneath anterior hip props via the presentation of the audit to the arthroplasty surgeons
10	16/17_038	Butterfly scheme service evaluation	1. To continue to obtain feedback using the butterfly scheme carer survey 2. On the introduction of meridian establish what carer feedback will be captured via this system and then consider if this will be sufficient to influence and increase in volume of carer feedback, otherwise undertake a carers audit. 3. Undertake a review/random selection of the ward alerts and review the notes and whether 'this is me' passport is used
11	17/18_010	DNA patients within the orthotics department	1. Update posters on a monthly basis. 2. Share results with clinic receptionists/secretaries to make them aware of findings
12	18/19_013	Combined Multi-disciplinary shoulder clinic	1. Include details in progress meetings and patient education sessions. Inform team members about this by email 2. Discuss with Consultants attending the clinic 3. Present findings and discuss this to MDT members in a departmental presentation 4. Discussion with MDT members and identify outcome measures to be used in this clinic and implement
13	18/19_018	Quality of life after medial patellofemoral ligament reconstruction	No action plan required due to high compliance and implementation of original evaluation action plan

Participation in Clinical Research

Research at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continues to flourish. The total number of Health Research Authority approved (including Ethical approval) studies active during 2018-19 was 90, of which 58 are National Institute for Health Research (NIHR) recognised, a rise of 10% on 2017-18. These studies fall into 7 of the 8 NIHR speciality areas. They include commercial, academic and RJAH sponsored studies.

The number of patients receiving relevant health services provided or subcontracted by Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee and recognised by the NIHR was 800.

RJAH continues to work with the NIHR and Local Clinical Research networks (LCRN) strategic aims to grow the number of Chief Investigators within the West Midlands. It is one of the leading sites with respect to encouraging and supporting non-medic Chief and Principle Investigators.

During 2018-19 research at RJAH contributed to 18 publications, which shows our commitment to transparency and desire to improve patient outcomes and experience

CQUIN framework

A proportion (2.5%) of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and its Commissioners through the CQUIN (Commissioning for Quality and Innovation) payment.

The schemes are designed to support the ambitions of the Five Year Forward view and directly link to the NHS mandate. The CQUIN schemes focus on two areas:-

1. Clinical Quality and transformational indicators
2. Supporting local areas

To achieve the CQUIN goals, there was a requirement for provider contribution and health economy wide collaboration which supports the NHS in delivering better quality standards for patients, improve the working environment for staff, and deliver financial balance.

Indicator	Indicator Name
1a	Improvement of health and wellbeing of NHS staff
1b	Healthy food for NHS staff, visitors and patients
1c	Improving the uptake of flu vaccinations for frontline clinical staff
2a	Timely identification of patients with sepsis in emergency departments and acute inpatient settings
2b	Timely treatment of sepsis in emergency departments and acute inpatient settings

2c	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
2d	Reduction in antibiotic consumption per 1,000 admissions
3	Advice & Guidance
4	Accessible Information
5	Ongoing collaboration as part of the STP
A1	Spinal Surgery: Network / Outcomes / Governance
A2	End of Life Care
A3	Paediatric Networked Care

The total income conditional upon achieving quality improvement and innovation goals at the end of 2018/19 was £1,469K compared to £1,398K in 2017/18. The Trust achieved the full amount available.

CQC registration

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration is without conditions. The Care Quality Commission has not taken any enforcement action against The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2018/19.

During November and December 2018, the CQC carried out an inspection of the Trust and at this time, the Trust was given an overall rating of 'Good' with care found to be 'Outstanding', with the breakdown of ratings show in the table below:

Ratings for The Robert Jones and Agnes Hunt Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Surgery	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Critical care	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019
Services for children and young people	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Outpatients	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Diagnostic imaging	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Overall*	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019

The full CQC inspection report can be found at the following link: https://www.cqc.org.uk/provider/RL1/services

In response to the inspection report from February 2019, the Trust has put in place a robust action plan to address the areas for improvement highlighted by the CQC. Completion of this action plan will be monitored by the Quality & Safety Committee with quarterly updates to the Board of Directors.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2018-19.

Secondary Uses Service Submission

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patients care
- 100.00% for outpatient care

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

- 100% for admitted patients care
- 100% for outpatient care

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Raise the awareness and profile of data quality, developing within the Trust a positive culture, through encouraging best practise and promoting new processes, and ensuring that all staff recognises that they have a responsibility for ensuring a high standard of Data Quality.
- Maintain a robust Audit framework that provides assurance for key performance indicators as reported in the Trust's Integrated Performance Report (IPR).
- To monitor and review a set of data quality KPI's focussing on any areas of concern.
- Improve the Data Quality in relation to 18 week referral to treatment time (RTT) through audit, validation and education of both clinical and non-clinical teams, providing support and advice when needed.
- To ensure compliance with all data quality standards as specified within the Data Security and Protection Toolkit.

Information Governance

The requirements of the new Data Security and Protection Toolkit (DSPT) are designed to encompass the National Data Guardian review's 10 data security standards.

The revised DSPT support key requirements under the General Data Protection Regulation (GDPR), identified in the NHS GDPR checklist.

The Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance DSPT score overall for 2018/19 was STANDARDS MET.

Clinical coding error rate

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was not subject to the Audit Commission's Payment by Results clinical coding audit during 2018-19.

An internal audit was conducted with the results as outlined below:

Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct
100%	98.56%	100%	98.43%

Seven Day Working

The seven day services programme has been designed to ensure patients receive high quality consistent care across all seven days of the week. As an elective centre, the Trust does not receive emergency admissions in the same way as an acute hospital, being aware of emergency admissions in advance which enable the Trust to ensure appropriate multi-disciplinary teams are in place. The Trust offers a number of seven day services appropriate to the service requirements of an orthopaedic elective centre. This is regularly reviewed based upon patient requirements and feedback, to ensure our services reflect the needs of our patients.

Terms and Conditions of Service of Doctors and Dentists in Training

As part of the 2016 Terms and Conditions for Junior Doctors it was agreed that additional safeguards would be put in place to protect the working hours of doctors in training. This included a Guardian of Safe Working to champion safe working hours and provide assurance to the Board in this regard.

The Trust has in place a Guardian of Safe Working who provides regular reports to the Quality and Safety Committee and the Trust Board regarding the work that has been undertaken to safeguard working hours for junior doctors.

The tables below provides information on the vacant shifts and gaps in rotas broken down by month and specialty as reported to the Board. Where there are vacancies, in the interests of patient safety, every effort is made to fill the shifts with internal locum or agency staff:

Vacant Shifts 2018-19

Specialty	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Trauma and Orthopaedics	6	15	6	4	1	7	2	5	0	3	9	0
Medicine	13	5	8	0	0	0	0	0	0	0	0	0
MCSI	18	16	14	7	7	6	6	7	9	9	4	7
Total	37	37	28	11	8	13	8	12	9	12	13	7

Gaps in Rota 2018-19

Specialty	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Trauma and Orthopaedics	0	0	0	0	0	0	0	5	0	0	0	0
Medicine	0	0	0	0	0	0	0	0	0	0	0	0
MCSI	0	0	0	1	0	0	0	0	0	0	0	0
Total	0	0	0	1	0	0	0	5	0	0	0	0

The Trust does not have a significant issue with gaps in rotas as these are usually filled with through temporary arrangements. However, the Trust recognises the impact temporary staffing can have on patient care and is pursuing active recruitment where possible. Further it is involved in overseas fellowship programme. The impact of these actions can be seen in the reducing number of vacant shifts as the financial year progressed.

NHS Outcomes Framework: Review of performance against mandated indicators

The NHS Outcomes Framework sets out high level national outcomes which the NHS should be aiming to improve. The Framework provides indicators which have been chosen to measure these outcomes and stipulates the methodology to be used in order to enable accurate benchmarking.

An overview of the indicators is provided in the table below and the data provided has been calculated using the specified methodology. It is important to note that, whilst these indicators must be included in the Quality Accounts, the most recent available national data for the reporting period is not always for the most recent financial year. Where this is the case, an * is included next to the indicator. The following data has been taken from the HSIC website and is based on the most up to date data available at the time of writing.

Mortality

During 2017/18 the Trust put in place a Learning from Deaths Policy in line with national requirements. This policy ensures that the Trust reviews all deaths in line with the NHSE/NHSi framework. We record all of our expected and unexpected deaths and all have a mortality review completed. These results are reviewed through the Trust mortality group. We have a lead consultant who chairs this committee and these reports to the Quality and Clinical Governance Committee chaired by our Medical Director.

Because of the low numbers of deaths across the organisation the HSMR and SHIMI are not monitored by the Trust. Further, the standardised mortality rates for hospitals, produced nationally by Dr Foster are not applicable to small specialist Trusts like The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, again because the numbers of deaths that occur are too small for change to be statistically significant. However, there is ongoing monitoring of all deaths which occur within the Trust with oversight by the Quality and Safety Committee and reporting to the Board.

During 2018-19 nine patients of Robert Jones and Agnes Hunt Orthopaedic Hospital died. This comprised the following number of deaths which occurred in each quarter of that reporting period: two in the first quarter; two in the second quarter; one in the third quarter and four in the fourth quarter.

By 31 March 2019, eight case record reviews and one investigation have been carried out in relation to the nine deaths.

In no cases was a death subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: two in the first quarter; two in the second quarter; one in the third quarter and four in the fourth quarter.

No patient deaths, representing 0% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the

patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter.

Due to the low number of deaths that occur in the hospital, it is possible for each and every death to be tracked and reviewed and the data provided above is therefore accurate.

Notwithstanding the information above, through the case record reviews and investigations the Trust identified opportunities to strengthen its high dependency care and this was also picked up through the recent CQC inspection. The Trust has in place an action plan to address this and this is being monitored by the Quality and Safety Committee.

There were no case record reviews and no investigations completed which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the structured judgement review methodology in the last quarter and the Trust's serious incident process or learning from deaths review method before that.

0 representing 0% of the patient deaths during 2017-18 are judged to be more likely than not to have been due to problems in the patient care.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

Due to the small numbers of death that occur at the hospital it is possible for every death to be reviewed in detail.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has continued with the implementation of the ongoing Learning from Deaths Policy introduced during 2017-18.

Helping people recover from episodes of ill health or following injury

Readmission Rates

During 2018/19 the percentage of patients aged 0-15 years old, readmitted to the hospital within 28 days of discharge was 0.19% (as at 8 April) and for 16+ years old it was 1.0%.

	Readmission rate for 0-15 year olds	Readmission rate for 16+ years old
2015-16	0.17	0.76
2016-17	0.78	0.63
2018/19	0.19 (as of March)	0.91*

*This data excludes re-admissions to other hospitals

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- No comparative data is now available

- Data is submitted and checked on a monthly basis as part of regular performance reporting.

- The data has been subject to external audit

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust will take action to improve this percentage by

-Improving understanding of readmission rates linked to infection

-Continuing discharge planning at pre-operative appointments

PROMS data

Patient Reported Outcome Measures (PROMS) measures health gain in patients undergoing hip replacement and, knee replacement, varicose veins and groin hernia surgery in England, based on responses to a questionnaire before and after surgery.

PROMS collect information on the effectiveness of care delivered to NHS patients, as perceived by the patients themselves, making it a particularly important indicator which adds to the wealth of information available on the care delivered to NHS funded patients to complement existing information on the quality of services.

This report shows the NHS Digital data presented to the public and is based on the improvement seen in joint replacement six months after the operation. The data is currently published quarterly and shows where NHS England have both pre-operative and 6 month follow-up scores available so this does mean that the number of modelled records is less than the number of procedures actually carried out in that period. The number of modelled records will always lag the number of procedures by 6 months. Four areas are reported on by NHS England, Primary Hip replacements, Revision Hip replacements, Primary Knee replacements and Revision Knee replacements.

The table below summarises the Trust's performance as reported in the year 2018/19 for hip and knee replacements as the only PROMS procedures offered by the Trust and provides a comparator to the national average and the highest and lowest scores nationally. Data is also provided for previous years with the publication dates as follows:

- 2014-15 Final Release - August 2016
- 2015-16 Final Release - August 2017
- 2016-17 Final Release - August 2018
- 2017-18 Final Release – February 2019

The Trust's data published in February 2019 shows that the Trust achieves good outcomes for its patients, particularly given the complex nature of the procedures it carries out.

Primary Hip Replacement

	EQ5D Index			Oxford Score		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
National Average	0.438	0.445	0.468	21.607	21.8	22.68
Highest Score	0.510	0.537	0.566	24.755	25.123	26.299
Lowest Score	0.321	0.310	0.376	16.884	16.428	18.871
Robert Jones and Agnes Hunt	0.414	0.453	0.489	20.847	22.211	23.574

Revision Hip Replacement

	EQ5D Index			Oxford Score		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
National Average	0.283	0.29	0.289	13.206	13.512	13.901
Highest Score	0.374	0.362	0.322	16.209	16.504	17.664
Lowest Score	0.224	0.239	0.142	9.358	10.253	10.735
Robert Jones and Agnes Hunt	0.236	0.334	0.298	11.163	13.719	15.912

Primary Knee Replacement

	EQ5D Index			Oxford Score		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
National Average	0.320	0.325	0.338	16.365	16.546	17.259
Highest Score	0.398	0.404	0.417	19.970	19.884	20.635
Lowest Score	0.198	0.242	0.234	11.955	12.335	13.156
Robert Jones and Agnes Hunt	0.316	0.318	0.354	17.027	17.843	18.541

Revision Knee Replacement

	EQ5D Index			Oxford Score		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
National Average	0.258	0.273	0.292	11.98	12.346	13.124
Highest Score	0.335	0.296	0.328	14.157	13.781	15.444

Lowest Score	0.190	0.156	0.196	8.328	8.602	9.374
Robert Jones and Agnes Hunt	0.190	0.251	0.328	8.505	10.946	14.392

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

-The Trust is a specialist orthopaedic hospital that continually monitors patient outcomes and best practice to ensure the outstanding patient care and achievements

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by

-Continuing to review both national and local data to identify any areas where improvements can be made.

-Internally collecting and monitoring of PROMs in other specialities not currently covered by the national programme.

Staff Survey

The principal aim of the staff survey is to gather information which will help the Trust to improve the working lives of our staff and so help to provide better care for patients. The staff survey provides the Trust with a wealth of information detailing staff views about working at the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.

One of the questions asked in the survey relates to the Friends and Family Test i.e. would a staff member recommend the Trust as a treatment provider to their family or friends.

Staff who would recommend the Trust to their family or friends	**2016** **%**	**2017** **%**	**2018 (Q1 and Q2)*** **%**
National Average (All Trusts)	69	59	81
Highest	95	96	99
Lowest	45	42	46
Robert Jones and Agnes Hunt	93	93	94

*Data is not captured for Q3 and the Q4 data has not yet been published

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

-The Trust continues to participate and improve the Staff survey results

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by

-An annual objective for 2019-20 aimed at enabling staff to flourish at work

-Implementation of the five year people plan

Ensuring that people have a positive experience of care

Responsiveness to Inpatient's Personal Needs

We await the final CQC benchmark report for the 2018 survey due to be published in June 2019.

	2013/14	2014/15	2015/16	2016/17	2017/18
National Average	68.7	68.9	69.6	68.1	68.6
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	81.6	79.8	82.0	82.5	81.7
Highest	84.2	86.1	86.2	85.2	85.0
Lowest	54.4	59.1	58.9	60.0	60.5

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust has a robust patient experience programme in place, that facilitates learning and implementing changes based on patient experience

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions in this area:

-Continued implementation of its Patient Experience Strategy

-Improved patient involvement in the investigation of its incidents

-Introduction of real time feedback on patient experiences

Patient Friends and Family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Patients are asked to answer the following question: "How likely are you to recommend our organisation to friends and family if they needed similar care or treatment" on the day of discharge or after they have had a clinic appointment. They are invited to respond to the question by choosing one of six options, ranging from "extremely likely" to "extremely unlikely".

	2015/16	2016/17	2017/18	2018/19
National Average	96%	96%	96%	96% (to Jan 19)
Highest Score	100%	100%	100%	100% (to Jan 19)
Lowest Score	75%	75%	76%	80.7% (to Jan 19)
Robert Jones and Agnes Hunt	99%	100%	99%	99% (to Jan 19)

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

-The Trust has a robust patient experience programme in place, that facilitates learning and implementing changes based on patient experience

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to maintain this percentage:

-Continuation of the Patient Panel, with three co-chairs ensuring co-production with our patients

-Continued implementation of the Patient Experience Strategy

Treating and caring for people in a safe environment and protecting them from avoidable harm

VTE Assessment

Our patients often have difficulties mobilising which places them at an increased risk DVT or PE and as such the Trust's VTE assessment is of utmost importance to ensure that patient's do not suffer avoidable DVT or PE.

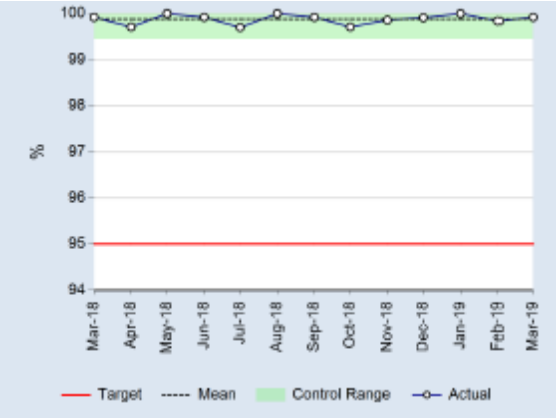
The Trust has in place a robust system of audit to measure compliance with the VTE assessment process. Further, any incidence of DVT or PE is subject to a full root cause analysis review to ensure that learning is taken. The Quality and Safety Committee receives regular reports on the Trust's work on VTE prevention.

The chart below outlines the percentage compliance for VTE assessments for the year (up to Dec 2018) and the preceding two years:

	2016-17	2017-18	2018-19
Average	95.75%	95.3%	95.6%
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	100%	99.9%	99.9%
HIGHEST	100%	100%	100%
LOWEST	71.42%	64.3%	63.2%

Performance for the year 2018-19 by month was as follows:

VTE Assessment Compliance



RJAH has maintained the required percentage of VTE assessments completed. The Trust monitors this through the monthly performance reports. During 2018-19 the Trust implemented recommendation from the internal auditors regarding the capture of the data in order to improve the VTE data quality.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

-The Trust has in place a clinical lead for VTE who champions the VTE process amongst the

clinical staff

-Regular audits are undertaken to check compliance with follow up actions where required

-The Quality and Safety Committee receives regular reports on compliance with VTE assessments.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to maintain this percentage, and so the quality of its services, by:

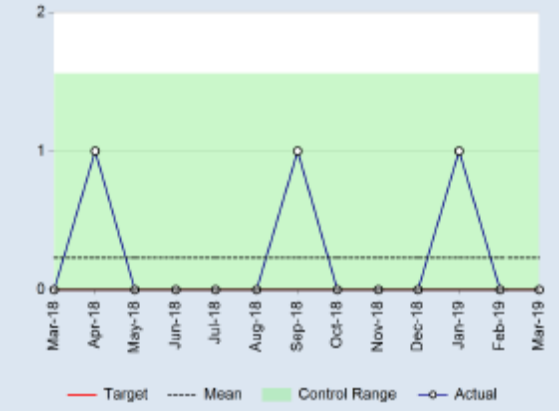
-Ongoing documentation audits to ensure the completion of the necessary risk assessments are further implemented

C.difficile Infections

The Trust measures infection control performance as a rate of Trust apportioned cases per 1000, 00 bed days of cases amongst patients aged 2+

The Trust has had 3 attributable cases of C Difficile for the year 2018/19. This was against a target issued by NHSE of 2. Of the three attributable cases, two were appealed and there were no lapses of care identified.

Number of C.Difficile Infections



	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	1.9	3.8	0.0	0.0	2.3	*
HIGHEST	37.1	62.2	24.3	82.7	91.0	*
LOWEST	0.0	0.0	0.0	0.0	0.0	*

* Benchmark data next due for publication July 2019

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

-Data is reported and monitored on a monthly basis.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

-Continuing to carry out regular audits and monitoring instances of non-compliance with the Trust infection control and prevention practices

Number of patient safety incidents and % resulting in severe harm /death

The hospital has a robust and established incident management process in place. The Trust utilises an electronic reporting system which enables all incidents to be tracked from the point of reporting and on-going monitoring until closure of an incident, therefore promoting timely response to serious incidents.

The table and graph below shows the number of patient safety incidents reported each month during the reporting period and a breakdown by severity grading for these, including the proportion of incidents resulting in severe harm or death.

Patient Safety Incidents Reported per 1000 Bed Days

Period of Coverage	Rate of incidents	Number of incidents
Oct 17 – Mar 18	37.40	900
Apr 17 – Sep 17	38.30	820
Oct 16 – Mar 17	36.90	797
Apr 16 – Sep 16	31.90	704
Oct 15 - Mar 16	36.80	871
Apr 15 - Sep 15	29.60	752
Oct 14 - Mar 15	29.0	761
Apr 14 - Sep 14	26.3	684
Oct 13 - Mar 14	9.7	689
Apr 13 - Sep 13	7.2	510

Patient Safety - Severe Harm / Death

Period of Coverage	Rate of incidents	Number of incidents
Oct 17 – Mar 18	0.03	4
Apr 17 – Sep 17	0.04	5
Oct 16 – Mar 17	0.14	3
Apr 16 – Sep 16	0.00	0
Oct 15 - Mar 16	0.04	1
Apr 15 - Sep 15	0.08	5
Oct 14 - Mar 15	0	0
Apr 14 - Sep 14	0.12	3
Oct 13 - Mar 14	0.07	5
Apr 13 - Sep 13	0.01	1

Serious Incidents

In 2018/19 the Trust reported ten serious incidents as defined by the NHS England Serious Incident Framework. All of these incidents have had Root Cause Analysis completed and reports prepared for presentation and agreement at Quality and Safety Committee. In addition, all our serious incidents have been reviewed by the Clinical Commissioning Group to ensure they are in line with the NHSE Framework.

Incidents that have been reported and investigated relate to the following areas:

- Information Governance
- Pressure Ulcers
- Falls
- Awareness Under Anaesthetic

In comparison, during 2017/18 the Trust reported eight serious incidents of which none were never events.

Never Events

These are defined as serious, largely preventable patient safety incidents. All never events have a Root Cause Analysis completed which is presented and agreed at the Quality and Safety Committee as per the Trust's Serious Incident Management Policy.

In 2018-19 there was 1 never event. This compares to 2017-18 when there were 0 never events.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

-The Trust has continued to undertake reconfiguration work on Datix to ensure more accurate capture of themes and trends in the categories of incident

-Introduction of Safety Champions to undertake daily rounds visiting departments across the Trust to share learning and understand safety issues

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

-Continuing to embed the Safety Champions

-Benchmarking of incident reporting against other Specialist Trusts

-Continuing to report a no blame culture to encourage incident reporting

PART 3

Review of Quality

Summary of Performance Status for Quality Priorities Set for 2018/19

In line with the Trust's Quality Improvement Strategy, and in discussion with the Board of Directors, Council of Governors and other relevant stakeholders, the Trust identified the following key priorities for 2018/19:

- Safety: Ensuring the safe transfer both in and out of the hospital through the implementation of the Patient Passport
- Safety: 100% completion of the WHO Safety Checklist
- Effectiveness: Implementation and monitoring of behavioural characteristics
- Patient Experience: 95% of staff having undertaken management of deteriorating patient training
- Patient Experience: Improved collection and use of patient feedback

Progress made for quality priorities 2018/19

The following section gives a detailed account of the progress we have made for each of the priority areas and how the improvement work will be maintained in the coming year. In this section, we also discuss the quality priorities that we will be taking forward into 2019/20 and those that we will be retiring from the Quality Accounts.

It is important to remember that even though some priorities may be retired, this is not to say that the work ceases, but rather that the processes and systems for continued management of the improvement goal are well established and can be maintained outside of the Quality Account process

Safety

Priority One: Ensuring the safe transfer both in and out of the hospital through the implementation of the Patient Passport

We said that we would work to improve the quality of handover information for patients being transferred into and out of the hospital through the use of a patient passport.

During 2018-19 the focus has been on developing the passport and then working to roll this out across the organisation. Whilst there is evidence of its use, this varies from department to department and there is insufficient tracking to enable adequate assurance. Accordingly, the Trust recognises that there is more work to be done to ensure the use of passport is embedded across all areas and has therefore carried this priority forward to 2019-20.

Priority Two: 100% completion of the WHO Safety Checklist

We said that we would improve patient safety and avoid preventable incidents related to surgery such as wrong site surgery and that this would be done through quantitative and qualitative measure of the WHO Safety Checklist.

During 2018-19 the Trust benchmarked its WHO process against other organisations and undertook a complete review of its process. The new process was piloted successfully with a revised WHO Policy introduced to roll out the new process across the sub specialties.

This work was undertaken in a multi-disciplinary manner with input from a cross section of clinical staff across Surgery, Theatres and Anaesthetics. The work was supported by a programme of Human Factors Training which has been rolled out across the organisation.

Compliance with the use of the WHO Safety Checklist is audited on a regular basis with 100% compliance achieved.

There has been significant focus on the WHO Safety Checklist during 2018-19 and that this work has gained good momentum. In light of this, the priority will not be carried forward to 2019-20.

Clinical Effectiveness

Priority Three: Implementation and monitoring of behavioural characteristics

We said that we would take the Trust's values and cultural ambition to create a defined set of behavioural dos and don'ts that could be taken on by all projects, performance management, recruitment, induction etc.

The Trust developed 'Signature Behaviours' following a series of focus groups and workshops and the following pages outlines these. During January 2019 the Executive Team launched the 'Signature Behaviours' with new years resolutions linked to them.

Linked to this objective was an ambition to achieve 95% compliance with appraisals across the Trust and a reduction in the number of grievances. The Trust's performance in these areas is outlined below:

Measure	2017-18	2018-19
Appraisal Compliance	94.53%	90.54%
No of Grievances	8	4

This has been fully implemented and the priority will not be carried forward to 2019-20.

Signature Behaviours Launched January 2019

Value 1: Friendly

We will...	We will not...
1) Look for the positives in someone's ideas before the negatives	1) Take advantage of other's kindness or skills
2) Seek to work with others to deliver better outcomes	2) Be quick to dismiss others' contributions
3) Listen with an open mind	3) Behave in a discourteous manner – verbally or physically
4) Be honest in a considerate manner	4) Bully or undermine people
5) Speak up when we have a gap in our knowledge or understanding	5) Ignore other members of staff if they are felt to be beneath us

Value 2: Caring

We will...	We will not...
1) Consider the impact of our decisions on others before acting	1) Abuse our position over others by showing favouritism, or discrimination in any way
2) Do what we say we are going to do (or provide an explanation if we are delayed/ no longer able to)	2) Allow our personal moods to affect others
3) Support others personally and professionally – especially when they are struggling or managing a stressful situation	3) Ignore changes in normal behaviours when we see them
4) Acknowledge good will and performance or behaviours as it happens	4) Expect others to work 'above and beyond' when we are not prepared to do so ourselves or because we are staying later
5) Consider others' needs as well as our own	5) Make others feel foolish for admitting a gap in their knowledge or understanding

Value 3: Excellence

We will...	We will not...
1) Encourage each other to express ideas on improvements and to share best practices	1) Allow processes to undermine or detract from meeting patient service needs
2) Speak up if we can see a safer, more efficient or cost-effective way of doing things	2) Discourage someone from trying or sharing a better way of doing things
3) Look for the positives, not the negatives, when others express ideas and views	3) Reject opportunities to improve the way we work
4) Provide only constructive feedback - that will help others to develop or improve	4) Leave things to others that we can fix ourselves
5) Act on feedback to improve our personal performance	5) Apportion blame for an unknowing/ unintended error

Value 4: Professional

We will...	We will not...
1) Fulfil our roles and responsibilities to the best of our ability	1) Be satisfied with mediocre or worse
2) Encourage our colleagues to do the best job possible	2) Do the bare minimum
3) Openly share ideas and best practice with colleagues	3) Engage in negative gossip
4) Actively participate in personal and professional learning and development	4) Speak in a manner that is intended to upset or intimidate other staff members to get what we want
5) Fully contribute to the team's performance	5) Deliberately avoid or ignore problems or difficult situations which we can help resolve

Value 5: Respect

We will...	We will not...
1) Learn from our mistakes by taking appropriate action to prevent reoccurrence	1) Complain about situations without suggesting solutions
2) Take responsibility for resolving problems within our influence	2) Disregard others' feelings
3) Challenge inappropriate behaviour, or poor working practices	3) Patronise others
4) Politely engage with people, even at times of disagreement	4) Escalate issues we have with a person without first speaking to that individual to resolve
5) We will respect the skillsets of all staff irrespective of position	5) Be disproportionate in our responses to situations

Patient Experience

Priority Four: 95% of clinical staff have undertaken management of deteriorating patient training

We recognised that clinical deterioration can occur at any stage of a patient's

treatment or illness but that patients were more vulnerable during medical or surgical interventions. It was therefore important to ensure that staff are trained to interpret any changes in patient conditions and institute appropriate clinical management. The Trust therefore committed to training staff in the management of deteriorating patients.

During 2018/19 the Trust trained 50% of its clinical staff in the management of the deteriorating patient, however all registered professionals have undertaken either immediate life support or an advance life support courses which are recognised by the European Resuscitation Council

as the gold standard The Trust recognises that there is more work to be done to ensure robust identification and management of deteriorating patients and has therefore carried this priority forward to 2019-20.

Priority Five: Improved collection and use of patient feedback

We said that we would implement an electronic solution to enable the collection of real time patient feedback. This was in recognition of the significant role patients play in improving its services. The Trust views every instance of patient feedback as an opportunity to improve its services and care going forward and ultimately improve the patient experience.

It was recognised that the Trust's responsiveness to patient feedback could be improved through realtime collection of the feedback which in turn would enable remedial action to make improvements to be taken more promptly.

The Trust has been moving away from collecting FFT data using paper and from November 2019 has been using a real time patient feedback system called Meridian. Ipads have been used to collect the data and for March 2019, 72% of surveys were collected electronically. Staff have also had training to view patient feedback in real time as they come in and provide a response. As part of the Meridian project some patients will also receive a text asking for their feedback and this is planned for July 2019.

Staff can view a dashboard in Meridian as below for their FFT results:

There has been implemented with further development work planned for 2019. The priority will therefore not be carried forward to 2019-20.

Local Quality Indicators *

In addition to the Quality Priorities for 2018-19 the Trust has selected a number of local quality indicators. These remain the same as those reported in 2018-19.

Safety

Falls

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall.

Preventing the risk of patient falls can be achieved by identifying those patients at risk of falling and applying a multidisciplinary multifactorial management and intervention plan which identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay, these may include:

- cognitive impairment
- continence problems
- falls history, including causes and consequences (such as injury and fear of falling
- footwear that is unsuitable or missing
- Health problems that may increase their risk of falling
- medication
- postural instability, mobility problems and/or balance problems
- syncope syndrome
- visual impairment

whilst maintaining a patient's right to dignity, privacy, independence and their right to make informed choices about the risks they take.

The Trust has sustained its falls collaborative work which aspires to reduce the amount of falls if possible, but certainly to reduce the number and severity of harm. The current inpatient ward falls per 1,000bed days is 2.37. All patients are given a patient information leaflet regarding falls prevention.

Summary of actions/preventative measures taken:

Joint school- The interactive classroom style 'Joint School' is a very important part of the planning preparation for surgery and helps patients to know what to expect when they come into hospital
• what to bring into hospital
• physiotherapy exercises
• type of anaesthetic
• post-operative pain relief

Polypharmacy and anaesthetic review – Patient information collected at pre-op. All patients are measured for frailty, pain and their risk of a fall this is highlighted within the patient care

record. A full review of medications is undertaken as well as an anaesthetic assessment. Medication is then prescribed accordingly to promote the enhanced recovery pathway.

Immediate post fall follow-up – the introduction of the post fall assessment tool and action plan has enriched consistency of data recorded and monitored through the Datix system. The assessment incorporates information gathered from the patient which is central to understanding contributing factors to the fall. A post fall safety multidisciplinary 'huddle' enables clarification as to why the patient fell and what lessons can be learnt. This information can then be shared to the wider teams for shared learning.

Patient education and staff training – facilitated fall prevention workshops have continued since May 2017 as part of clinical staff mandatory training and feedback from staff has been very positive. Areas covered are National Guidance and Trust Policy, Risk Assessment & Management Plans, interactive sessions on scenario's from Datix, Post Fall Assessment Tool, Patient Experience and Safety Huddle, continuation of further tests of change and a practical methods of retrieval from the floor. Leaflets and posters have also been reviewed.

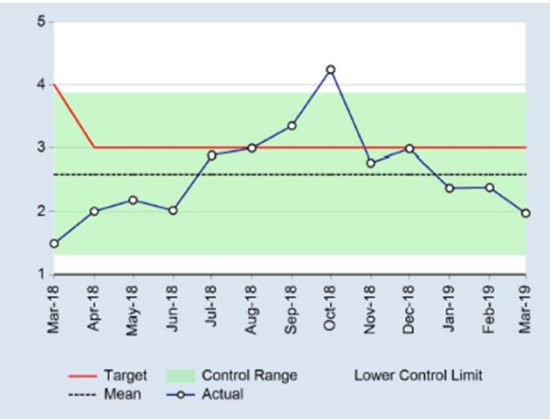
Intentional Rounding - Intentional rounding (IR) is a structured process whereby nurses in hospitals carry out regular checks, usually hourly, with individual patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items. The widespread implementation of IR across the UK was driven by the recommendations of the Francis Inquiry.

Bay Nursing – Nursing 'at risk' patients in one ward bay. This was initially implemented on Sheldon Ward which reduced the number of falls to below the mean. Bay nursing means that the bay is constantly supervised by a dedicated nurse. This provides patients and their carers with the knowledge that patients will have more time with nursing staff and as such improves patient satisfaction. Staff have their work station and are able to coordinate activities without leaving the bay. Due to this success Bay Nursing has been cascaded to other appropriate ward area as required.

Staff will continue to scrutinise falls within the trust specifically looking for ways in which improvements in communication of patient's risk factors can be made so that their journey will be as safe as possible.

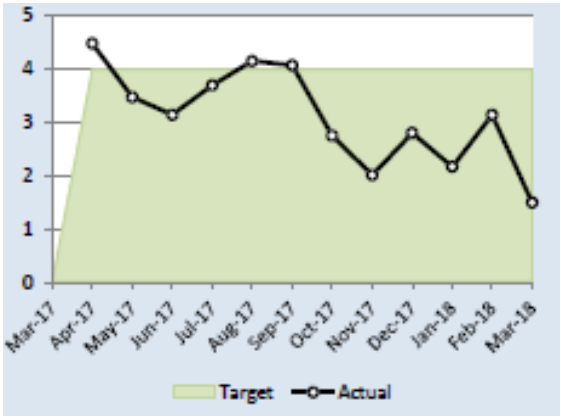
The following chart outlines the performance relating to falls for the year calculated per 1000 bed days:

Inpatient Falls per 1000 Bed Days 2018-2019



Source: Integrated Performance Report March 2019

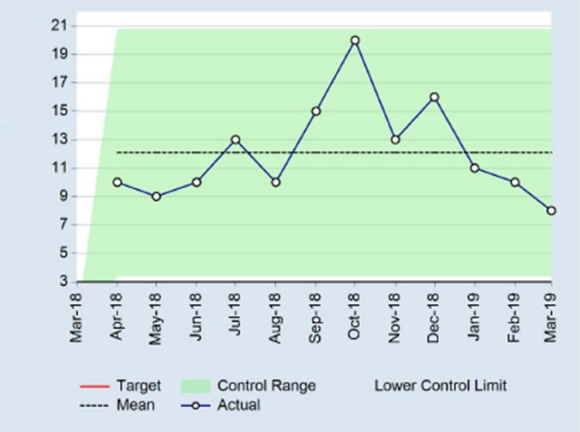
Inpatient Falls per 1000 Bed Days 2017-2018



Source: Integrated Performance Report March 2018

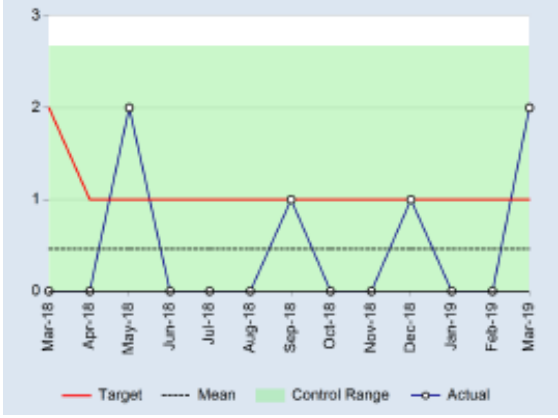
It is imperative to not only scrutinise the volume of falls but also any harm that may have been caused as a result of a fall. The data below reflects the harm of each fall and reflects that for the duration of 2018-19 there have been 4 moderate or severe harms to patients as a result of falling all of which have been fully investigated with a root cause analysis and presented so that lessons can be learnt.

Total Patient Falls 2018—19



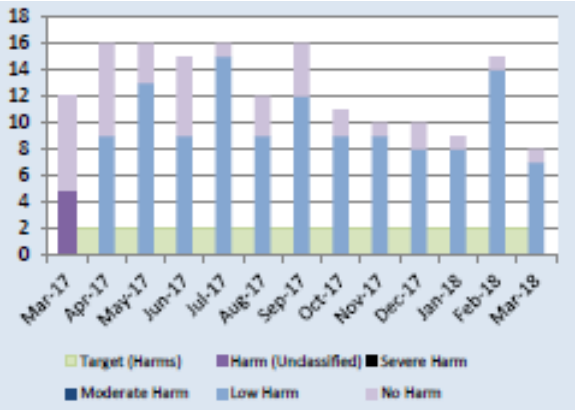
Source: Integrated Performance Report March 2019

Falls Moderate / Severe Harm 2018-19



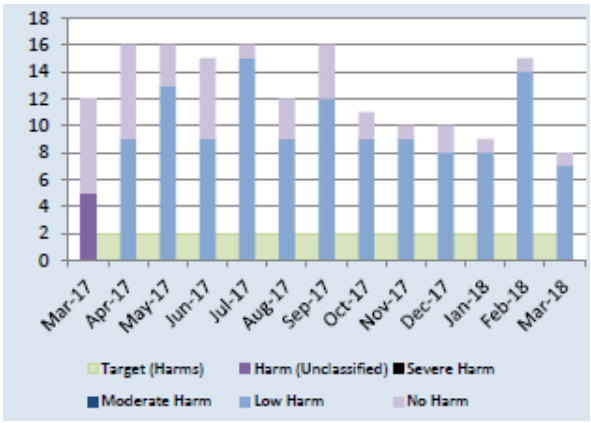
Source: Integrated Performance Report March 2019

Total Patient Falls 2017—18



Source: Integrated Performance Report March 2018

Falls Moderate / Severe Harm 2017-18



Source: Integrated Performance Report March 2018

Medication Incidents

Medication errors are any patient's safety incidents (PSIs) where there has been an error in the process of prescribing, preparing, dispensing, and administering, monitoring or providing advice on medicines. These PSIs can be divided into two categories; errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose or a failure to monitor, such as international normalised ratio for anticoagulant therapy.

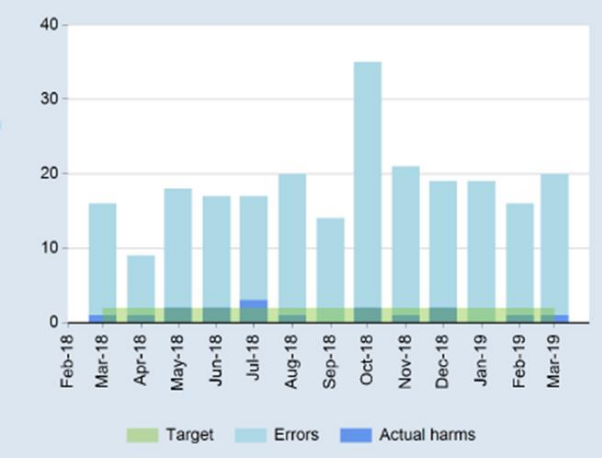
The Trust have continued to monitor the amount of harm experienced from patient medication incidents together with monitoring the total number of incidents amongst all clinical areas of the organisation.

We have a medication safety group in place chaired by our Chief Pharmacist. Both the Chief Pharmacist the Safety Pharmacist and the clinical teams work together to ensure that medication incidents are reported and learning occurs.

Ward walkabouts were introduced in 2016-17 and continued to take place in 2018-19 and have maintained the increased reporting of medication incidents whilst the harms have remained low.

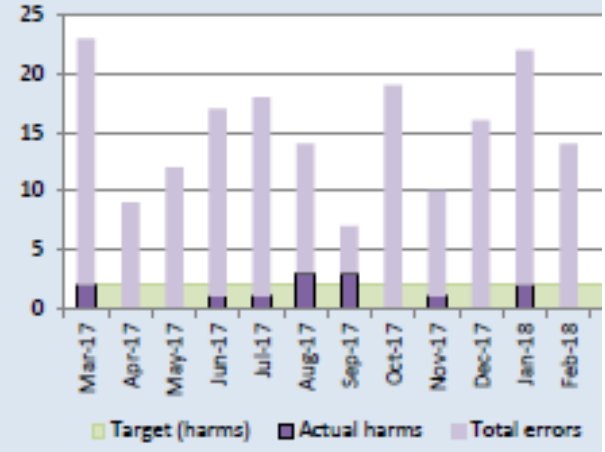
The chart below tracks our progress across the year in relation to the number of incidents and the levels of harm associated with these:

Medication Incidents 2018-19



Source: Integrated Performance Report March 2019

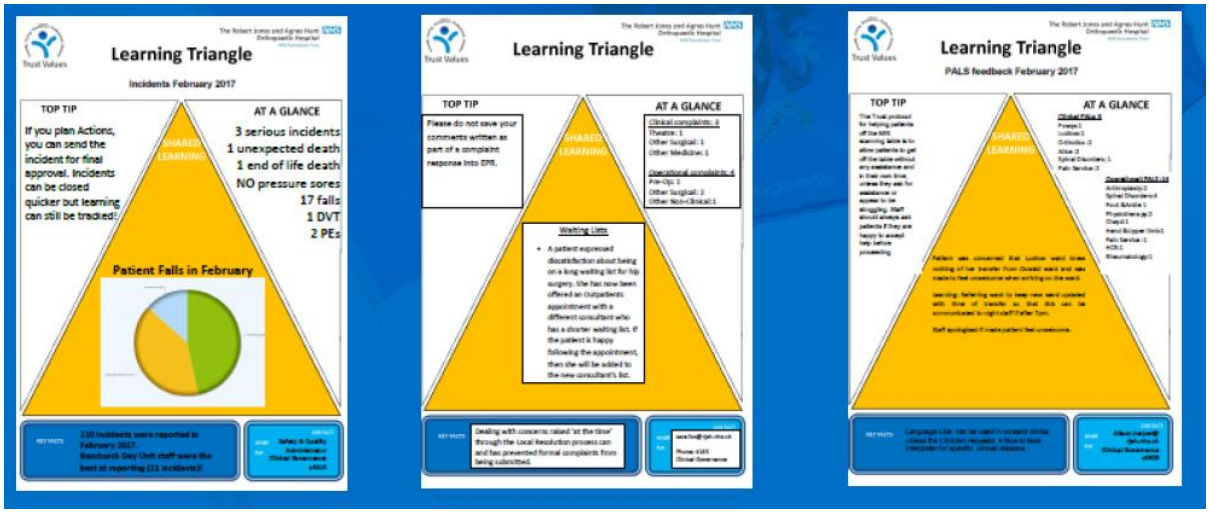
Medication Incidents 2017-18



Source: Integrated Performance Report March 2018

Learning Lessons from incidents

Lessons learned from incidents are shared across the Trust which are displayed in each area or department on a monthly basis.



Improving Learning from Incidents

- Incidents within the Trust are reported via Datix Web and at the time of reporting, the reporter is asked for their email address. This enables a feedback email to be automated back to the reporter once the incident investigation is completed. During 2018-19 audits were undertaken to ensure this was happening consistently.
- In August 2018 we held a patient safety summit which was attended by over 50 clinical staff from across the Trust as well as external regulators and stakeholders. Human factors was a main focus for the event along with a review of the learning gained across the trust from our serious incidents and the recent changes to the Never Event Framework.
- The Trust's management of serious incidents during 2018-19 has seen an increased involvement of patients to ensure learning is also from a patient perspective. All serious incidents now have a Patient Liaison person nominated.
- Finally, during 2018-19 the Trust introduced Safety Champions to undertake a walk of the hospital for an hour each day, visiting different areas to share learning first hand but also to understand from staff any safety concerns they have.

Sign up to Safety

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has committed its support to 'Sign up to Safety', an NHS England National Patient Safety Campaign.

Sign up to Safety was announced in March 2014 by the Secretary of State for Health. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has signed up to the campaign and our commitment to the five pledges are:

1. **Putting safety first.**

Committing to reduce avoidable harm in the NHS.

- Continue to monitor harm through the monthly patient and medicines safety thermometer tool, using the data to identify areas for improvement and putting in place actions to address those areas.
- Comply with safer staffing requirements, displaying daily information on ward staffing boards
- Utilise the national initiative from NHS England around the identification of Acute Kidney Injury (AKI) to improve the identification of this for someone using our services

2. **Continually learn.**

Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.

- Continue to actively participate and share learning with the West Midland Safety Collaborative to promote improvements across the NHS
  Continue to share learning from incidents and patient feedback at the Incident Action Review Committee (IARC)Monitor and audit actions arising from Serious Incidents (SIs) and other serious adverse events to ensure that actions have been effective.
- Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe services are.

3. **Being honest.**

Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

- Continue to ensure that Duty of Candour is applied across the Trust
- Link in with the Local Health Economy (LHE) to strengthen and develop our learning
- Provide regular updates to the Patient Panel of progress against our Sign up to Safety action plan

4. **Collaborate.**

Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

- Introduce change collaboratives for key areas relating to patient harm
- Celebrate what we do well

5. **Being supportive.**

Help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate the progress.

- Continue a rolling programme of themed reviews at the Incident Action Review Committee (IARC)
- Where harm has occurred, this will be shared to ensure maximum learning
- Encourage all staff to Sign up to Safety and complete personal pledges
- Have an annual safety culture event to celebrate achievements in safety

Schwartz Rounds- Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research into the effectiveness of Schwartz Rounds shows the positive impact that they have on individuals, teams, patient outcomes, and organisational culture

Human Factors- We recognise that at the heart of our approach to quality and safety improvement, there needs to be awareness of the interactions between people, and between people and non-human elements involved in complex systems. Human Factors is not a stand-alone solution, but rather a broad approach that ensures that people have a better understanding of how people are affected by the teams they work with, the systems they operate, and the environment they work within. It ensures that people know how the combination of the factors affects patient safety and wellbeing so that consistently
safe and reliable care can be provided to our patients.
Our Behavioural Characteristics was launched in 2016, setting out the expectations for all staff to take responsibility for their professional behaviour, to work effectively with others, and to challenge and be honest where they feel things are not right. This is a key element in establishing a Human Factors approach

Co-Ordination Centre- The Co-ordination Centre will be a central place that holds information, and will be used to host twice daily multi-disciplinary team (MDT) meetings aimed at allowing us to respond more effectively to real-time information about service demand. It has been created as part of our organisational strategy to deliver Operational Excellence, and it is intended to be an entirely patient-focussed approach that will help to tackle bed pressures and other resource issues as and when they arise.

Releasing Potential- As part of our leadership development programme 'Releasing Potential' managers are undertaking a full diagnostics to support their understanding of their own and others behaviours, and the influence/impact that their behaviours have on others.

Sustaining Quality Through Assessment and Review (STAR). This is a performance assessment framework is a structured process linking to the 6 C's Nursing strategy, Essence of Care standards and Care Quality Commission (CQC) essential standards.
The 14 standards set within the framework are measured by collating evidence through observation of care, reviewing written documentation, asking questions with both patients and staff. Each standard is subdivided into three elements, Environment, Care and Leadership. This is to reflect those aspects of practice that is necessary for the efficient running of wards.

Effectiveness

The National Institute for Health & Clinical Excellence (NICE) guidance

In 2018/19 NICE published 160 Guidance's to which there were:

- 44 clinical guidelines & National Guidelines
- 39 Interventional procedures
- 66 Technology appraisals
- 7 Medical Technologies guidance's
- 3 Diagnostic Guidance's

- 1 Highly Specialised Technology Guidance
- 0 Public Health Guidance's

Nice also produced 49 advice/recommendations to which there were:

- 2 Evidence Summaries
- 26 Medtech innovation briefings
- 21 Quality Standards

A baseline assessment was carried out for guidance's relevant to the Trust and where appropriate audits were undertaken to measure compliance are put in place. Audits that are being carried out or have been carried out in 2018/19 in relation to NICE guidance include:

- Patient Group Direction Policy Audit MPG 2
- Assessing and document the risk of venous thromboembolism CG 92
- National Rheumatology Audit CG 79, QS 33
- Reaudit Urological Service Provision CG 148
- Physical Activity in Children aged 5-18 PH 17
- Reaudit of Pneumonia in adults CG 191
- Medications prescription and dispensing for inpatients at MCSI NG 5
- Evaluation of incidence of DVT in patients undergoing lumbar fusion surgery QS 29
- Botox administration in Children with Cerebral Palsy CG 145
- Reaudit of Acute Kidney Injury among In-patients CG 169

Sustaining Quality through Assessment & Review (STAR)

Our vision as an organisation is "Aspiring to deliver world class patient care" with the Trust's ambition to be a leading centre for high quality, sustainable orthopaedic and related care achieving excellence.

Written within the Robert Jones & Agnes Hunt Orthopaedic (RJAH) NHS Quality Strategy 2017-2020 defining quality and quality governance encompasses three equally important elements, care that is safe, care that is effective, and care that provides positive patient and staff experience.

Sustaining Quality through assessment and review (STAR) is identified within the trust's Quality Strategy, and is incorporated in aim 4 of the Trust's quality aim as an objective and measure - providing effective and reliable care.

What is STAR

STAR is a quality and safety accreditation process taking a trust wide uniform approach in monitoring quality standards of patient care. It offers managers and their staff a structure of expectations for their wards and departments, and provides assurance for staff, patients, relatives, visitors and the senior management team, that there is a practical robust system in place monitoring compliance against national standards including the Care Quality Commission (CQC) Key lines of enquiry (KLOE'S)

The STAR has been developed to provide information relating to the contribution of nursing and contributions from various other member of the multidisciplinary team in effective healthcare delivery.

Progress to date during 2018/19

The STAR performance assessment framework has continued to be undertaken on all the adult wards, and one paediatric ward within the trust, and is now being rolled out to other clinical areas. Currently there are:

- Four areas which include two wards, Pre-operative Assessment Unit, and High Dependency Unit are at 3 STARS
- Four Wards, and three clinical areas which are Main Outpatients, Baschurch unit (admit day of surgery and day case unit), and the Pre-Operative assessment unit are at 4 STARS.
- Three wards are currently at 5 STAR status

The STAR assessment tool has also been developed in a number of areas as a bespoke assessment as not all areas are the same in relation to the 14 core standards. However the fundamental of care standards have remained consistent throughout the process which is essential when creating bespoke STAR assessments tools. The STAR assessment has been triangulated to the Care Quality Commission (CQC) five key lines of enquiry (KLOE'S) Safe, Effective, Caring, Responsive and Well led. By having the STAR framework it supports and provides staff with a robust and effective process for clinical areas to demonstrate compliance against these CQC standards.

Specific bespoke STAR assessment tools have been developed and undertaken is Theatre, Recovery and Anaesthetics which was created in 2015, Main Outpatients Department created in 2016, Paediatrics created in 2017 and more recently Pre-Operative assessment unit and High Dependency Unit in 2018

The roll out within other areas during 2018 is the Radiology department which is being worked on now which will link in with the national CQC Key Lines of enquiry, and triangulate to the ISAS standards (Imaging Services Accreditation Scheme)

5 STAR Success

During 2018-19 three wards have successfully achieved, and maintained their 5 STAR status which is a fantastic achievement. Other areas are progressing through their STAR journey having reached 4 STARS, and are now ready to apply for 5 STAR status. These areas are Theatre/Anaesthetics/Recovery Unit, Clwyd Ward, Wrekin Ward, Gladstone Ward, and Main Outpatients Department. These areas will be applying for this status during 2019/20

STAR Conference 2018

In November 2018 the Sustaining Quality through Assessment and Review conference was held to celebrate and mark the 5 year anniversary of STAR. This event was a great success giving staff the opportunity to share with key stakeholders and colleagues what they have achieved through STAR and what they have learnt through this experience. The aim of the day was to focus and promote quality and safety of our patients and by having such an event it engaged, and helped to empower staff. It was a time for staff to celebrate their successes and achievements supporting the delivery of the Trust's Quality strategy

Recent Care Quality Commission Inspection November/December 2018

The trust's recent CQC inspection was given an overall rating of Good. Within each of the five key lines of enquiry (KLOE'S) each was given an overall rating of good with a rating of outstanding for care, which is a fantastic achievement for the Trust.

The STAR assessment process has been recognised within the summary section and subsequent sections of the CQC report, and reported the following "The trust had developed a quality improvement process to monitor care standards and identify improvements. The Sustaining Quality Through Assessment and Review (STAR) assessment is a trust wide approach in monitoring quality standards of patient care within the clinical environment".

Having the recognition of STAR as an effective accreditation tool to measure effective reliable care is essential. It supports the trusts quality strategy priorities to ensure there is an effective process of monitoring quality and safety at ward/department level.

Health and Safety

Health and Safety incidents are monitored on an ongoing basis throughout the year. All incidents are investigated and remedial actions taken to prevent or reduce the likelihood of reoccurrence. Those incidents reported that involve specified injuries, dangerous occurrences or result in a member of staff taking more than seven days off work as a result of a work-related accident are also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

During 2018-19 there were 3 incidents reported to the HSE under the requirement of the RIDDOR regulations. This is compared to 3 in 2017-18, 2 in 2016-17 and 1 in 2015/16.

The Trust has a pro-active programme of safety inspections which are carried out by Staffside union accredited safety representatives in conjunction with the Health and Safety Advisor. The Governance department has instigated a 'Safety Champions' initiative in order to raise the profile of safety throughout the Trust.

The Health and Safety Committee meets on a bi-monthly basis and a Chair's report is presented to the Trust Risk Management Committee.

Key health and safety actions in 2018-19 include:

- The appointment of a Health and Safety Advisor to undertake the roles of Competent Person for safety, Medical Devices Safety Officer and Central Alerting System Liaison Officer.
- Reviews of the Trust Health and Safety Policy and Estates & Facilities safety policies and procedures.
- Completion of the NHS Premises Assurance Model (PAM) for Estates and Facilities which gave assurance that the department's governance and safety activities were effective.

Experience

Highlights of the Patient Experience Strategy

The Trust continues to improve the patient experience aligning actions outlined in the Patient Experience Strategy 2017-2020.

The main aims of the Strategy are:

- Actively engage with patients and carers, encouraging all feedback and demonstrating genuine learning from listening.
- Identifying our key ambitions to improve patient and carer experience throughout the Trust
- Providing the best possible experience means getting the basics right, making sure our patients feel safe and well-cared for, that they have trust and confidence in the staff caring for them and that they receive excellent quality care in a clean and pleasant environment.

A key vision of this Strategy is to work in partnership with our patients, staff and stakeholders. The Trust has embedded this by the appointment of patients as co-chairs of the patient panel which has been working well. 2 patient panel members have shared the role rotating every 6 meetings.

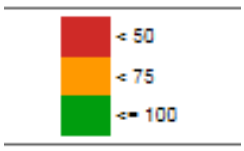
To enhance co-production between staff and patients, the patient panel terms of reference has been reviewed alongside the Patient Experience committee. It has been decided to merge the two committees to form a new forum called the Patient Participation Group (PPG), a name that patient panel members came up. The purpose of the PPG is to work with staff and local partners to develop concepts and models of co-production to ensure services are truly patient centred as well as support the Patient Experience Strategy and Quality Improvement Strategy 2017-2020.

During 2018-2019, the Trust has been seeing the benefits of investing in Meridian, an electronic system to monitor patient experience. This was implemented in November 2018 and patients are asked a number of questions in relation to their inpatient stay or clinic appointment. Questions cover a number of aspects about their care, hospital food, ward cleanliness, hygiene as well as privacy and dignity.

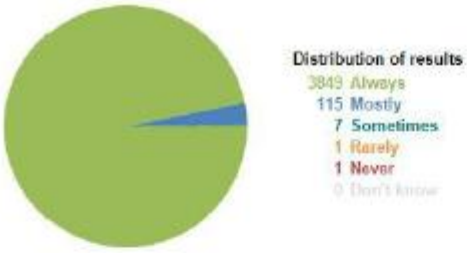
Results continue to be high. See below charts of questions from Meridian feedback surveys from November 2018 to March 2019:

A heat map of all questions from Meridian.

Ward/Clinic	Returns	FFT	Total	Cared for	Food	Clean	Staff friendly	Noise at night	Hand hygiene	Dignity Respect	Overall
Baschurch	1488	99	99	100	97	100	100	99	100	100	99
Clwyd	333	98	98	99	89	98	99	81	98	98	97
Gladstone	52	91	91	93	85	94	98	84	97	97	90
HDU	30	100	100	100	100	100	100	96	100	100	100
Kenyon	226	98	98	98	90	99	99	85	98	99	97
Ludlow NHS	189	98	98	99	88	98	99	90	98	99	98
Menzies	1	100	100	100	100	100	100	100	100	100	100
Oswald	131	99	99	99	93	100	99	96	99	100	99
Powys	347	99	99	99	89	99	99	82	98	99	98
Sheldon Inpatients	60	97	97	95	91	95	94	79	97	95	90
Sheldon IV Day Cases	146	98	98	100	94	100	99	98	98	98	98
Sheldon Physio patients	34	98	98	98	93	98	99	89	98	98	97
Sheldon Ward MCSI Spinal patients	25	86	86	93	85	97	95	70	98	94	89
Sheldon Ward Rheumatology Patients	30	99	99	100	94	99	100	82	98	100	100
Theatres	914	99	99	100	97	100	100	96	100	100	99
Wrekin	51	96	96	94	85	96	96	82	97	96	91
Total	4055	99	99	99	94	99	99	91	99	99	98

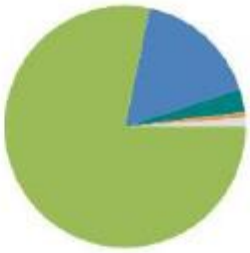


7. Were staff caring and compassionate? (3973 responses)



Distribution of results
3849 Always
115 Mostly
7 Sometimes
1 Rarely
1 Never
0 Don't know

8. Did you like the food provided, if you were offered any? (If not please leave blank) (3305 responses)



Distribution of results
2588 Always
552 Mostly
101 Sometimes
21 Rarely
4 Never
39 Don't know

9. Did you feel the ward was clean? (3953 responses)

Distribution of results
3821 Always
114 Mostly
7 Sometimes
0 Rarely
0 Never
11 Don't know

10. Did you find the staff welcoming and friendly? (3278 responses)

Distribution of results
3206 Always
59 Mostly
2 Sometimes
1 Rarely
2 Never
8 Don't know

11. Did you feel that the noise levels were acceptable at night? (2635 responses)

Distribution of results
1654 Always
459 Mostly
98 Sometimes
35 Rarely
15 Never
374 Don't know

12. Did the staff practice good hand hygiene? (3576 responses)

Distribution of results
3401 Always
120 Mostly
7 Sometimes
3 Rarely
0 Never
45 Don't know

13. Was your privacy/ dignity & comfort respected? (3951 responses)

Distribution of results
3862 Always
79 Mostly
3 Sometimes
2 Rarely
4 Never
1 Don't know

14. How would you rate your overall experience? (3892 responses)

Distribution of results
3707 Excellent
168 Good
10 Fair
4 Poor
3 Don't know

Within the Patient Experience Strategy, there are 3 'Always Events'.

Always Event 1

Improving the patient Journey

The SWAN model of care is being adopted across the Trust to support staff, patients and relatives with the End of Life care.

Funding was received to cover training and the purchase of SWAN boxes. A number of staff have received bespoke training including ward staff, porters and facilities staff and e-learning will be rolled out to key staff.

SWAN boxes will be on all wards including a box for our Children's ward and will contain bags keepsakes, note pad and pens.

There have been a number of small gestures planned to help bereaved families and carers including:

- Free car parking for bereaved families, we should ensure this always happens and wards staff are aware of who to contact to make it happen
- Hot drink & a cake vouchers for relatives in our Swan boxes
- SWAN signs – ensure all staff aware of what these mean so that appropriate level of respect is given from all staff

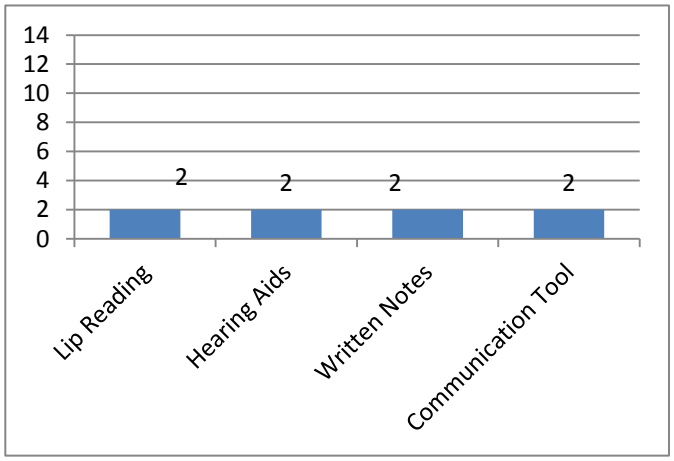
Always Event 2

Improving Communication

Although the Trust conforms to the requirements of the Accessible Information Standard we want to have the right information about our specific patients' needs as they start their care pathway with us.

We carried out two surveys see if additional work could be done in order to enhance the patient's pathway and provide communication support that patients may need from the Trust.

From the survey 2% out of patients said they had communication requirements, the graph below



Finally, a carers Café is still be held in the main entrance every other month in collaboration with the carers centre and social care.

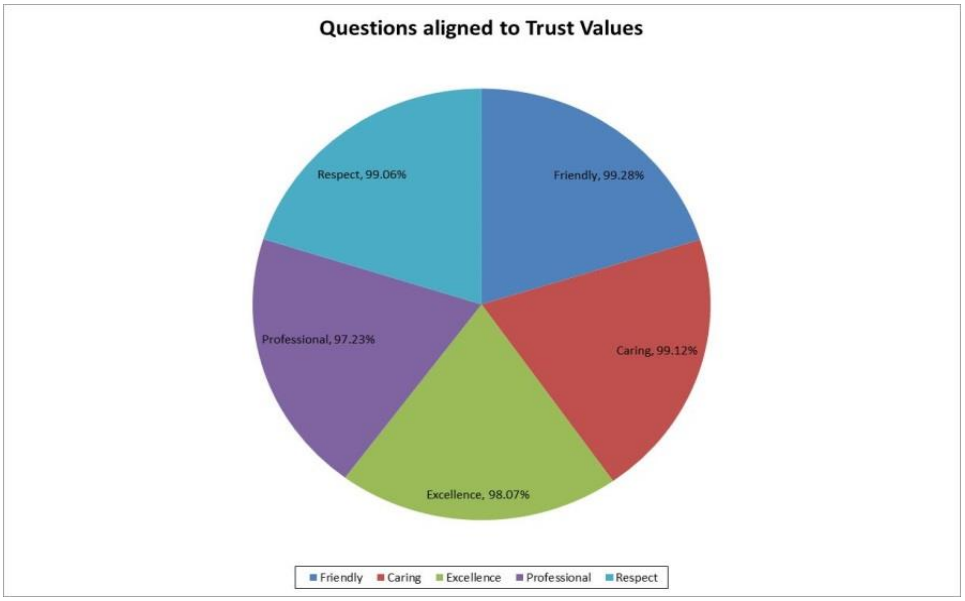
Always Event 3

Meeting the Care needs of our Patients

The STAR process has been fully reviewed to ensure the focus remains on meeting the care needs of our patients. During 2018-19 three wards have successfully achieved, and maintained their 5 STAR status with a number of other areas progressing through their STAR journey having reached 4 STARS, namely; Theatre/Anaesthetics/Recovery Unit, Clwyd Ward, Wrekin Ward, Gladstone Ward, and Main Outpatients Department. These areas will be applying for a 5 STAR status during 2019/20

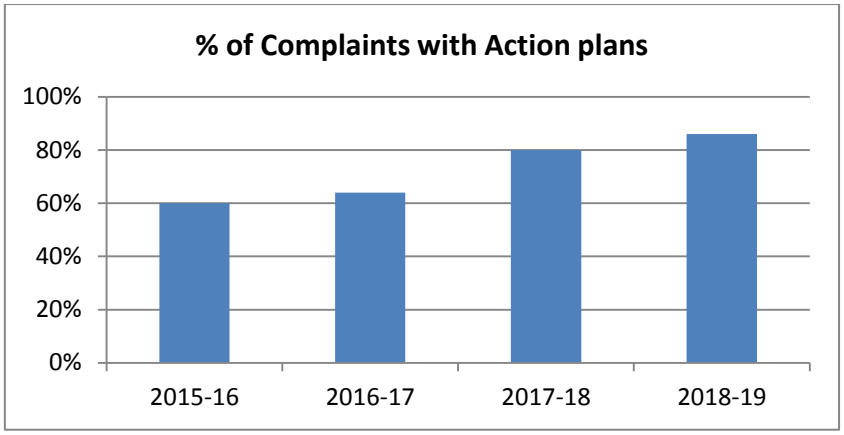
Members of the Governance team have started to carry out regular safety walkabouts, in a bid to ensure concerns relating to patients care, safety, incidents and learning from them are discussed openly

The surveys questions in Meridian have been mapped to the Trust Values shown below:-



Learning from Patient Feedback/Changes in Practice or Service Improvement

The Trust recognises the opportunity patient feedback provides to identify areas for improvement and it is for this reason it committed to increasing the percentage of complaints with resultant action plans. The graph below shows how performance in this area has improved with the target of 88% of complaints having action plans being achieved for 2018-19.



Patient Stories

How we use Patient Stories?

The Trust regularly listens to patient stories and shares learning from these with the clinical teams. The monthly Trust Board meetings start with a patient or staff story. This can be told by the patient or carer or staff member attending the meeting in person or by sharing the story in writing.
The Board welcome hearing about both positive and negative experiences and the clinical teams share the learning from the experience and agree actions to be taken. Patient stories have also been shared on the Trust's 'Leading with Potential' Course, locally at team meetings

Health watch Shropshire Shropshire attend the Trust twice a month to collect Patient and Carers stories in the main entrance.

How are patient stories collected?

The Clinical Governance Team contact patients following either a PALS contact, complaint or a referral from a department of a suitable patient story. We also ask for patients who have made a complaint if they want to do a patient story.

Patient consent is always obtained so that the patient is aware that their story is being shared across the Trust. They are asked if want a reply and whether to share their story anonymously or not.

Where have we collected and shared patient/staff stories from?

- A patient thankful for receiving the pain management injections
- A patient having a hip replacement
- A patients journey through the Baschurch Unit
- A patient staying over Christmas on Oswald ward under the care of the Tumour team

Actions from patient stories

All stories are generally complimentarily and where patients make a suggestion or improvement these are followed up. Please find some improvements from stories collected and shared at meetings.

- Following comments about extending the Joint School this has been extended beyond hip and knees to include upper limb.

- From a patient story on Oswald, the Trust will to provide a refund for 8 TV remote controls. The Trust will be looking at what improvements can be made to the wifi, recognising that this is important for patients.

- Following a story on Baschurch, improvements have been made to the storage of luggage and extra charging points for phones and kindles.

Sit and See Observations

The Sit and See observation tool captures and records the smallest things that can make the biggest difference to patient care.

Since April 2018-March 2019 there have been 66 observations across wards and departments. 5 of these observations had passive feedback included and 1 observation had poor feedback included.

There are 12 active Sit & See Observers, of which 8 are Patient volunteers or Trust Governors.

15 actions have been taken following observations. Staff are encouraged to share positive results at ward or department meetings. Themes on any poor or passive observation have been about:

- Staff attitude and behaviour, i.e. chewing gum and being abrupt while explain/answering patient questions
- Clutter in the corridors/bays

Some examples of Positive practice identified from 'Sit and See' during 2018-19:

Powys: You said… We did posters on display.

MOPD: All staff noted to welcome patients into OP room

Sheldon: Water on all bed tables and also in corridor for all to use.

HDU: Staff welcoming to a visitor and reassured her of husband's progress

Examples of Passive and Poor themes across the wards:

Observation: Ludlow: Physiotherapist quite blunt when answering a patients question about how she was managing walking

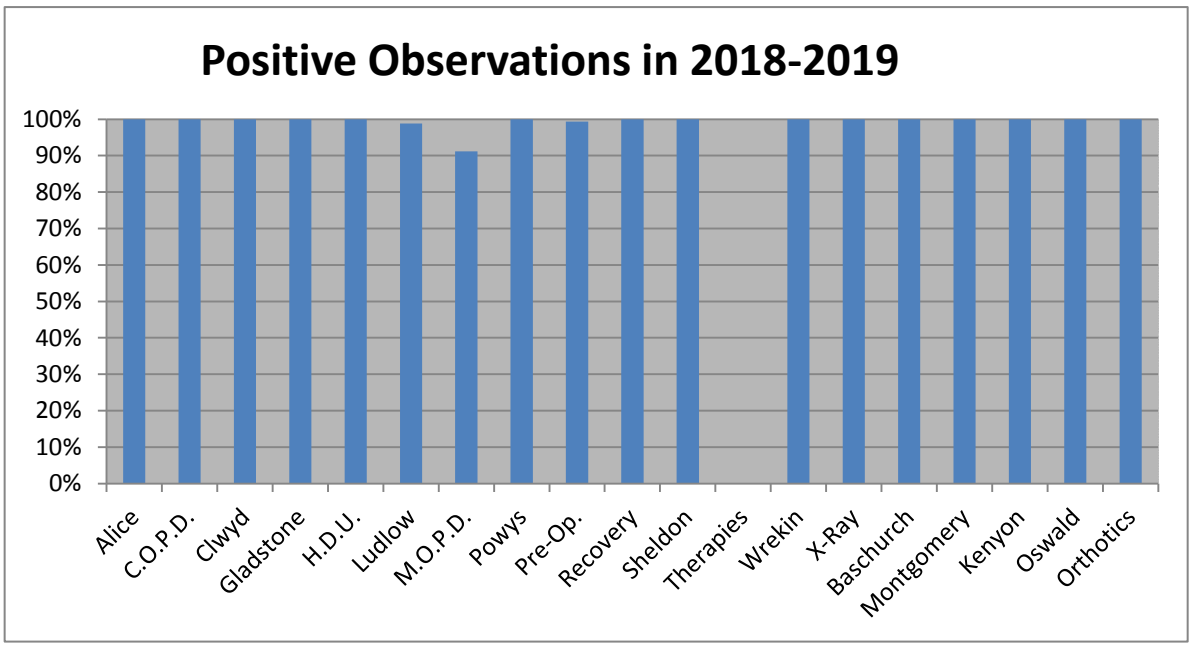
Observation: Pre-op: Patient did not understand abbreviations and stats board

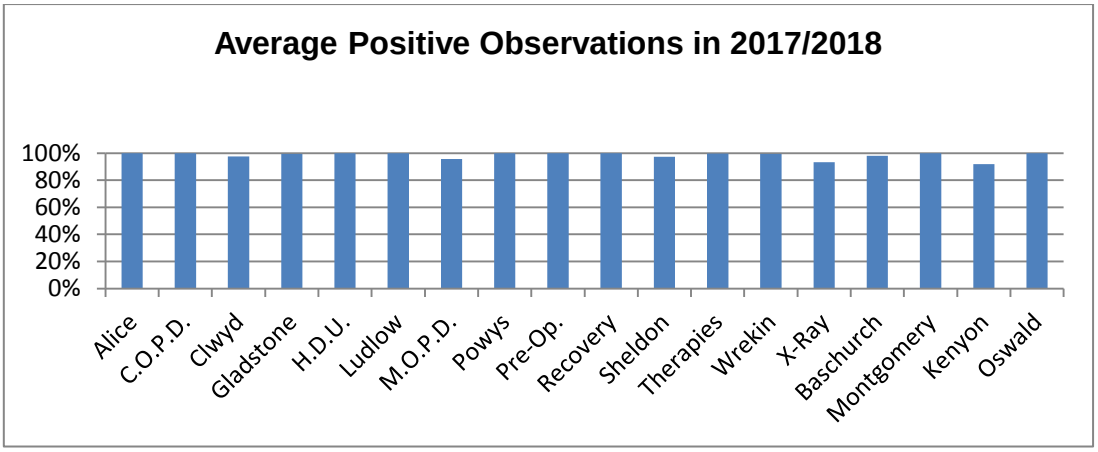
Observation: X-ray: HCA chewing gum when calling out patients name

Observation: Sheldon: 2 trollies and some equipment left around

All examples of passive or poor themes are taken up with the relevant ward or department to ensure improvements are made.

The graph below show the average number of positive observations of care by department ad provides a comparator to the previous year:





Patient Safety Walkabouts

During 2017-18 the Trust introduced Patient Safety Walkabouts. These consist of a member of the Executive Team, a Non-Executive Director and a Governor attending a ward or department to observe the quality and safety of the service.

These have continued during 2018-19 and to date a total of18 walkabouts have been undertaken with positive feedback from both those attending and those working within the departments regarding the value of these visits.

They provide a clear opportunity for staff to be able to raise any safety concerns they may have and enable senior management to witness first hand the services being provided across the organisation.

Given the value of these felt by all involved, it is planned that these walkabout will continue in 2019-20

Back to the Floor

During 2017-18 the Trust held two back to the floor events whereby senior managers went to work in departments for the day. This interaction, as with the patient safety walkabouts, provided opportunity for staff to provide feedback on their experiences of working in the department. Equally it enables senior managers to speak with patients being cared for in those areas to hear first-hand experiences.

These events have continued during 2018-19 with two further Back to Floor days held.

Freedom to Speak Up Guardians

In November 2018 the role of the three FTSU Guardians was reviewed. After consultation it was decided that one of the Guardians, Liz Hammond, would be contracted in to the FTSUG role for 7.5 hrs a week.

All referrals via the RJAH FTSUG e-mail address, the RJAH App and personal one to one's will have been dealt with by Liz Hammond since 1st February 2019. Hilary Pepler and Jan Greasley are also continuing in their roles as FTSUG and will have access to the referrals.

There will be a relaunch of the role, App and other contact details at the beginning of May. The App is in the process of being updated with relevant information to enable staff to speak up.

The FTSUG's will also be visiting all departments over the next year to encourage staff to Speak Up and to give reassurances that this is a confidential service, that staff will be supported if they raise a concern and that feedback will be forthcoming.

Staff induction will also have a 30 minute slot to introduce new staff the the FTSUG, explain the role and how they can raise a concern.

All concerns received either by e-mail, App or one to one's will be entered into the App data base so that a true reflection of the type and volume of concerns can be accurately recorded.

INTEC, who provide the App are adding a case referral data base for the Guardians to use. An additional page for Equality and diversity monitoring will be added so that the Guardians can analysis the data to see if there are any trends within the raising concerns. This is an optional page and staff are not obliged to fill it in.

Since April 2018 there have been over 13 concerns raised via the App and 1 via the Trust e-mail address.

Data continues to be submitted for each quarter to the National Guardians' Office regarding the numbers of referrals.

National Quality Indictors

Staff Survey results

Overall the 2018 staff survey results are an improvement on the previous year. 94% of respondents would be happy with the standard of care provided if a friend or relative needed treatment and 79.5% of respondents would recommend the Trust as a place to work.

Our overall engagement score was comparable with other acute specialist trusts.

Response Rate	2016		2017		2018		Trust Change
	Trust	National Average	Trust	National Average	Trust	National Average	
	42%	44%	41.5%	45%	45%	53%	+3.5%

We are improvement-driven

Question	2016	**2017**	**2018**	**2018 Comparator average**
I am able to make suggestions to improve the	76%	76.4%	78.6%	77.3%

work of my team/dept				
I am able to make improvements happen in my area of work	50.4%	55.2%	63.3%	62.5%
Feedback from patients/service users is used to make informed decisions within my directorate/department	57.5%	60.3%	66.4%	62%

Job satisfaction (recognition)

Question	**2016**	**2017**	**2018**	**2018 Comparator average**
(I am satisfied with) The recognition I get for good work	51.1%	51.2%	59.9%	60%
(I am satisfied with) The extent to which the organisation values my work	40.6%	43.3%	55%	54.6%

We listen

Question	**2016**	**2017**	**2018**	**2018 Comparator average**
I know who the senior managers are here	71.6%	78.6%	85.5%	84.6%
Communication between senior managers and staff is effective	31.4%	39.4%	45.1%	46.2%

We're getting better at learning from errors and incidents

Question	**2016**	**2017**	**2018**	**2018 Comparator average**
My organisation treats staff who are involved in an error, near miss or incident fairly	48.3%	55.7%	64.6%	63.3%
My organisation encourages us to report error, near misses or incidents	86.6%	90%	93.2%	91.5%

When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again	63.5%	71.8%	77.3%	76.4%
We are given feedback about changes made in response to reported errors, near misses and incidents	47.8%	58.3%	62.6%	62.4%

We have effective appraisals

Question	2016	2017	2018	2018 Comparator average
My appraisal - helped me improve how I do my job	12.8%	18.1%	22.3%	24.4%
My appraisal - helped me agree clear objectives	25%	33.4%	36.4%	37.8%
My appraisal - left me feeling my work is valued by my organisation	22.4%	27.9%	35.8%	36.1%
The Values of my organisation were discussed as part of the appraisal process	29.1%	34.6%	42.7%	40.4%

Single Oversight Framework

The following section outlines the Trust's performance against the relevant indicators and performance thresholds set out in the NHS Improvement Single Oversight Framework where this data does not appear elsewhere in the report.

Referral to Treatment Times (RTT)

	Info taken from the published annual accounts				
Indicator for Disclosure	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate	**90.89%**	**86.28% (based on Q4 only)**	**88.51%**	**89.49%**	**90.26%**
All cancers: 62-day wait for first treatment from:	**78.95%**	**93.75%**	**92.59%**	**75.76%**	**58.33%**

• urgent GP referral for suspected cancer • NHS Cancer Screening Service referral					
C. difficile – meeting the C. difficile objective	**2**	**0**	**0**	**0**	**3**
Maximum 6 week wait for diagnostic procedures	**99.33%**	**99.8%**	**99.84%**	**99.57%**	**98.96%**
Venous thromboembolism (VTE) risk assessment		**100%**	**100%**	**99.9%**	**99.9%**

APPENDICES

Statement of Directors' responsibility in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance 'Detailed Requirements for Quality Reports 2018/19'

- The content of the Quality Report is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2018 to March 2019
    - Papers relating to quality reported to the board over the period April 2018 to March 2019
    - Feedback from the Trust's Lead Governor dated 21 May 2019
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
    - The latest national patient survey 2018
    - The latest national staff survey 2018
    - the Head of Internal Audit's annual opinion of the trust's control environment dated May 2019
    - CQC inspection report dated February 2019
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

- The performance information reported in the Quality Report is reliable and accurate

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

23 May 2019 Chairman

23 May 2018 Date Chief Executive

Lead Governor's Submission on the Quality Account Report for 2018-19 of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

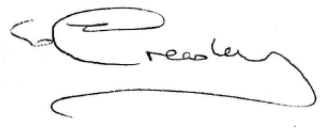
The Quality Account Report 2018-19 demonstrates the continued significant achievements the Trust has made over the last year this is particularly evident through the Inpatient Survey Results, Staff Survey Results and the findings of the CQC

The Governors continue to be involved in events, patient safety and patient experience initiatives and they welcome these opportunities to provide input on behalf of their member. In addition, seeing how the services run and hearing directly from patients about their experiences provides assurance to the Council of Governors that the patient needs are consistently being met.

It is reassuring that the hospital continues to be a place staff would recommend to their friends and family as a place of treatment, with 94% of our staff prepared to make such a recommendation. This really is testimony to the quality of the care being provided.

The Council of Governors have been involved in the consideration and agreement of the priorities for 2019-20 and we are looking forward to supporting the Trust with its continued quality improvements.

On behalf of the Council of Governors, I would like to congratulate the Trust on its quality performance for 2018-19.



Jan Greasley
Lead Governor

21 May 2019

Independent Auditors Report to the Council of Governors of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Independent auditor's report to the council of governors of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust on the quality report

We have been engaged by the council of governors of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Number of patients on incomplete pathways who have been waiting no more than 18 weeks, as a percentage of the total number of patients on incomplete pathways; and
- Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

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

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation Trust annual reporting manual' issued by NHS Improvement.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation Trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below:
  - board minutes for the period April 2018 to April 2019;
  - papers relating to quality reported to the board over the period April 2018 to April 2019;
  - feedback from Shropshire and Telford and Wrekin Clinical Commissioning Groups dated 21st May 2019;
  - feedback from governors, dated 21st May 2019;
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17th of May 2019;
  - the latest national patient survey 2018;
  - the latest national staff survey 2018; and

- Care Quality Commission inspection report, dated 21st February 2019; and
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2019.

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation Trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the 'documents').

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

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

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation Trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these

criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation Trust annual reporting manual'.

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

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation Trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the 'NHS Improvement Detailed requirements for external assurance for quality reports 2018/19' for foundation Trusts; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation Trust annual reporting manual' and supporting guidance.

Deloitte LLP
Birmingham
United Kingdom
24 May 2019

Glossary

ADOS	Admit on Day of Surgery
AED	Automated External Defibrillator
AKI	Acute Kidney Injury
ALS	Advanced Life Support
BLS	Basic Life Support
CAF	Common Assessment Framework
CARMS	Clinical Audit Registration and Management
CAS	Central Alerting System
CCG	Clinical Commissioning Group
CKD	Chronic Kidney Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CTPA	Computed Tomography Pulmonary Angiography
Datix	Incident reporting system used by the Trust
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguard
EPALS	European Paediatric Advanced Life Support
EPMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Records
FFT	Friends & Family Test
HCR	Healthcare Records
HSE	Health & Safety Executive
IARC	Incident Action Review Committee
IHCR	Integrated Health Care Record
ILS	Immediate Lift Support
INR	International Normalised Ration
IOSH	Institute of Occupational Safety and Health
KAFO	Knee Ankle Foot Orthoses
KIDS	Kids Intensive Care and Decision Support
KPI	Key Performance Indicator
LADO	Local Area Designated Office
MCQ	Multiple Choice Questions
MCSI	Midland Centre for Spinal Injury
MHRA	Medicines Health & Regulatory Agency
MOPD	Main Outpatient Department
MRSA	Methicillin Resistant Staphylococcus Aureus
MSL	Medical Services Limited
MSSA	Methicillin Sensitive Staphylococcus Aureus
MTC	Major Trauma Centre
NEBOSH	National Examination Board in Occupational Safety and Health
NICE	National Institute for Health & Clinical Excellence
NIHR	National Institute of Health Research
NJR	National Joint Registry
NPSA	National Patient Safety Agency

NRLS	National Reporting and Learning System
NSCISB	National Spinal Cord Injury Strategy Board
OSS	Oxford Shoulder Score
PALS	Patient Advice and Liaison Service
PDSA	Plan Do Study Act
PICU	Paediatric Intensive Care Unit
PILS	Paediatric Immediate Life Support
PLACE	Patient Led Assessment of the Care Environment
PONV	Post-Operative Nausea and Vomiting
PROM	Patient Reported Outcome Measures
RCA	Root Cause Analysis
RCN	Royal College of Nursing

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (the 'foundation trust') and its subsidiary (the 'group'):

- **give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2019 and of the group's and foundation trust's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the consolidated statement of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of cash flow;
- the group and foundation trust statements of changes in equity; and
- the related notes 1 to 38.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Summary of our audit approach

Key audit matter	The key audit matter that we identified in the current year was Recognition of NHS clinical revenue.
Materiality	The materiality that we used for the group financial statements was £2.26m which was determined on the basis of 2% of revenue.
Scoping	The focus of audit work was on the foundation trust, with work performed at the Trust's head offices in Oswestry directly by the group audit engagement team, led by the audit partner.
Significant changes in our approach	There have been no changes in the audit scope during the year.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Recognition of NHS Clinical Revenue	
Key audit matter description 	As described in note 1 Accounting Policies and note 1.26 Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are key sources of estimation uncertainty in the recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to: • the complexity of the Payment by Results regime, in particular in determining the level of over performance and revenue to recognise; • the judgemental nature of accounting for disputes, including in respect of outstanding over performance income for quarters 3 and 4; and • the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and agreement of future year contracts. Details of the group's income, including £53.9m (2017/18: £52.9m) of Commissioner Requested Services, are shown in note 3.2 to the financial statements. NHS receivables of £3.8m (2017/18: £5.0m) are shown in note 21 to the financial statements. The Group earns revenue from a wide range of Commissioners, increasing the complexity of agreeing a final year-end position.
How the scope of our audit responded to the key audit matter 	We evaluated the design and implementation of controls over recognition of Payment by Results income, including settling disputes and recognition of over performance. We performed detailed substantive testing on a sample basis of the recoverability of over performance income and adequacy of provision for underperformance through the year, and evaluated the results of the NHS wide agreement of balances exercise.

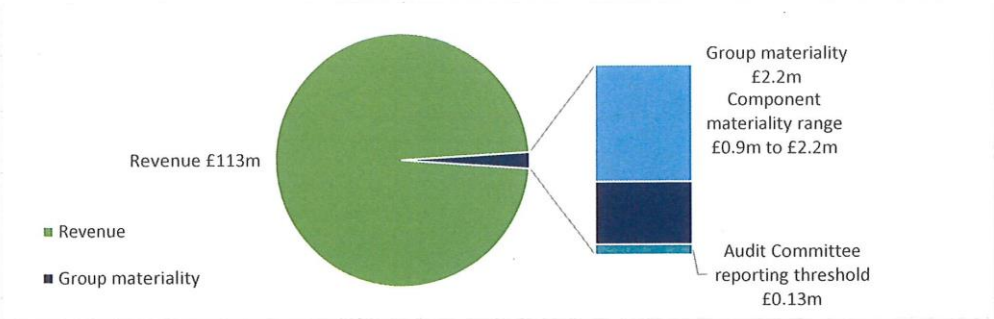
	We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.
Key observations	Based on the work performed above we have concluded that the revenue and provisions recognised are appropriate.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation trust financial statements
Materiality	£2.26m (2017/18: £2.2m)	£2.24m (2017/18: £2.1m)
Basis for determining materiality	2% of revenue (2017/18: 2% of revenue)	2% of revenue (2017/18: 2% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the group is a non-profit organisation, and revenue is a key measure of financial performance for users of the group financial statements.	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the foundation trust financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £113k (2017/18: £107k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed at the Trust's head offices in Oswestry directly by the audit engagement team, led by the audit partner.

Our audit covered all of the entities within the Group, including The Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund, which account for 100% (2017/18: 100%) of the Group's net assets, revenue and surplus.

Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality.

At the Group level we also tested the consolidation process.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

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, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

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

In our opinion:

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

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

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 Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of the Robert Jones and Agnes Hunt 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 foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Gus Miah (Senior statutory auditor)
for and on behalf of Deloitte LLP
Statutory Auditor
Birmingham, United Kingdom
24 May 2019

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2019

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Foreword to the Accounts

These accounts, for the year ended 31 March 2019, have been prepared by the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust Group, comprising the Foundation Trust and the related hospital charity. They have been prepared in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Mark Brandreth**

Job title **Chief Executive & Accounting Officer**

Date **23 May 2019**

Consolidated Statement of Comprehensive Income

	Note	Group 2018/19 £000	Group 2017/18 £000	Foundation Trust 2018/19 £000	Foundation Trust 2017/18 £000
Operating income from patient care activities	3	104,906	99,324	104,906	99,324
Other operating income	4	8,584	8,424	8,008	8,187
Operating expenses	7	(108,200)	(104,186)	(107,946)	(103,967)
Operating surplus from continuing operations		**5,290**	**3,562**	**4,968**	**3,544**
Finance income	12	44	12	39	10
Finance expenses	13	(150)	(174)	(150)	(174)
PDC dividends payable		(1,669)	(1,563)	(1,669)	(1,563)
Net finance costs		**(1,775)**	**(1,725)**	**(1,780)**	**(1,727)**
Other gains	14	6	4	6	4
Surplus for the year from continuing operations		**3,521**	**1,841**	**3,194**	**1,821**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	(4,253)	-	(4,253)	-
Revaluations	18	249	8,061	249	8,061
Total other comprehensive income / (expense) for the period		**(4,004)**	**8,061**	**(4,004)**	**8,061**
Total comprehensive income / (expense) for the period		**(483)**	**9,902**	**(810)**	**9,882**

All income and expenditure is derived from continuing operations and there are no minority interests in the Group.

Statement of Financial Position

	Note	Group		Foundation Trust	
		31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Non-current assets					
Intangible assets	15	2,624	2,298	2,624	2,298
Property, plant and equipment	16	68,879	72,344	68,879	72,344
Receivables	21	892	933	892	933
Total non-current assets		**72,395**	**75,575**	**72,395**	**75,575**
Current assets					
Inventories	20	1,199	1,003	1,199	1,003
Receivables	21	8,125	8,442	8,039	8,516
Cash and cash equivalents	23	6,687	5,083	5,673	4,249
Total current assets		**16,011**	**14,528**	**14,911**	**13,768**
Current liabilities					
Trade and other payables	25	(10,165)	(10,674)	(10,143)	(10,665)
Borrowings	27	(1,191)	(1,176)	(1,191)	(1,176)
Provisions	29	(87)	(91)	(87)	(91)
Other liabilities	26	(174)	(139)	(174)	(139)
Total current liabilities		**(11,617)**	**(12,080)**	**(11,595)**	**(12,071)**
Total assets less current liabilities		**76,789**	**78,023**	**75,711**	**77,272**
Non-current liabilities					
Borrowings	27	(5,884)	(7,060)	(5,884)	(7,060)
Provisions	29	(157)	(196)	(157)	(196)
Total non-current liabilities		**(6,041)**	**(7,256)**	**(6,041)**	**(7,256)**
Total assets employed		**70,748**	**70,767**	**69,670**	**70,016**
Financed by					
Public dividend capital		33,719	33,260	33,719	33,260
Revaluation reserve		20,905	24,909	20,905	24,909
Income and expenditure reserve		15,046	11,847	15,046	11,847
Charitable fund reserves	19	1,078	751	-	-
Total taxpayers' equity		**70,748**	**70,767**	**69,670**	**70,016**

The notes on pages 175 to 214 form part of these accounts.

The financial statements on pages 170 to 174 were approved by the Board and signed on its behalf by:

Signed: 

Name : Mark Brandreth

Position: Chief Executive & Accounting Officer

Date: **23 May 2019**

Statement of Changes in Equity - Group

For year ended 31 March 2019	Group				
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Charitable fund reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' & others' equity at 1 April 2018 - brought forward	**33,260**	**24,909**	**11,847**	**751**	**70,767**
Impact of implementing IFRS 9 on 1 April 2018	-	-	5	-	**5**
Surplus for the year	-	-	3,062	459	**3,521**
Impairments	-	(4,253)	-	-	**(4,253)**
Revaluations	-	249	-	-	**249**
Public dividend capital received	459	-	-	-	**459**
Other reserve movements	-	-	132	(132)	**-**
Taxpayers' & others' equity at 31 March 2019	**33,719**	**20,905**	**15,046**	**1,078**	**70,748**

For year ended 31 March 2018	Group				
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Charitable fund reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' & others' equity at 1 April 2017 - brought forward	**33,260**	**16,848**	**10,026**	**731**	**60,865**
Surplus for the year	-	-	1,762	79	**1,841**
Revaluations	-	8,061	-	-	**8,061**
Other reserve movements	-	-	59	(59)	**-**
Taxpayers' & others' equity at 31 March 2018	**33,260**	**24,909**	**11,847**	**751**	**70,767**

The charitable fund reserves consist of restricted and unrestricted funds which may be spent at the discretion of the trustees in line with the Charity's objectives.

Statement of Changes in Equity - Trust

For year ended 31 March 2019	Foundation Trust			
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' & others' equity at 1 April 2018 - brought forward	**33,260**	**24,909**	**11,847**	**70,016**
Impact of implementing IFRS 9 on 1 April 2018	-	-	5	**5**
Surplus for the year	-	-	3,194	**3,194**
Impairments	-	(4,253)	-	**(4,253)**
Revaluations	-	249	-	**249**
Public dividend capital received	459	-	-	**459**
Taxpayers' & others' equity at 31 March 2019	**33,719**	**20,905**	**15,046**	**69,670**

For year ended 31 March 2018	Foundation Trust			
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' & others' equity at 1 April 2017 - brought forward	**33,260**	**16,848**	**10,026**	**60,134**
Surplus for the year	-	-	1,821	**1,821**
Revaluations	-	8,061		**8,061**
Taxpayers' & others' equity at 31 March 2018	**33,260**	**24,909**	**11,847**	**70,016**

Information on reserves

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 organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in Note 19.

Statement of Cash Flows

	Note	Group 2018/19 £000	Group 2017/18 £000	Foundation Trust 2018/19 £000	Foundation Trust 2017/18 £000
Cash flows from operating activities					
Operating surplus		5,290	3,562	4,968	3,544
Non-cash income and expense:					
Depreciation & amortisation	7	3,237	2,893	3,237	2,893
Income recognised in respect of capital donations	4	(243)	(15)	(320)	(22)
(Increase) / decrease in receivables and other assets		555	(2,831)	611	(2,907)
(Increase) / decrease in inventories		(196)	63	(196)	63
Increase / (decrease) in payables & other liabilities		(658)	995	(659)	1,023
Increase / (decrease) in provisions		(43)	(12)	(43)	(12)
Movements in charitable fund working capital		(92)	5	-	-
Net cash flows from operating activities		**7,850**	**4,660**	**7,598**	**4,582**
Cash flows from investing activities					
Interest received		35	10	35	10
Purchase of intangible assets		(469)	(5)	(469)	(5)
Purchase of PPE		(3,383)	(2,101)	(3,383)	(2,101)
Sales of PPE		6	5	6	5
Receipt of cash donations to purchase assets		243	15	320	22
Net cash flows from charitable fund investing activities		5	2	-	-
Net cash flows used in investing activities		**(3,563)**	**(2,074)**	**(3,491)**	**(2,069)**
Cash flows from financing activities					
Public dividend capital received		459	-	459	-
Movement on loans from DHSC		(1,176)	(1,201)	(1,176)	(1,201)
Interest on loans		(152)	(177)	(152)	(177)
PDC dividend paid		(1,814)	(1,509)	(1,814)	(1,509)
Net cash flows used in financing activities		**(2,683)**	**(2,887)**	**(2,683)**	**(2,887)**
Increase / (decrease) in cash & cash equivalents		**1,604**	**(301)**	**1,424**	**(374)**
Cash & cash equivalents at 1 April - b/f		**5,083**	**5,384**	**4,249**	**4,623**
Cash & cash equivalents at 31 March	23	**6,687**	**5,083**	**5,673**	**4,249**

Notes to the Accounts

Note 1 Accounting Policies

1.0 Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19, issued by the Department of Health & Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected.

The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

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

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment.

1.3 Consolidation

Subsidiaries

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.

Robert Jones and Agnes Hunt Orthopaedic Hospital Charity

The Trust is the corporate Trustee to the Robert Jones and Agnes Hunt Orthopaedic Hospital Charity. The Trust has assessed its relationship to the charity and determined it to be a subsidiary because the Trust is exposed to, or has the rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charity, and has the ability to affect those returns and other benefits through its power over the fund.

The charity's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Trust's accounting policies; and
- Eliminate intra-group transactions, balances, gains and losses.

Details of the charity's key accounting policies and potential variances to IFRS treatment:

- Incoming resources – legacy income – under the SORP the charity recognises revenue when its receipt is probable which is in line with IAS 18.
- Resources expended or provided for – grants made or accrued for. Under the SORP the charity accrues for expenditure when a past event has triggered a requirement to pay, in line with the requirements of IAS 37.

The Trust accounts for no other subsidiaries or any associates, joint ventures or joint operations.

1.4 Income

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enable an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year-end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to its patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

The transaction price is based on the agreed tariff for the completed procedures, although this may be over-ridden by the prior agreement of year-end settlements based on forecast activity for March in order to facilitate a timely closedown of the accounts. Where a patient care spell is incomplete at the year-end, income relating to the partially complete spell is accrued in the same manner as other income and agreed with the commissioner.

Where there are contract/invoice challenges, revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with commissioners but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Note 1 Accounting Policies (continued)

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the Trust does not disclose information regarding the performance obligations part of a contract that has an original expected duration of 1 year or less.
- The Trust does not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The GAM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme (ICR), designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form, and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts, in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or 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 value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition of the benefit.

Other income

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.

Note 1 Accounting Policies (continued)

1.5 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, 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

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The scheme is not designed in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's 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 operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Other Expenses

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

1.7 Property, Plant & 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;
- the cost of the item can be measured reliably; and either
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their individual useful lives.

Note 1 Accounting Policies (continued)

Measurement

All property, plant and equipment is measured initially at cost, representing the cost 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 measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front-line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use, are measured at fair value where there are no restrictions on sale at the reporting date, and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations of specialised buildings based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust has elected to use an optimised approach for a modern equivalent asset valuation at its current site.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying 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 enterprise 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.

Note 1 Accounting Policies (continued)

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, where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Software which is integral to the operation of hardware, for example 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, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised. It is recognised as an operating expense in the period in which it is incurred.

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.

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

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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income-generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.9 Depreciation & Amortisation

Freehold land (as it is considered to have an infinite life), assets under construction/development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year-end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

1.10 Impairments

At each financial year-end, the Trust checks whether there is any indication that any of its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is an indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year-end.

Impairments that arise from a clear consumption of economic benefits 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:

- The impairment charged to operating expenses; and
- The balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of 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.

1.11 Non-Current Assets Held for Sale

Non-current assets intended for disposal are re-classified 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 is 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 abandoned or significant changes made to it.

Following re-classification, the assets are measured at the lower of their existing carrying amount and their "fair value less costs to sell". Depreciation then ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as Held for Sale. Instead, it is retained as an operational asset and its useful life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.12 Donated & Grant Funded Assets

Donated and grant funded non-current assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed 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 purchased assets.

1.13 Leases

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

The Trust as lessee

Assets held under finance leases are initially recognised at the commencement of the lease. The asset is recorded as property, plant and equipment, with a corresponding liability for the obligation to the lessor. 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. Thereafter, the asset is accounted for as an item of property, plant and equipment.

Lease payments are apportioned between a finance cost and the repayment of the liability, so as to achieve a constant rate of finance over the life of the lease.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 Inventories

Inventories are valued at the lower of cost and net realisable value using the First In First Out (FIFO) method.

Inventory stocks are valued at current prices as, due to the high turnover of stocks, this is considered by the Trust to be a reasonable approximation to fair value using the FIFO method.

The Trust does not consider it appropriate to account for inventory stocks where their total value is less than £10k, so their transactions are accounted for in revenue.

1.15 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.16 Financial Assets & Financial Liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics.

This includes 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 and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs, except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition. All the Trust's financial assets and liabilities are measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

Receivables are assessed and expected credit losses determined, so a provision for impairment can be made, based on the following criteria:

- A provision for impairment for outstanding Injury Cost Recovery (ICR) notifications of 21.89% as notified by the Compensation Recovery Unit. This has been reviewed and judged as a reasonable estimate against local claim withdrawal history.
- Receivables relating to invoices raised by the Trust to Welsh, Scottish and Northern Irish NHS bodies are discussed with these bodies and specific provisions made where required.
- All other receivables relating to invoices raised by the Trust are reviewed and specific provisions made where applicable with the remainder provided for on the basis of customer type and local receipting history.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

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

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

The Trust has not applied HM Treasury's discount rates because either settlement is expected within one year and/or the impact of discounting is not material.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with the ongoing activities of the entity.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to them, and in return they settle all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 29 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The 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 NHS Resolution 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.

1.18 Contingencies

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust; or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 Public Dividend Capital (PDC) & PDC Dividend

Public dividend capital (PDC) is a type of public sector equity finance, which represents the Department of Health and Social Care's investment in the Trust. It was originally based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets);
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short-term working capital facility);
- any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (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.

1.20 Value Added Tax

Most of the activities of the 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation Tax

The Trust has determined that it has no corporation tax liability as its income generation activities are all ancillary to its core health objectives and not in competition with the private sector.

1.22 Foreign Currencies

The functional and presentational currency of the Trust is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise.

A transaction which is denominated in a foreign currency is translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are re-translated at the spot exchange rate on 31 March.

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 the Statement of Comprehensive Income in the period in which they arise.

1.23 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. If there are any at 31 March, they are disclosed in a separate note to the accounts.

1.24 Losses & 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 on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its 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 accruals basis with the exception of provisions for future losses.

Note 1 Accounting Policies (continued)

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical accounting judgements

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Charitable funds – determining whether charitable funds are a subsidiary of the Trust, and whether they are material, to determine whether or not to consolidate (see Note 1.3).

Key sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amount of assets and liabilities within the next financial year.

1. **Property valuations** – as detailed in Note 18, Avison Young provided the Trust with a valuation as at 31 March 2019 of land and building assets (estimated fair value and remaining useful life), based on depreciated replacement value, using the modern equivalent asset method of valuation. This valuation, which is based on estimates, led to a decrease in the carrying value of the Trust's land and buildings of £4m. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.

2. **Healthcare income** – discussions are held with all commissioners regularly regarding activity levels against their contracts, particularly around the year-end. Over and under performance against contracts is calculated and the relevant income adjustments made. £3.6m of income from over-performance against contract activity was offset by £1.2m of under-performance against contracts with other commissioners. In addition, partially completed spells are calculated as at 31 March and the income accrued. This involves estimation of the amount and timing of when performance obligations have been satisfied in line with IFRS 15.

1.27 Early adoption of standards, amendments & interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1 Accounting Policies (continued)

1.28 Standards, amendments & interpretations in issue but not yet effective or adopted

IFRS 16 Leases – application required for accounting periods beginning on or after 1 January 2019 but not yet adopted by the FReM (postponed to 2020/21).

IFRS 17 Insurance Contracts – application required for accounting periods beginning on or after 1 January 2021 but not yet adopted by the FReM.

IFRS 23 Uncertainty over Income Tax Treatments – application required for accounting periods beginning on or after 1 January 2019.

Of the above standards, only IFRS 16 is expected to have an effect on the financial statements, with increased leased items being brought on to the Statement of Financial Position. The full impact of this has not yet been quantified.

Note 2 : Operating Segments

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust Group consists of the Foundation Trust and the related NHS charity. The segmental analysis based on the Group entities is shown below.

	Group	
	2018/19 £000	2017/18 £000
Foundation Trust income attributable to the Group	112,782	107,452
Charity income attributable to the Group	708	296
Total RJAH Group operating income	**113,490**	**107,748**
Foundation Trust surplus attributable to the Group	3,194	1,821
Charity surplus attributable to the Group	327	20
Total RJAH Group operating surplus	**3,521**	**1,841**
Foundation Trust net assets attributable to the Group	69,670	70,016
Charity net assets attributable to the Group	1,078	751
Total RJAH net assets	**70,748**	**70,767**

No material income attributable to the Group was received by the Charity from any single source during 2018/19 or 2017/18.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is a specialist hospital with only one business element of healthcare. Reports to the Board (the Chief Operating Decision Maker as defined by IFRS 8 Operating Segments) are on this basis.

Therefore no further analysis is required for the Foundation Trust.

Note 3 : Operating Income From Patient Care Activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Commissioner requested services are defined within the Foundation Trust's provider licence and are services that commissioners believe would need to be protected in the event of provider failure. All the acute services income in the table below is derived from commissioner requested services.

No income for healthcare is received by the charity, so the income below relates solely to the Foundation Trust.

Note 3.1 : Income from patient care activities (by nature)

	Group & Foundation Trust	
	2018/19 £000	2017/18 £000
Acute services		
Elective income	56,436	55,481
Non-elective income	4,586	4,367
First outpatient income	6,625	6,418
Follow-up outpatient income	10,026	8,580
High cost drugs income from commissioners (excluding pass-through costs)	4,516	5,236
Other NHS clinical income	15,214	13,073
All services		
Private patient income	5,776	5,447
Agenda for Change pay award central funding	974	-
Other clinical income *(includes injury cost recovery scheme)*	753	722
Total income from activities	**104,906**	**99,324**

Note 3.2 : Income from patient care activities (by source)

	Group & Foundation Trust	
	2018/19 £000	2017/18 £000
Income from patient care activities received from:		
NHS England	16,518	15,639
Clinical commissioning groups	53,898	52,864
Department of Health & Social Care	974	-
Other NHS providers	46	64
Non-NHS: private patients	5,776	5,447
Injury cost recovery scheme *(note 1)*	694	655
Non-NHS: other *(note 2)*	27,000	24,655
Total income from activities	**104,906**	**99,324**

Note 1 - injury costs recovery scheme income is subject to a provision for impairment of receivables of 21.89% to reflect expected rates of collection.

Note 2 - the majority of the non-NHS other income is from Welsh NHS bodies for patients referred by Welsh GPs, not necessarily living in Wales, and with a Welsh postcode (2018/19: £26,929k and 2017/18: £24,553k).

Note 3 - there was no income from oversea visitors in either 2018/19 or 2017/18.

Note 4 : Other Operating Income

	Group		Foundation Trust	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:				
Research & development (contract)	738	814	738	814
Education & training (excl notional apprenticeship levy income)	1,241	1,448	1,241	1,448
Non-patient care services to other bodies	43	21	43	21
Provider sustainability / sustainability & transformation fund income (PSF / STF) *(note 1)*	2,350	1,807	2,350	1,807
Sale of goods & services	1,239	1,233	1,226	1,233
Catering	529	521	529	521
Car parking	421	361	421	361
Other contract income *(note 2)*	376	1,221	389	1,221
Other non-contract operating income:				
Education & training - notional income from apprenticeship fund	97	19	97	19
Receipt of capital grants & donations	243	15	320	22
Charitable and other contributions to expenditure	-	2	55	54
Rental revenue from operating leases	599	666	599	666
Charitable fund incoming resources	708	296	-	-
Total other operating income	**8,584**	**8,424**	**8,008**	**8,187**

Note 1 - the PSF (previously the STF) is a mechanism to allocate centrally held support to NHS provider organisations, based on the achievement of a number of performance targets.

Note 2 - other contract income includes contributions to services, sponsorship income, and accommodation/room rental.

Note 5 : Additional Information on Contract Revenue Recognised In The Period

	Group & Foundation Trust 2018/19 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end (i.e. release of deferred income)	139

Note 6 : Fees & Charges

There are no fees or charges where individually the full costs exceed £1m.

Note 7 : Operating Expenses

Note 7.1 : Analysis of operating expenses

	Group	
	2018/19 £000	2017/18 £000
Purchase of healthcare from non-NHS & non-DHSC bodies	-	36
Staff and executive directors' costs	64,114	59,494
Remuneration of non-executive directors	110	109
Supplies & services - clinical (excluding drugs costs)	20,397	20,411
Supplies & services - general	1,423	1,600
Drug costs (drugs inventory consumed & purchase of non-inventory drugs)	6,460	7,213
Inventories written down	121	162
Consultancy costs	260	313
Establishment *(note 1)*	886	922
Premises	4,303	4,321
Transport (including patient travel)	789	708
Depreciation on property, plant & equipment	3,122	2,816
Amortisation on intangible assets	115	77
Movement in credit loss allowance: contract receivables / contract assets	80	-
Movement in credit loss allowance: all other receivables & investments	-	84
Audit fees payable to the external auditor		
audit services - statutory audit	52	52
other auditor remuneration (external auditor only)	14	22
Internal audit costs	59	121
Clinical negligence	2,325	2,446
Legal fees	63	42
Insurance	97	64
Research & development	662	680
Education & training	461	392
Rentals under operating leases	1,013	879
Redundancy	106	-
Car parking & security	87	67
Losses, ex-gratia & special payments	26	137
Other support services *(note 2)*	479	510
Other NHS charitable fund resources expended	249	214
Other	327	294
Total	**108,200**	**104,186**

Note 1 - establishment costs include printing, stationery, telephones and postage.

Note 2 - other support services includes, payroll, procurement and occupational health.

Note 3 - operating expenses figures relating to the charity are the "Other NHS charitable fund resources expended" line above and £5k (2018/19 and 2017/18) of the "Audit services - statutory audit" line.

Note 7.2 : Other auditor remuneration

	Group	
	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	12	22
Expenses	2	-
Total	**14**	**22**

The limitation on auditor's liability for external audit work, in accordance with their engagement letter, is £1m (2017/18: £1m).

Note 8 : Impairment of Assets

	Group & Foundation Trust	
	2018/19 £000	2017/18 £000
Impairments charged to the revaluation reserve	4,253	-
Total impairments	**4,253**	**-**

This impairment relates to the full revaluation of land and buildings carried out in the year.

Note 9 : Employee Benefits

Note 9.1 : Staff costs

	Group & Foundation Trust	
	2018/19 £000	2017/18 £000
Salaries & wages	50,378	46,650
Social security costs	4,690	4,387
Apprenticeship levy	227	213
Employer's contributions to NHS pensions	5,880	5,474
Pension cost - other	7	3
Termination benefits	106	24
Temporary staff (including agency)	4,419	4,403
Total gross staff costs	**65,707**	**61,154**
Recoveries in respect of seconded staff	(752)	(941)
Total staff costs	**64,955**	**60,213**
Of which: costs capitalised as part of assets	156	112

Note 9.2 : Retirements due to ill-health

During 2018/19 there were no early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). There is therefore no additional liability. (The estimated additional pension liabilities of the ill-health retirements in 2017/18 are £32k).

Note 10 : Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019 is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care has recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018, Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

The Group also makes contributions to the National Employment Savings Trust (NEST) pension scheme. This is a defined contribution scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008.

Note 11 : Operating Leases

Note 11.1 : Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

The Trust rents out a small proportion of the hospital buildings to partner organisations which complement the service it provides.

	Group & Foundation Trust	
	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	599	666
Total	**599**	**666**
Future minimum lease receipts due:		
- not later than 1 year	300	580
- later than 1 year & not later than 5 years	163	109
Total	**463**	**689**

Note 11.2 : Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

The Trust has one significant operating lease for an operating theatre modular building (Menzies Day Case Unit) at a cost of £412k for 2018/19 (£398k in 2017/18). Other smaller leases relate to medical equipment, including an MRI scanner and a CT scanner, I/T equipment and lease cars.

	Group & Foundation Trust	
	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,013	879
Total	**1,013**	**879**
Future minimum lease payments due:		
- not later than 1 year	1,006	894
- later than 1 year & not later than 5 years	2,444	2,156
- later than 5 years	1,173	1,418
Total	**4,623**	**4,468**

The future minimum lease payments represent the remaining contractual obligations. The remaining duration of contracts will vary as leases reach maturity at different dates.

Note 12 : Finance Income

	Group	
	2018/19 £000	2017/18 £000
Interest on bank accounts	39	10
NHS charitable fund investment income	5	2
Total finance income	**44**	**12**

Note 13 : Finance Expenditure

	Group & Foundation Trust	
	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health & Social Care	150	173
Interest on late payment of commercial debt	-	1
Total finance costs	**150**	**174**

The Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015:

Total liability accruing in year under this legislation as a result of late payments	-	1
Amounts included within interest payable from claims made under this legislation	-	1

Note 14 : Other Net Gains

	Group & Foundation Trust	
	2018/19 £000	2017/18 £000
Gains on disposal of assets	6	5
Losses on disposal of assets	-	(1)
Net gains on disposal of assets	**6**	**4**

Note 15 : Intangible Assets

All intangible assets are held by the Foundation Trust.

Note 15.1 : Intangible assets - 2018/19

	Group & Foundation Trust		
	Software licences	Intangible assets under development	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**795**	**1,738**	**2,533**
Additions	384	57	**441**
Reclassifications	88	(88)	**-**
Valuation / gross cost at 31 March 2019	**1,267**	**1,707**	**2,974**
Amortisation at 1 April 2018 - brought forward	**235**	**-**	**235**
Provided during the year	115	-	**115**
Amortisation at 31 March 2019	**350**	**-**	**350**
Net book value at 31 March 2019	**917**	**1,707**	**2,624**
Net book value at 1 April 2018	**560**	**1,738**	**2,298**

The minimum and maximum useful economic lives of the software licences are 2 years and 7 years respectively. Useful economic lives reflect the total life of an asset, not the remaining life.

Note 15.2 : Intangible assets - 2017/18

	Group & Foundation Trust		
	Software licences	Intangible assets under development	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**1,875**	**538**	**2,413**
Additions	93	88	**181**
Reclassifications	(1,112)	1,112	**-**
Disposals / derecognition	(61)	-	**(61)**
Valuation / gross cost at 31 March 2018	**795**	**1,738**	**2,533**
Amortisation at 1 April 2017 - brought forward	**219**	**-**	**219**
Provided during the year	77	-	**77**
Disposals / derecognition	(61)	-	**(61)**
Amortisation at 31 March 2018	**235**	**-**	**235**
Net book value at 31 March 2018	**560**	**1,738**	**2,298**
Net book value at 1 April 2017	**1,656**	**538**	**2,194**

Note 16 : Property, Plant & Equipment

All property, plant and equipment is held by the Foundation Trust.

Note 16.1 : Property, plant & equipment - 2018/19

	Group & Foundation Trust								
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**1,455**	**66,273**	**148**	**486**	**8,491**	**25**	**1,654**	**319**	**78,851**
Additions	-	2,430	-	320	676	-	217	18	**3,661**
Impairments *(note 1)*	-	(4,253)	-	-	-	-	-	-	**(4,253)**
Revaluations *(note 1)*	168	(2,282)	72	-	-	-	-	-	**(2,042)**
Reclassifications	-	293	-	(293)	-	-	-	-	**-**
Disposals / derecognition *(note 2)*	-	-	-	-	(120)	-	-	-	**(120)**
Valuation/gross cost at 31 March 2019	**1,623**	**62,461**	**220**	**513**	**9,047**	**25**	**1,871**	**337**	**76,097**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**14**	**-**	**-**	**5,146**	**25**	**1,116**	**206**	**6,507**
Provided during the year	-	2,268	9	-	603	-	210	32	**3,122**
Revaluations *(note 1)*	-	(2,282)	(9)	-	-	-	-	-	**(2,291)**
Disposals / derecognition *(note 2)*	-	-	-	-	(120)	-	-	-	**(120)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**5,629**	**25**	**1,326**	**238**	**7,218**
Net book value at 31 March 2019	**1,623**	**62,461**	**220**	**513**	**3,418**	**-**	**545**	**99**	**68,879**
Net book value at 1 April 2018	**1,455**	**66,259**	**148**	**486**	**3,345**	**-**	**538**	**113**	**72,344**

Note 1 - the revaluations and impairments are as a result of the revaluation of all land and buildings by Avison Young. This resulted in an upwards revaluation for land and dwellings and a downwards revaluation (impairment) for other buildings.

Note 2 - the disposals relate to the old CT scanner, replaced by a new one in 2018/19.

Note 16.2 : Property, plant & equipment - 2017/18

	Group & Foundation Trust								
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**1,455**	**58,966**	**135**	**532**	**7,592**	**25**	**2,369**	**272**	**71,346**
Additions	-	862	-	191	1,099	-	38	50	**2,240**
Revaluations *(note 1)*	-	6,046	13	-	-	-	-	-	**6,059**
Reclassifications	-	399	-	(237)	-	-	(162)	-	**-**
Disposals / derecognition *(note 2)*	-	-	-	-	(200)	-	(591)	(3)	**(794)**
Valuation/gross cost at 31 March 2018	**1,455**	**66,273**	**148**	**486**	**8,491**	**25**	**1,654**	**319**	**78,851**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**-**	**-**	**-**	**4,805**	**25**	**1,477**	**179**	**6,486**
Provided during the year	-	2,011	5	-	540	-	230	30	**2,816**
Revaluations *(note 1)*	-	(1,997)	(5)	-	-	-	-	-	**(2,002)**
Disposals / derecognition *(note 2)*	-	-	-	-	(199)	-	(591)	(3)	**(793)**
Accumulated depreciation at 31 March 2018	**-**	**14**	**-**	**-**	**5,146**	**25**	**1,116**	**206**	**6,507**
Net book value at 31 March 2018	**1,455**	**66,259**	**148**	**486**	**3,345**	**-**	**538**	**113**	**72,344**
Net book value at 1 April 2017	**1,455**	**58,966**	**135**	**532**	**2,787**	**-**	**892**	**93**	**64,860**

Note 1 - the revaluation is as a result of the desk-top revaluation of land and buildings by the Valuation Office Agency.

Note 2 - the disposals relate to beds disposed of as part of the bed replacement scheme, and old I/T equipment.

Note 16.3 : Property, plant & equipment financing - 2018/19

	Group & Foundation Trust								
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	1,623	49,149	220	513	2,875	-	545	70	**54,995**
Owned - donated	-	13,312	-	-	543	-	-	29	**13,884**
NBV total at 31 March 2019	**1,623**	**62,461**	**220**	**513**	**3,418**	**-**	**545**	**99**	**68,879**

Note 16.4 : Property, plant & equipment financing - 2017/18

	Group & Foundation Trust								
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	1,455	51,879	148	486	2,896	-	538	78	**57,480**
Owned - government granted	-	313	-	-	-	-	-	-	**313**
Owned - donated	-	14,067	-	-	449	-	-	35	**14,551**
NBV total at 31 March 2018	**1,455**	**66,259**	**148**	**486**	**3,345**	**-**	**538**	**113**	**72,344**

Note 16.5 : Economic lives of property, plant & equipment

The minimum and maximum useful economic lives of each class of asset are given in the table below. Useful economic lives refect the total life of an asset, not the remaining life.

	Group & Foundation Trust	
	Min Life Years	Max Life Years
Land	N/A	N/A
Buildings excluding dwellings	5	67
Dwellings	6	61
Plant & machinery	5	31
Transport equipment	7	7
Information technology	3	8
Furniture & fittings	5	15

Note 17 : Donations of Property, Plant & Equipment

The Foundation Trust did not receive any physical donations of property, plant and equipment in either 2018/19 or 2017/18.

Cash donations were received by the Foundation Trust to purchase property, plant and equipment. All cash received was utilised for this purpose. Donations were received from:

The League of Friends - £238k (2017/18: £15k)

The RJAH charity - £77k (2017/18: £7k)

Other - £5k (2017/18: nil)

Note 18 : Revaluations of Property, Plant & Equipment

For 2018/19, a full revaluation of land and buildings was undertaken by Avison Young with an effective date of 31 March 2019. This resulted in an overall decrease in value of £4,004k.

The valuations were undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the NHS, and the requirements of the RICS Valuation Professional Standards.

The valuations are carried out on a Modern Equivalent Asset (MEA) basis, using an optimised approach to land and building constitution.

Note 19 : Analysis of Charitable Fund Reserves

The Robert Jones and Agnes Hunt Orthopaedic Hospital Charity accounts are consolidated within these accounts. The Charity is fully controlled by the Foundation Trust as its corporate trustee, and is therefore consolidated in full into the Group.

The charitable fund reserves can be made up of 2 types of funds:

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Currently there are both unrestricted and restricted funds held by the charity. Balances are:

	Group	
	31 March 2019 £000	31 March 2018 £000
Unrestricted funds:		
Unrestricted income funds	957	751
Restricted funds:		
Other restricted income funds	121	-
	1,078	**751**

Note 20 : Inventories

All inventories are finished goods and are held by the Foundation Trust.

	Group & Foundation Trust	
	31 March 2019 £000	31 March 2018 £000
Drugs	147	148
Consumables	992	810
Energy	60	45
Total inventories	**1,199**	**1,003**

Inventories recognised in expenses for the year were £11,629k (2017/18: £11,794k). Write-down of inventories recognised as expenses for the year were £121k (2017/18: £162k).

Note 21 : Receivables

Note 21.1 : Analysis of receivables

	Group		Foundation Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Contract receivables*	6,978	-	6,978	-
Trade receivables*	-	1,440	-	1,440
Accrued income*	-	4,590	-	4,590
Allowance for impaired contract receivables / assets*	(442)	-	(442)	-
Allowance for other impaired receivables	-	(425)	-	(425)
Prepayments (non-PFI)	1,181	1,266	1,181	1,266
Interest receivable	4	-	4	-
PDC dividend receivable	84	-	84	-
VAT receivable	202	170	202	170
Other receivables	14	1,401	32	1,475
NHS charitable funds: trade and other receivables	104	-	-	-
Total current receivables	**8,125**	**8,442**	**8,039**	**8,516**
Non-current				
Contract receivables*	1,103	-	1,103	-
Allowance for impaired contract receivables / assets*	(241)	-	(241)	-
Allowance for other impaired receivables	-	(265)	-	(265)
Prepayments (non-PFI)	30	39	30	39
Other receivables	-	1,159	-	1,159
Total non-current receivables	**892**	**933**	**892**	**933**
Of which receivable from NHS and DHSC group bodies:				
Current	3,790	5,004		
Non-current	-	-		

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 21.2 : Allowances for credit losses - 2018/19

	Group & Foundation Trust	
	Contract receivables & contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2018 - brought forward	**-**	**690**
Impact of implementing IFRS 9 (& IFRS 15) on 1 April 2018	685	(690)
New allowances arising	63	-
Changes in existing allowances	45	-
Reversals of allowances	(28)	-
Utilisation of allowances (write-offs)	(82)	-
Allowances as at 31 March 2019	**683**	**-**

Note 21.3 : Allowances for credit losses - 2017/18

IFRS 9 & IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Group & Foundation Trust
	2017/18
	£000
Allowances as at 1 April 2017	**609**
Increase in provision	88
Amounts utilised	(3)
Unused amounts reversed	(4)
Allowances as at 31 March 2018	**690**

Note 22 : Non-Current Assets Held for Sale

There were no non-current assets held for sale in either 2018/19 or 2017/18.

Note 23 : Cash & Cash Equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Foundation Trust	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
At 1 April	**5,083**	**5,384**	**4,249**	**4,623**
Net change in year	1,604	(301)	1,424	(374)
At 31 March	**6,687**	**5,083**	**5,673**	**4,249**
Broken down into:				
Cash at commercial banks & in hand	18	514	8	10
Cash with the Government Banking Service	6,669	4,569	5,665	4,239
Total cash and cash equivalents	**6,687**	**5,083**	**5,673**	**4,249**

Note 24 : Third Party Assets Held by the Trust

There were no third party assets held in either 2018/19 or 2017/18.

Note 25 : Trade & Other Payables

	Group		Foundation Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Trade payables	2,894	2,539	2,894	2,539
Capital payables	1,129	879	1,129	879
Accruals	3,056	4,314	3,056	4,314
Receipts in advance & payments on account	2	2	2	2
Social security costs	713	660	713	660
Other taxes payable	642	599	642	599
PDC dividend payable	-	61	-	61
Accrued interest on loans *(note 1)*	-	17	-	17
Other payables *(note 2)*	1,707	1,593	1,707	1,594
NHS charitable funds: trade & other payables	22	10	-	-
Total current trade & other payables	**10,165**	**10,674**	**10,143**	**10,665**
Of which payables from NHS & DHSC group bodies:	1,291	1,316		

Note 1 - following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within Note 27. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 2 - other payables mainly includes outstanding pension contributions and payments to staff.

Note 26 : Other Liabilities

	Group & Foundation Trust	
	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	156	128
Deferred grants	18	11
Total other current liabilities	**174**	**139**

These liabilities relate to income from private patients received in advance of treatment, and research income/grants received in advance of the research taking place.

Note 27 : Borrowings

Note 27.1 : Analysis of borrowings

	Group & Foundation Trust	
	31 March 2019 £000	31 March 2018 £000
Current		
Loans from DHSC	1,191	1,176
Total current borrowings	**1,191**	**1,176**
Non-current		
Loans from DHSC	5,884	7,060
Total non-current borrowings	**5,884**	**7,060**
Total borrowings	**7,075**	**8,236**

The outstanding loan is a £10m capital investment loan taken out in August 2015, repayable over 10 years at an interest rate of 1.92%. The principal is repaid at 6 monthly intervals until February 2025. The loan was used to finance the building of the Theatre and Tumour Unit.

Note 27.2 : Reconciliation of liabilities from financing activities

The only financing activity the Trust has is the DHSC loan.

	Group & Foundation Trust
	2018/19 £000
Carrying value at 1 April 2018	**8,236**
Cash movements:	
Financing cash flows - payments of principal	**(1,176)**
Financing cash flows - payments of interest	**(152)**
Non-cash movements:	
Impact of implementing IFRS 9 on 1 April 2018	**17**
Application of effective interest rate	**150**
Carrying value at 31 March 2019	**7,075**

Note - in the year of adoption, a comparative disclosure is not required for this reconciliation.

Note 28 : Finance Leases

There were no finance leases held in either 2018/19 or 2017/18.

Note 29 : Provisions for Liabilities & Charges

	Group & Foundation Trust			
	Pensions (early departures)	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2018	**114**	**13**	**160**	**287**
Arising during the year	-	7	-	**7**
Utilised during the year	(39)	(1)	(8)	**(48)**
Reversed unused	-	(2)	-	**(2)**
At 31 March 2019	**75**	**17**	**152**	**244**
Expected timing of cash flows:				
- not later than 1 year	38	17	32	**87**
- later than 1 year & not later than 5 years	37	-	120	**157**
- later than 5 years	-	-	-	**-**
Total	**75**	**17**	**152**	**244**

The pensions relate to NHS pensions payable to staff given early retirement prior to 1995. These are administered and invoiced for by the NHS Business Services Agency Pensions Division with total liability estimated based on life expectancy.

The legal claims relate to employer's and public liability claims handled by NHS Resolution. Liability is limited to the scheme excess.

Other relates to the dismantling charges for the day case unit at the end of the lease and a claim from a supplier.

At 31 March 2019, £9,767k was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2018: £18,694k).

Note 30 : Contingent Assets & Liabilities

There were no contingent assets in 2018/19 or 2017/18.

	Group & Foundation Trust	
	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(16)	(14)
Gross value of contingent liabilities	**(16)**	**(14)**

Note 31 : Contractual Capital Commitments

	Group & Foundation Trust	
	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	1,667	756
Total	**1,667**	**756**

Note 32 : Other Financial Commitments

The Group is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made:

	Group & Foundation Trust	
	31 March 2019 £000	31 March 2018 £000
Not later than 1 year	644	776
After 1 year and not later than 5 years	265	607
Total	**909**	**1,383**

Note 33 : Financial Instruments

Note 33.1 : Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with commissioners and the way those commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Foundation Trust's investment policy limits the investment of surplus funds to institutions with a low risk rating. The charity's investment policy is consistent with that of the Foundation Trust. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

The Group's treasury management operations are carried out by the finance department. For the Foundation Trust, this is within parameters defined formally within its Standing Financial Instructions and policies agreed by the board of directors. For the charity, this is within parameters defined formally within the charity's governing document and the Charitable Funds Committee terms of reference. Treasury activity is subject to review by the Group's internal auditors.

Currency risk

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

Interest rate risk

The Foundation Trust holds a DHSC loan, with interest charged at the prevailing National Loans Fund rate when the loan was taken out. The Foundation Trust therefore has low exposure to interest rate fluctuations. The charity has no borrowings.

Credit risk

Because the majority of the Foundation Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the receivables note. The charity does not hold material receivables balances. With its income coming from voluntary donations and legacies, the charity is also considered to have a low exposure to risk.

Liquidity risk

The Group's operating costs are incurred under contracts with commissioning organisations, which are financed from resources voted annually by Parliament. The Foundation Trust funds its capital expenditure from resources voted annually by parliament, internally generated surpluses, donations, and through borrowing via the National Loans Fund. The Group is not, therefore, exposed to significant liquidity risks.

Note 33.2 : Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 as the measurement categories differ to those in the current year analysis.

2018/19 - all at amortised cost under IFRS 9	**Group 31 March 2019 £000**	**Foundation Trust 31 March 2019 £000**
Receivables (excluding non-financial assets)	7,416	7,416
Cash & cash equivalents	5,673	5,673
Consolidated NHS Charitable fund financial assets	1,118	-
Total at 31 March 2019	**14,207**	**13,089**

2017/18 - all loans & receivables under IAS 39	**Group 31 March 2018 £000**	**Foundation Trust 31 March 2018 £000**
Trade & other receivables (excluding non-financial assets)	6,065	6,065
Cash & cash equivalents	4,249	4,249
Consolidated NHS Charitable fund financial assets	834	-
Total at 31 March 2018	**11,148**	**10,314**

Carrying value (book value) of these financial assets is assumed to be a reasonable approximation of fair value.

Note 33.3 : Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 as the measurement categories differ to those in the current year analyses.

2018/19 - all at amortised cost under IFRS 9	**Group 31 March 2019 £000**	**Foundation Trust 31 March 2019 £000**
Loans from the Department of Health & Social Care	7,075	7,075
Trade & other payables (excluding non-financial liabilities)	8,786	8,786
Consolidated NHS charitable fund financial liabilities	22	-
Total at 31 March 2019	**15,883**	**15,861**

2018/19 - all at amortised cost under IAS 39	**Group 31 March 2018 £000**	**Foundation Trust 31 March 2018 £000**
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health & Social Care	8,236	8,236
Trade & other payables (excluding non-financial liabilities)	9,344	9,344
Consolidated NHS charitable fund financial liabilities	10	-
Total at 31 March 2018	**17,590**	**17,580**

Carrying value (book value) of these financial liabilities is assumed to be a reasonable approximation of fair value.

Note 33.4 : Maturity of financial liabilities

	Group		Foundation Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
In one year or less	9,999	10,530	9,977	10,520
In more than one year but not more than two years	1,176	1,176	1,176	1,176
In more than two years but not more than five years	3,528	3,528	3,528	3,528
In more than five years	1,180	2,356	1,180	2,356
Total	**15,883**	**17,590**	**15,861**	**17,580**

Note 34 : Losses & Special Payments

	Group & Foundation Trust			
	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	7	1	1	-
Bad debts & claims abandoned	81	82	70	3
Stores losses & damage to property	2	121	2	162
Total losses	**90**	**204**	**73**	**165**
Special payments				
Ex-gratia payments	100	16	76	123
Special severence payments	1	4	-	-
Total special payments	**101**	**20**	**76**	**123**
Total losses and special payments	**191**	**224**	**149**	**288**

Losses and special payments are accounted for on an accruals basis, but exclude provisions for future losses.

Note 35 : Application of New Standards

Note 35.1 : Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, and a new forward-looking 'expected loss' impairment model.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £17k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £5k increase in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1,366k.

Note 35.2 : Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient in C7A of the standard, removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 36 : Related Parties

During the year no Department of Health & Social Care ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Group.

The Department of Health is regarded as a related party. During the year the Group 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. The most significant are:

NHS England
NHS Resolution
Shropshire CCG
Telford & Wrekin CCG
West Cheshire CCG

The Group has had a number of material transactions with UK devolved governments. These transactions have been for the provision of healthcare, mainly with Welsh NHS bodies which are funded by the Welsh Assembly.

Betsi Cadwaladr University LHB
Powys LHB

The Group has also had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Shropshire Council in respect of non-domestic rates.

Note 37 : Events After the Reporting Date

There were no events after the reporting date.

Note 38 : Control Total Reconciliation

The table below shows the Foundation Trust's performance against the control total set by NHS Improvement.

	Foundation Trust	
	2018/19	2017/18
	£000	£000
Surplus for the year	**3,194**	**1,821**
Remove capital donations/grants I&E impact	288	532
Adjusted financial performance	**3,482**	**2,353**
Less provider sustainability fund (PSF)	(2,350)	(1,807)
Adjusted financial performance, excluding PSF	**1,132**	**546**
Control total excluding PSF	(1,104)	(513)
Performance against the control total, excluding PSF	**28**	**33**