The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Annual Report and Accounts 2020–2021

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Annual Report and Accounts for the period of 1 April 2020 to 31 March 2021

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

Contents

ANNUAL REPORT

INTRODUCTION

Statement of Chairman, Substantive and Acting Chief Executive Officer

At The Robert Jones and Agnes Hunt (RJAH) 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 we receive from our patients on the quality of the care and services that we provide.

The following Annual Report details our performance for the 2020/21 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.

It won't come as any surprise that we start by recognising the profound impact that the Covid-19 pandemic had on the NHS, the effects of which we are still experiencing. At the beginning of the pandemic we suspended our non-emergency elective work and took on orthopaedic trauma work for Shropshire, Telford & Wrekin, and ambulatory trauma work for North Wales, as part of supporting the regional response to the Covid-19 pandemic.

Between March and September 2020, Chief Executive Officer Mark Brandreth was working in a national role as part of the NHS response to the pandemic and so was away from RJAH, and during this period Stacey Keegan, Chief Nurse, took on the role of Acting CEO supported by our Senior Leadership Team. We would like to place on record our grateful thanks to Stacey for her calm, compassionate and tenacious leadership during that period of immense challenge. Our thanks also go to the Senior Leadership Team for their hard work and support.

We were able to resume some elective work during the autumn of 2020, before the second wave of the pandemic took hold. In January 2021, we paused routine elective surgery in order to release staff to support critical care services across Shropshire, Telford & Wrekin. We also had staff working in the vaccination service at this important time.

We would like to express our sincere thanks to **all** of our staff for their hard work during the most difficult period our NHS has ever faced – be it those who were redeployed from their usual roles at RJAH to work with our partners at Shrewsbury and Telford Hospital NHS Trust (SaTH) or perhaps on other duties within the Trust, to those who have and are continuing to support the excellent vaccination service, those colleagues doing their jobs from home and, of course, those who continued to work in their usual roles at RJAH despite the clear uncertainties and anxieties they faced. Each and every member of our staff has worked tremendously hard to either care for our patients or support the delivery of care and we are both proud of their efforts and grateful for all that they have collectively achieved.

There are so many reasons to look back on this last year with pride. A real highlight was the opening of the RJAH Vaccination Hospital Hub at the beginning of January 2021. By early March

2021, the hub transitioned into a vaccination centre, meaning more people are able to get vaccinated at the RJAH centre, as patients became able to book their appointments through the national booking system.

Once again, we were also delighted with the excellent feedback we received from our patients over the past year. Overall patient experience at RJAH was rated as the best in the country compared to other NHS Trusts, according to the annual Adult Inpatient Survey carried out by the Care Quality Commission (CQC). As part of the survey results, RJAH was also named as one of just nine organisations placed in the top band of Trusts delivering results that are considered "much better than expected", delivering patient experience that is substantially better than elsewhere. The same survey also saw the food we prepare and serve at RJAH rated as the best in the country for the 14th time in 15 years, as well as the wards being highlighted as the cleanest in the country – for the second year running.

Then there was the National NHS Staff Survey – of the 57% of RJAH staff who responded to the staff survey, a record 96% of staff said they would be happy with the standard of care provided if a friend or relative needed treatment. It is the fourth year in a row that the Trust secured the highest marks in response to this question from a survey completed by staff at more than 300 NHS employers. We also scored highly as a place to work, with 79% of staff saying they would recommend RJAH.

At the end of March 2021, the Trust bid farewell to Mr Steve White, who retired from his role as Chief Medical Officer, a post he had held since 2012. We would like to thank him for all of his hard work, support and leadership during that time. Succeeding Mr White was experienced Consultant Anaesthetist Dr Ruth Longfellow, who previously worked in the role of Associate Medical Director. She assumed her new role in April 2021, immediately after the period covered by this report.

In terms of technology, a brand new, state-of-the-art MRI scanner was unveiled in the Radiology department in October 2020. The new scanner formed part of an investment of over £1 million to replace the oldest of the Trust's two scanners, meaning that RJAH is once again at the forefront of scanning capability and image quality, especially for those patients with hip and knee replacements.

During an unprecedented year we continue to focus on delivery of safe, high quality services for our patients, underpinned by robust business management.

A Covid-19 financial framework was put in place across the NHS to simplify financial arrangements to support organisational responses to the pandemic.

Under the framework the Trust was required to control expenditure and deliver a breakeven position across the year, and this was achieved successfully under a block contract regime and with top up funding as required as part of the additional support put in place during Covid-19. The Trust also secured additional funding to recognise the cost of untaken leave at the year-end which has been carried forward into 2021/22 and £3.2m funding to recognise lost income from non NHS services which helped the Trust finish the year with an overall surplus of £4.5 million. This allows for additional investment in the capital programme to improve care for patients.

It is important to note that the Shropshire, Telford and Wrekin Integrated Care System has significant financial issues with an underlying deficit target of £110m for 2021/22 and towards the end of 2020/21 was placed into formal "financial recovery support" by NHS England/Improvement. As a partner in the system we must continue to support improvement in the financial position and

support the delivery of a sustainable financial plan. This will lead to an impact on our financial position in future years as we share some of this burden.

At the beginning of the 2021/22 financial year across the country and locally we have started to see the number of Covid-19 cases and Covid-19 related hospital admissions reduce. This comes as a great relief. However, our focus now is on tackling our waiting lists, which have almost doubled over the past year. That will be no mean feat and will require our staff to be as well cared for as our patients. We have to ensure our colleagues continue to be supported during this time of ongoing challenge. We are confident, that with the right support from colleagues and the understanding of our patients, we shall start to see the waiting times for treatment reduce as all of our staff work collectively and commit to getting them back to where they were in as short a period of time as possible. As a Trust Board, we shall do all that we can to support our staff in this task.

Frank Collins
Chairman

Mark Brandreth
Chief Executive Officer

Stacey Keegan
Acting Chief Executive Officer

Highlights of the year

The Trust had plenty of reasons to celebrate in 2020/21. Here are just a few of our many achievements from the year:

- At the beginning of the Covid-19 pandemic, we suspended our non-emergency elective work and took on orthopaedic trauma work for Shropshire, Telford & Wrekin, and for North Wales, as part of supporting the regional response to the Covid-19 pandemic. Some of our elective work resumed for a time, before the second wave of pandemic hit. During January 2021, we took the decision to pause routine elective surgery in order to release staff to support critical care services across Shropshire, Telford & Wrekin, or to work in the vaccination team.

- Patient experience at RJAH was rated as the best in the country, according to the annual Adult Inpatient Survey. RJAH was named as one of just nine organisations placed in the top band of Trusts delivering results that are considered “much better than expected”, with patient experience that is substantially better than elsewhere.

- The coronavirus vaccination programme took a step forward in Shropshire, Telford & Wrekin today at the beginning of January 2021, with the opening of the county’s second hospital hub at RJAH. By early March 2021, the hospital hub transitioned into a vaccination centre, meaning more people are able to get vaccinated at the RJAH centre, as patients will be able to book their appointments through the national booking system.

- The RJAH vaccination centre team administered their 20,000th jab just over six weeks after opening to patients.

- A record 96% of staff, who completed the NHS Staff Survey, said they would be happy with the standard of care provided if a friend or relative needed treatment. It is the fourth year in a row that the Trust secured the highest marks in this question, in a survey completed by staff at more than 300 NHS employers. We also scored highly as a place to work, with 79% of staff saying they would recommend RJAH.

- The food that the RJAH Catering team produce and serve was once again highlighted in the Adult Inpatient Survey as the best in the country – for the 14th time in 15 years.

- The NHS Rainbow Badge was launched in June 2020. The badge provides staff with a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as LGBTQ+, and acts as visual symbol identifying the person wearing it as someone who is there to listen.

- Infection prevention and control measures at RJAH were highlighted by the Care Quality Commission (CQC), following an assessment of the Trust’s infection control arrangements.

- A brand new, state-of-the-art MRI scanner was unveiled in the Radiology department during October 2020. The new scanner formed part of an investment of over £1 million to replace the eldest of the Trust’s two scanners. It means that RJAH is at the forefront of scanning capability and image quality, especially for those patients with hip and knee replacements.

- Professor Sally Roberts, who is head of the Spinal Studies and Cartilage Repair Research Group, as well as a Keele University Research Scientist, was awarded the Presidential Medal by the British Orthopaedic Research Society. She was awarded the prestigious medal for her contributions to the research of the intervertebral disc and cell based therapies to treat disc degeneration and repair cartilage, and in turn, improving the lives of patients suffering musculoskeletal disease.

- RJAH patient, Lottie O’Byrne was selected as a regional winner in the prestigious NHS Parliamentary Awards. Lottie supports the Trust to provide care packages for children and young people who have undergone spinal fusion surgery – a procedure she had herself back in October 2018 following her scoliosis diagnosis. She was recognised in the NHS Rising Star Award category, which aims to celebrate those who are under 30 years old, who give up their time, lend their experiences and deliver better services for themselves and others in their area.

PERFORMANCE REPORT

Overview of Performance

Statement from the Chief Executive Officer

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 2020/21. 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

Overall patient experience at RJAH was rated as the best in the country, according to the annual Adult Inpatient Survey. RJAH was named as one of just nine organisations placed in the top band of Trusts delivering results that are considered "much better than expected", with patient experience that is substantially better than elsewhere.

The coronavirus vaccination programme took a step forward in Shropshire, Telford & Wrekin at the beginning of January 2021, with the opening of the county's second hospital hub at RJAH. By early March 2021, the hospital hub transitioned into a vaccination centre, meaning more people are able to get vaccinated at the RJAH centre, as patients will be able to book their appointments through the national booking system.

Caring for Staff

A record 96% of staff, who completed the NHS Staff Survey, said they would be happy with the standard of care provided if a friend or relative needed treatment. It is the fourth year in a row that the Trust secured the highest marks in this question, in a survey completed by staff at more than 300 NHS employers. We also scored highly as a place to work, with 79% of staff saying they would recommend RJAH.

Caring for Finances

A Covid-19 financial framework was put in place across the NHS to simplify financial arrangements to support organisational responses to the pandemic.

Under the Covid framework the Trust was allocated block funding and was required to control expenditure to deliver a breakeven position across the year, this was supported by a central funding top up during the first half of the year when expenditure in response to the pandemic was at its most volatile. The Trust also secured additional funding of £1.4m to recognise the future cost of covering for exceptionally high untaken annual leave during the year and £3.2m funding to recognise lost income from non NHS services which helped the Trust finish the year with an overall surplus of £4.5 million. This allows for additional investment in the capital programme to improve care for patients.

It is important to note that the Shropshire, Telford and Wrekin Integrated Care System has significant financial issues with an underlying deficit target of £110m and towards the end of 2020/21 was placed into formal "financial recovery support" by NHS England. As a partner in the system we must continue to support improvement in the financial position and support the delivery of a sustainable financial plan. This will lead to an impact on our financial position in future years as we share some of this burden.

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

Trust Values

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 principle risks are collated the following themes:

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

During 2020/21 the key risks facing the Trust were in relation to its ability to safely provide care to its patient's during Covid-19. A number of infection control measures were put in place in line with national guidance which significantly impacted on the Trust's activity levels. In addition, staff were re-deployed to help partners with care for Covid-19 patients.

Also during 2020/21 the Trust identified and managed a number of supply risks relating to EU Exit. These risks were managed through the emergency planning protocols with a system, regional and national oversight with appropriate mitigations in place.

The key risks and issues facing the Trust for 2020/21 are reflective of the challenges the NHS is facing across the country in relation to Covid-19. As part of the NHS response to the pandemic all elective activity was ceased and working practices had to change significantly in order to socially distance. These challenges are not over and the risks for the forthcoming year will be focussed on the delivery of the following two key areas:

- Restoring and recovering service for our patients
- Maintaining safe environment for our staff and patients

The above will be underpinned by the need to develop and implement new ways of working and it is recognised that risks relating to this will need to be considered and managed.

With regard to financial risks, looking towards 2021/22 there is a system financial framework in place and measures are in place to ensure the going concern of the Trust.

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 review via the Risk Management Committee and approval at Trust Board and it was last reviewed in October 2019 and is next due for review in 2022.

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".

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
14 June 2021

ACCOUNTABILITY REPORT

Directors' Report

The report includes the following:

- Meet the Board
- Delivery of the 2019/2020 strategic plan
- Looking ahead: vision for the Trust for 2021/22
- The strategic priorities for 2021/22
- 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 2020 to 31 March 2021. The directors' report incorporates an analysis of the delivery of the 2020/21 strategic plan during that period and the vision for 2021/22.

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 later in the report:

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 Officer

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.

In 2020, Mark went on a secondment to work for NHS England as part of the National Covid-19 Response Team.

Stacey Keegan
Acting Chief Executive / Chief Nurse

Stacey joined RJAH as Interim Chief Nurse in November 2019, before being appointed substantively in March 2020. In response to the Covid-19 pandemic Stacey stepped in to act as Chief Executive Officer whilst Mark Brandreth, the substantive CEO, worked on the national response.

She joined from the Royal Orthopaedic Hospital Birmingham, where she held the position of Deputy Director of Nursing and Clinical Governance.

A trauma and orthopaedic nurse by background, she has held various leadership and management roles including Matron and Divisional Head of Nursing positions.

Stacey has an MSc in Senior Healthcare Leadership and the Elizabeth Garrett Anderson Award in Senior Healthcare leadership. She has experience and interest in nursing workforce redesign, recruitment and retention and patient involvement

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. Harry is the Trust Deputy Chairman and also Chairs the Risk Management Committee.

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.

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.

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 Risk Management Committee and Chairs the Trusts Quality and Safety Committee.

Rachel Hopwood
Non-Executive Director

Rachel joined the Board of Directors at RJAH in December 2019 and is Chair of the Finance, Planning and Digital Committee.

Prior to RJAH, Rachel was a Non-Executive Director and Deputy Chair of the Countess of Chester Hospital.

Rachel is a chartered accountant, qualifying with Ernst & Young, a major accounting and advisory firm. After a career in finance and investment banking in the City of London, latterly as an Executive Director at ABN AMRO, she relocated with her family back to Cheshire in 2008.

Prior to joining the Board, Rachel was a Non-Executive Director of Western Cheshire PCT and Lay Advisor to West Cheshire Clinical Commissioning Group. She is also a Director in a company providing risk, management and financial consultancy services in the region.

Craig Macbeth, Chief Finance and Planning Officer.

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

Craig 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.

Kerry Robinson Chief Performance, Improvement and Organisational Development Officer

Kerry started at RJAH in July 2016 as Director of Strategy and Planning. Kerry joined from the Countess of Chester Hospital NHS Foundation Trust where she was Assistant Director of Planning. She began her NHS career in 2008 at the Countess of Chester Hospital, having trained as an accountant.

As of 1 April 2019, Kerry's role changed to become lead director of Performance as well as retaining her existing roles as lead director for Service Improvement alongside her responsibility of implementing the Trust's Organisational Development Strategy.

Kerry has a passionate belief in caring for staff to deliver patient focused service design through successful partnership working and clinical engagement at all levels.

Steve White Chief Medical Officer

Steve White was appointed as Consultant Orthopaedic Surgeon at RJAH in 1993, after training in orthopaedics and trauma at Oxford where he developed an interest in arthritis of the knee and described with colleagues "Anteromedial Arthritis" together with its treatment by unicompartmental arthroplasty. Until 2009 he worked both at RJAH and SaTH carrying out knee and trauma surgery when he left to concentrate full time on knee surgery at RJAH. He took on more management roles as Clinical lead for Knee and Sports Surgery, then Surgical Director, and since 2012 the role of Medical Director.

After gaining a DM early in his career his research training has proved useful in developing improved surgical procedures and in critical appraisal, for example medico-legal reporting and the investigation of complaints on behalf of other Trusts. He is encouraged by working with great people to achieve continuing improvement in the care of patients, staff and finances at the Trust.

Steve also enjoys helping to lead in Shropshire, Telford and Wrekin, and within the National Orthopaedic Alliance to promote quality and efficiency.

Changes to the Board of Directors

During 2020/21 the following changes have been made to the Board of Directors:

Starters

Director	Date of Change
Christine Morris, Interim Chief Nurse	20 April 2020

Leavers

Director	Date of Change
Christine Morris, Interim Chief Nurse	29 September 2020

In addition to the above the Trust's substantive Chief Executive Officer, Mark Brandreth went on secondment to work for NHS England as part of the National Covid-19 Response Team. Mark's secondment commenced on 16 March 2020 and is concluded on 4 October 2020. In his absence Stacey Keegan was appointed Acting Chief Executive Officer and Christine Morris was appointed Interim Chief Nurse.

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 also published on the Trust's website.

Independence of Non-Executive Directors

The Trust assesses the independence of its Non-Executive Directors against the Foundation Trust (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. Further the Trust can confirm that no political donations were made in the current or prior year.

Delivery of the 2020/21 Strategic Plan

During 2020/21 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 key objectives with clearly defined measurable targets for each, however, the pandemic hit at the beginning of the financial year and it was clear that the Trust had one primary object to provide an appropriate response to Covid-19. The previously agreed objectives were therefore paused and revisited once the position had stabilised with the following 6 key objectives agreed for the last two quarters of the year. The table below provides a position statement against each of the objectives (as at 31 March 2021).

Annual Objective		Delivered by	Q4 Progress	Q3	Q4
1. **Accelerate the work to restore patients cared for to pre Covid-19 levels**					
1.1	This objective will focus on working towards an ambition of restoring to 100% of pre Covid-19 activity levels, delivering a process that ensure robust processes for harms reviews and clinical prioritisation, delivery of outstanding clinical outcomes, working towards minimising patient waiting times, a zero tolerance of delayed discharges and finally the development of a recruitment plan to support this work.	• Delivery of activity as agreed in the system plan • Completion of the clinical prioritisation process required by NHSE/I • Achievement of quality KPIs within the Integrated Performance Report • Minimising the number of patients waiting over 52 weeks • % WTE recruited of recruitment plan • Number of delayed discharges (without mitigations)	The Trust paused all non-urgent elective work at the beginning of the pandemic in order to support its partners with the Covid-19 crisis. The elective services were restored at in the summer of 2020 and following this there was a sustained and improved performance from September onwards with total elective theatre activity for December at 78% compared to 19/20 and 107% over plan. Outpatient activity for December was 100.7% against plan and at just under 80% compared to 19/20. In January 2021 the decision was taken to again pause non-urgent elective services in order to support local partners with the ongoing Covid-19 crisis and this resulted in the Trust being unable to meet this objective. Patient waiting times have continued to increase during this time and that Trust has treated patients in order of clinical priority in line with national guidance. The Trust has worked with its partners to reduce delayed discharges and will continue with this work. The Trust's Quality and Safety Committee is receiving regular reports on the Harms Review process with further work to do in order to achieve full assurance and work has commenced on a system wide harms review process.	**A**	**R**
2. **Maintain high infection control standards to support the restoration of activity**					
2.1	This objective will focus on ensuring appropriate Covid-	• Monitor patient and staff infection rates in relation to	The Trust continues to operate green and amber pathways for patients. Staff and environments have been risk	**G**	**G**

	19 free areas and strict application of hand hygiene with physical distancing and the use of masks, further it will aim to define and deliver a capital programme to support the maintenance of infection control standards whilst optimising activity. Overall the aim will be to have zero nosocomial infections.	reportable outbreaks • Audit outcomes in relation to maintenance of infection control standards • Presentation of a defined Capital Programme to Finance Planning and Digital Committee • Full capital allocation spend to time and budget	assessed in line with national guidance to ensure working environments are safe and Covid-19 secure and mask use across the site has continued with good compliance. The Trust's capital programme has been reviewed and agreed for 2021-22. The Trust has been self-assessed against the Infection, Prevention and Control Board Assurance Framework with an associated action plan for full assurance to be achieved.		
3. Support the wider healthcare system					
3.1	This objective will focus on how the Trust can play an active role in the system to support preparation for winter and wave 2 of the Covid-19 pandemic. The Trust will look at developing proposals for an increase in services available on a green pathway.	• Service proposal for green pathways • Attendance at system meetings	The Trust provided mutual aid throughout both the first and second wave of the pandemic and has played a signficiant role in the system's response to Covid-19. A System integrated planning framework has been agreed with work on delivery underway.	**G**	**G**
4. **Maintain emergency responsiveness**					
4.1	This objective will focus on ensuring the Trust has in place stable and effective EPRR arrangements	• Board reporting • EPRR Review	The Trust commissioned a full review from the CSU on it's EPRR arrangements and has accepted the recommendations of this review. The Trust has identified dedicated resource for the EPRR Lead role and work is ongoing with regard to the remaining recommendations.	**A**	**A**
5. **Focus on providing an environment for our workforce to 'flourish at work'**					
5.1	This objective will focus on implementation of the national people plan, improving staff wellbeing, taking clear actions to address systemic inequality	• Achievement of system / regional and national KPIs • Regular Board updates • Staff survey results and sickness absence figures	Risk assessments in place for all staff to ensure a Covid-19 secure working environment with a particular focus on BAME staff. A BAME network has been established with increased communications across the organisation.	**G**	**G**

	and ensuring a safe and Covid-19 secure working environment	• Staff risk assessments • Delivery of WRES action plan • BAME Network in place • PPE availability	The Trust is accessing national and system wellbeing initiatives as required. A system people plan is in place and aligned to the national people plan with all actions on track The Trust maintained it's staff survey results despite the difficult year. The Trust had in place daily tracking of the PPE stock and usage with no concerns identified.		
6. **Implement beneficial changes and lessons learnt from managing Covid-19**					
6.1	This objective will focus on undertaking listening sessions across the organisation, senior leadership development sessions and incorporation of lessons learnt into the 2021/22 operational plan	• Report on lessons learnt • Senior leadership development programme • Operational plan for 2021-22	After action reviews have been completed for wave 1 redeployment of staff, trauma and staff self-isolation with learning put in place. Redeployment for wave 2 completed with programme of support in place for returning staff. Learning from Wave 1 restart used in Wave 2 restart. Learning exercise across the organisation completed and reported through People Committee. After action reviews being completed for the vaccination hub.	**G**	**G**

Looking ahead for 2021/22

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 financial year will focus on building on the great work of the last three years. It will involve looking at those performance targets that have not been achieved in 2020/21 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 current strategy is;

1. We will become the local system integrator for Musculoskeletal (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 Outstanding – CQC assessment.	• 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.

It is recognised that the NHS as a whole is moving into a new era with ongoing challenges presented by Covid-19 and the impact of this on the work to recover and restore services. It is therefore anticipated that the Trust strategy may require review as events unfold and national requirements change to respond to the ongoing challenges.

The Corporate Objectives for 2021/22

Caring for Patients		
What will we do	**How will we do it**	**Measure**
Deliver the work to restart elective services	Deliver the modelling work to establish recovery. Develop a plan which is agreed by the Board. In the constraints of managing Covid-19, deliver Q1 activity based on roll over from Q3 20/21.	Model completed and presented to Board. Respond to planning requirements beyond Q1.
	Ensure the Trust has a clear understanding of number of all patients waiting (backlog). Deliver a process to ensure the waiting list is validated. Ensure patients are treated in priority order with newly added priority 2 patients being treated with 4 weeks and priority 2 backlog (pre wave 2) cleared by end of Q1.	Accurate data. Whilst treating in harms order, seek to minimise the number of patients waiting over 52 weeks recognising numbers will grow.
	Ensure full implementation of the harms review process and clinical prioritisation process (incl health inequalities requirements). Including actions to deliver for Metal on Metal patients.	Reduce the number of patients potentially subject to harms.
	Sustain our work to deliver outstanding clinical outcomes. Join the new formed National Clinical Information Programme (NCIP) for consultant reflection, improvement, appraisal and revalidation purposes.	NJR outcomes. PROMs. Specify targets within IPR. GIRFT reviews. Model Hospital data 'top quartile performance for orthopaedic pathways'. Report to Board on participation and outcomes.
	Establish a zero tolerance of delayed discharges by completing a review of the discharge and resettlement leadership and processes.	Report on leadership arrangements. Number of delayed discharges (without mitigations).
Maintain high infection control standards to support the restoration of activity	Minimise nosocomial infections with a focus on prevention and learning. Implement new/revised IPC guidance.	Number of outbreaks. Compliance with the IPC Board Assurance Framework. Audit programme in place with % measures of compliance and regular reporting via the IPC Quarterly report to Quality and Safety Committee.
Play an active part in the wider health system	Seek delivery of an ambition to operate as one Orthopaedic system for the ICS (across multiple sites).	Proposal prepared for consideration.
	Play an active part in the ICS Board and ICS committee arrangements.	Attendance at System meetings; RJAH plan which supports.
	Support and where appropriate lead the mobilisation of the MSK alliance.	Provide a report to Board committee.
Continuously improve the delivery of services	Commence the work to deliver the Headley Court Veterans Orthopaedic Centre.	Deliver to agreed timescales and budget.
	Specify a new microbiology service to support the work on infection, to commission in 2021-22.	Deliver the specification in 21/22.
	Prepare (and if commissioned) deliver the MDT knee revision service.	Report to FPD.
	Deliver the next stages in the business case process for a new EPR.	Specify stages.

	Implement 'Perfect Ward' a quality inspection and continuous improvement tool.	Project plan with a full role out by November 2021.
	Ensure stable and effective EPRR arrangements.	Deliver the actions from the March 21 review.

Caring for staff

What will we do	How will we do it	Measure
Focus on providing an environment for our workforce to 'flourish at work'	Deliver recruitment plan and new staffing models established from recovery modelling option.	Recruitment of 15 IR nurses. 0 HCSW vacancies. Increase in student placements by 22. First cohort of Nursing Associates. Deliver an orthopaedic practice course.
	Improve staff wellbeing by: Ensure staff have access to psychological support to ensure their mental wellbeing is looked after. Creating a safe space, such as Virtual Common Rooms, for staff to seek peer-to-peer support and contact with one another. Appointing a Wellbeing Guardian to help improve staff wellbeing and coordinate the work of the organisation to improving the wellbeing of staff.	Staff survey results and sickness absence rates. By improving the results for the questions relating to the following in the 'National Staff Survey.
	Clear action to address systemic inequality that may be experienced by some of our staff. Respond to the national requirements, including Board leadership.	Board report on risk assessment and detailed action plan. November 21. Delivery of Inclusion Action Plan. Staff network in place.
	Ensure a safe and Covid-19 secure working environment at home or on site.	Risk assessments in place for individuals and workplace with tracking of actions. All staff have access to PPE and are trained to use it.
	Deliver the milestones for 2021/22 set out in the Nursing Workforce Strategy.	15 IR nurses (10 Theatres, 5 wards). 0 HCSW vacancies. Increase of student placements by 22. First cohort of Nursing Associates. Deliver an accredited Orthopaedic Practice course.
Deliver Flu and Covid-19 vaccination programme	100% of staff offered vaccine.	Measurement to show 100% of staff offered and accepted or offered and declined.

Caring for finances

What will we do	How will we do it	Measure
Deliver Financial plan	Align investment decision making policy with revised system financial framework. Deliver an efficiency programme of at least 3%. Ensure activity delivery plan is managed within available sources of funding. Remove Covid-19 driven costs in a timely manner aligned to incident management step down.	Deliver on cost budget by 31st March 22.
	Deliver agreed cost base.	Deliver on cost budget by 31st March 22.
	Delivery of agency control total.	As demonstrated in Board reports.
	Maintain cash balances at trajectory and enable repayment of financing commitments.	As demonstrated in Board reports.

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 2020/21 the Trust paid 90% of the number of invoices and 89% of the value of invoices within the target. No late payment interest was due.

	2020/21		2019/20	
	Number of invoices	Value in £000s	Number of invoices	Value in £000s
Total invoices paid	33,429	74,634	38,655	83,226
Invoices paid within target	30,223	66,157	35,901	72,166
Percentage paid within target	90%	89%	93%	87%

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 Chief Nurse and Patient Safety Officer, the Chief Medical Officer, with the Chief Executive Officer being ultimately responsible.

The Trust has will be producing a Quality Account for 2020/21 which sets out its priorities and objectives in relation to quality improvements for the year, however, due to changes in the annual reporting requirements this is no longer included in the annual report and will be published separately. The usual assurance work over Quality Accounts for 2020/21 undertaken by our external auditors has been suspended, again due to the ongoing impact of Covid-19, this is in line with national guidance.

The Trust 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 67 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 2020/21.

Quality Outcomes

The Trust contributes to the National Registries to collect outcomes data. Currently these include:

- British Spine Registry
- National Ligament Registry
- UK Hand Registry
- Foot and Ankle Registry (BOFAS)
- British Hip Registry (NAHR)

The Trust also uses the National Joint Registry (NJR) to collect procedure details and the Trust's outcomes data is submitted directly by NHS Digital from data collected from the NHS PROMs Programme England.

The Quality Outcomes Manager and individual Consultants have access to the outcomes data held in registries and the individual consultant reports are used to inform their appraisals.

Results from surgical procedures are obviously analysed in arrears. The latest results were released February 2021 from NHS Digital and presented the Trusts finalised Patient Reported Outcome Measures (PROMs) in England for hip and knee replacement procedures (April 2019 to March 2020). The Trusts PROMs performance is also reported by the National Joint Registry and HQIP, covering the period 2020/21 and previous years. We compare ourselves with our neighbouring Trust, Shrewsbury and Telford Hospital NHS Trust and with the other four Specialist Orthopaedic Providers, Wrightington, Wigan and Leigh, Oxford University Hospital, Royal Orthopaedic Hospital and The Royal National Orthopaedic Hospital.

For primary knee replacements our patients were the "most improved" at 97% rating themselves as having improved, with the highest average adjusted post op Q score 38.464, the highest adjusted average health gain 19.188 and the most consistent outcome with the lowest standard deviation of adjusted health gain of 8.244.

For revision knee replacement our average for post op Q score was 29.080, with a health gain of 12.439. 86.7% of our patients rated themselves as improving post-operation and had the most consistent outcome with the lowest standard deviation of adjusted health gain of 8.871.

For primary hip replacements our patients were the most improved with 98.7% rating themselves as improved, with the highest average adjusted post op Q score 41.747, the highest adjusted average health gain 24.135 and the second most consistent outcome with the standard deviation of adjusted health gain of 7.445.

For revision hip replacements our patients had the second highest average post op Q scores at 34.886, the second highest Health Gain at 14.117, the second most improved patients at 90% and the most consistent outcome with the lowest standard deviation of adjusted health gain of 8.243.

Looking at the funnel plots provided, we are an outlier for better results in the adjusted primary knee replacements outcomes scores and have improved by 1.448 from 2018/19 results. We fall just under the adjusted average for revision knee replacement outcomes scores.

For primary hip replacement we are also an outlier for better results in the adjusted outcome scores and for revision hip replacements we are better than average and have an improvement of 3.730 from 2018/19 results.

In conclusion, we are a high volume provider of primary and revision knee and hip replacements, with outstanding results and, most importantly, with improving results on an annual basis.

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.

During 2020/21 the Trust introduced Quality Reports to be produced by each Unit and these have provided a good basis for scrutiny and challenge of the quality performance at operational level. These have continued to evolve and have been aligned to the Trust's performance metrics and the CQC standards in order to provide a cohesive overview and response of quality performance with a focus on patient engagement.

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 2020/21 the Trust has continued to work towards the delivery of these aims which informs the clinical priorities for the coming year. The performance against health care targets provides a platform in which the Trust is able to meet the

recommendations contained within the long term plan. The Trust is currently working on it's Quality strategy for 2021/22 onwards.

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 Structure***
- ***Performance Review Process***
- ***Cultural Behavioural Characteristics***

Aim 4 – Providing effective and reliable care
- *100% Delivery of WHO checklist*
- *Implementation of the Sepsis care bundle*
- *Continued development of the STAR accreditations 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: Improving 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 out 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 2020/21 compared to 2019/20:

Feedback	2020/21	2019/20	Diff from 2020/21 to 2019/20
Complaints	71	112	-41
Local resolution	30	29	1
PALS concerns	201	355	-154
PALS enquiries	2509	1085	1424
Compliments	4937	4996	-59

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 put in place a robust action plan to address the areas for improvement highlighted by the CQC. Completion of this action plan has been monitored via the Quality and Safety Committee with all actions except two completed. The two ongoing actions relate to the Trust's system for robust implementation of the accessible information standard and the ongoing work to mitigate risks of non-compliance with national standards for critical care. These

two actions are being taken forward by the CQC Group chaired by the Chief Nurse. The general themes for the actions that have been undertaken 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

The Trust was due to undergo a further inspection in Quarter 4 of 2019/20 however, this was paused in light of the Covid-19 pandemic and further information regarding a future inspection is awaited.

Patient Feedback

The Trust offers patients many mediums to feedback including email, Twitter and Facebook accounts, FFT surveys, national surveys, patient stories, patient forums 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

The Friends and Family Test (FFT) is an important feedback tool that provides a measure of patient experience that is used alongside other sources of patient insight data. Listening to the views of patients helps identify what is working well, what can be improved and also informs patient choice.

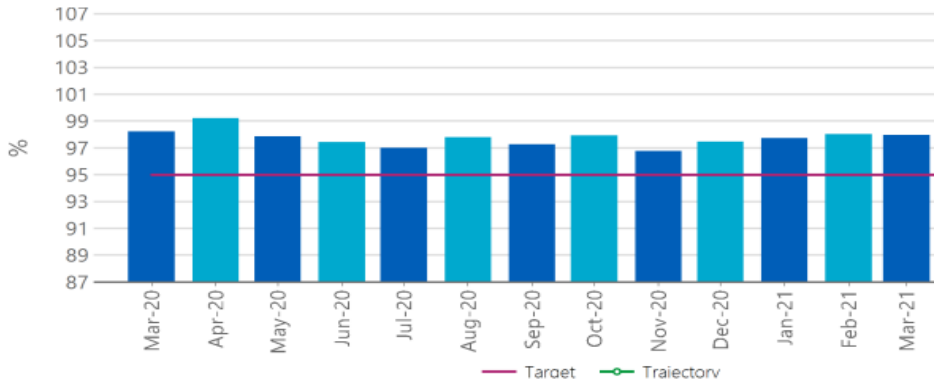
The FFT question "Overall, how was your experience of our service" was updated nationally in April 2020 and was designed to be a quick and simple mechanism for patients and other people who use NHS services to give their feedback.

The collection of FFT data was paused nationally from April 2020- November 2020 due to the Covid-19 pandemic. However SMS texting of patients to invite them to complete a FFT survey electronically (after discharge or clinic appointment) continued where this had been set up for a cohort of departments. The use of paper surveys and iPads to collect the data was also discouraged due to Infection control reasons.

In December 2020 further department were added to the SMS texting process to cover most wards and clinics.

For 2020/21, 9,008 patients completed a FFT survey and 97.7% of patients (inpatients and outpatients) said they would rate their experience as good or very good.

The chart below shows the average FFT score per month against a target of 95%:



The Trust is committed to improving the percentage of patients who would rate their experience as good or very good.

The FFT data is collected in real time using the IQVIA feedback system. Staff are sent an email alert as soon as a low score is received as feedback is immediately uploaded and available for staff to respond and action for their department.

The suggestions for improvements or negative comments 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 five years are as follows based on the average percentage of FFT score.

	2016/17	2017/18	2018/19	2019/20	2020/21
National Average	96%	96%	96%	96%	No data *
Highest Score	100%	100%	100%	100%	No data *
Lowest Score	75%	64%	76%	73%	No data *
The Robert Jones and Agnes Hunt	100%	99%	99%	99%	98%

*No data has been published by NHS England for 2020/21.

The slight decrease in the FFT score for 2021/21 is due to more low scores being received from outpatient areas clinics compared to previous years, 0.63%.

Stakeholder Relations

Stakeholder relationships have continued to be supportive and positive during 2020/21. 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.

In addition to this, the Trust has been working as part of the Shropshire, Telford and Wrekin Integrated Care System (STW ICS) therefore we have an improved relationship with local healthcare organisations as well as local authorities.

NHS Improvement's Well Led Framework

The Trust's work on well led is outlined in the Trust's Annual Governance Statement which is included in this report.

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
14 June 2021

Remuneration Report

This report contains the annual statement from the Chair of the Remuneration Committee and 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
- Rachel Hopwood, Non-Executive Director
- David Gilburt, Non-Executive Director
- Harry Turner, Non-Executive Director
- Paul Kingston, Non-Executive Director

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

The Nomination and Remuneration Committee met four times during the year (July, October, November 2020 and February 2021), and approved changes to the senior management structure to strengthen the Board of Directors as follows:

- Appointment of the Chief Medical Officer in line with Steve White's retirement in April 2021.

All of the members of the Committee attended all meetings with the following exception; Rachel Hopwood apologies were recorded in July and October 2020.

Senior Managers' Remuneration Policy

The remuneration of the Chief Executive Officer and Executives directly accountable to the Chief Executive Officer 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 Officer and Executives directly accountable to the Chief Executive Officer. This Framework was last reviewed and updated at the Remuneration Committee in July 2020.

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. Further in November 2020 a review of the Chief Executive and Director's salaries was undertaken by the Midlands Commissioning Support Unit, this review also gave consideration to those receiving salaries in excess of £150k.

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 2020/21 the Council of Governors approved the recommendation to a 12 month extension to the tenure of the existing Chair. This was to enable stability of the Trust's leadership and effective and robust recruitment of a replacement once the national crisis eases. The Chair's tenure ceases in January 2022 and the plan is therefore to commence recruitment of a new Chair in September 2021.

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 2022	N/A
Beacock, C Non-executive Director	4 July 2016	3 July 2022	N/A
Hopwood, R Non-executive Director	1 December 2019	30 November 2021	N/A
Gilburt, D Non-executive Director	1 December 2015	30 November 2021	N/A
Turner, H Non-executive Director	1 January 2017	31 December 2022	N/A
Kingston, P Non-executive Director	1 January 2019	31 December 2021	N/A
Brandreth, M Chief Executive Officer	1 April 2016	N/A	6 months
White, S Chief Medical Officer	1 June 2012	N/A	6 months
Macbeth, C Chief Finance and Planning Officer	1 April 2017	N/A	6 months
Robinson, K Chief Performance, Improvement and OD Officer	1 November 2019	N/A	6 months
Keegan, S Chief Nurse and Patient Safety Officer	18 November 2019 (Interim) 1 February 2020 (Substantive)	N/A	6 months
Morris, C Interim Chief Nurse	20 April 2020	30 September 2020	N/A

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 Officer has agreed the definition.

The value of pension related benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This derived value does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension entitlement table provides further information on the pension benefits accruing to the individual.

Senior Managers Remuneration 2020/21

Name and Job Title	Salary & fees (bands of £5,000)	Taxable benefits (to nearest £100) *Note 1*	Annual performance related bonuses (bands of £5,000)	Sub total of remuneration paid by the Trust (bands of £5,000)		All pension-related benefits (bands of £2,500) *Note 2*	Total (bands of £5,000)
	£'000	£	£'000	£'000		£'000	£'000
Frank Collins Chairman	35 - 40			35 - 40			35 - 40
Chris Beacock Non Executive Director	10 - 15			10 - 15			10 - 15
David Gilburt Non Executive Director	10 - 15			10 - 15			10 - 15
Rachel Hopwood Non Executive Director	10 - 15			10 - 15			10 - 15
Paul Kingston Non Executive Director	10 - 15			10 - 15			10 - 15
Harry Turner Non Executive Director	10 - 15			10 - 15			10 - 15
Mark Brandreth Chief Executive Officer *(From Oct 20)*	85 - 90	3,000	0 - 5	85 - 90		82.5 - 85	170 - 175
Craig Macbeth Chief Finance Officer	105 - 110	4,600	0 - 5	115 - 120		55 - 57.5	170 - 175
Stacey Keegan Acting Chief Executive Officer *(to Sep 20)* & Chief Nurse *(from Oct 20)*	110 - 115	4,900	0	115 - 120		205 - 207.5	325 - 330
Chris Morris Acting Chief Nurse *(to Sep 20)*	25 -30	0	0	25 -30		0	25 -30
Kerry Robinson Chief of Improvement, Performance & OD	90 - 95	4,600	0 - 5	100 -105		32.5 - 35	130 - 135
Steve White Chief Medical Officer	145 - 150	0	0	145 - 150		0	145 - 150

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. Steve White, Chief Medical Officer did not hold a clinical role during 2020/21

Senior Managers Remuneration 2019/20							
Name and Job Title	**Salary & fees (bands of £5,000)**	**Taxable benefits (to nearest £100) *Note 1***	**Annual performance related bonuses (bands of £5,000)**	**Sub total of remuneration paid by the Trust (bands of £5,000)**		**All pension-related benefits (bands of £2,500) *Note 2***	**Total (bands of £5,000)**
	£'000	**£**	**£'000**	**£'000**		**£'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 *(to Oct 19)*	5 - 10			5 - 10			5 - 10
David Gilburt Non Executive Director	10 - 15			10 - 15			10 - 15
Rachel Hopwood Non Executive Director *(from Dec 19)*	0 - 5			0 - 5			0 - 5
Paul Kingston Non Executive Director	10 - 15			10 - 15			10 - 15
Harry Turner Non Executive Director	10 - 15			10 - 15			10 - 15
Mark Brandreth Chief Executive Officer	160 - 165	6,100	5 - 10	170 - 175		72.5 - 75	245 - 250
Craig Macbeth Director of Finance	100 - 105	4,600	0 - 5	110 - 115		45 - 47.5	155 - 160
Sarah Bloomfield Director of Nursing *(to Oct 19)*	45 -50	0	0	45 -50		135 - 140	180 - 185
Stacey Keegan Director of Nursing *(from Nov 19)*	30 - 35	0	0	30 - 35		N/A	30 - 35
Nia Jones Director of Operations *(to Sep 19)*	45 - 50	2,310	0	45 -50		27.5 - 30	75 - 80
Kerry Robinson Director of Performance *(from Oct 19)*	40 - 45	2,310	0 - 5	45 -50		22.5 - 25	70 - 75
Steve White Medical Director	140 - 145	0	0	140 - 145		0	140 - 145

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.

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. All expenses relate to travel. Due to the Covid-19 pandemic, expenses for 2020/21 are low as meetings were rarely on-site.

Name	Role	2020/21	2019/20
Directors			
Frank Collins	Chairman	£1,357	£2,852
Chris Beacock	Non Executive Director	£281	£379
Alastair Findlay	Non Executive Director	£0	£629
David Gilburt	Non Executive Director	£337	£2,106
Harry Turner	Non Executive Director	£157	£3,270
Mark Brandreth	Chief Executive Officer	£300	£1,799
Craig Macbeth	Chief of Finance	£11	£1,207
Kerry Robinson	Chief of Performance, Improvement and OD	£55	£263
Steve White	Chief Medical Officer	£0	£193
Governors			
Peter David	Governor (Appointed) Voluntary Services Committee	£0	£300
Jan Greasley	Governor (Public) North Wales	£0	£101
Katrina Morphet	Governor (Public) Cheshire & Merseyside	£0	£346
Total		**£2,498**	**£13,445**

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.

1 employee received remuneration in excess of the highest paid director.

	2020/21	2019/20
Mid point of banded remuneration of highest paid director	192,500	192,500
Median remuneration of all staff	26,970	24,214
Ratio	7.1	7.9

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.

Senior Managers Pension Entitlement 2020/21

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 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021	Cash Equivalent Transfer Value at 31 March 2020	Real increase in Cash Equivalent Transfer Value
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mark Brandreth Chief Executive Officer *(From Oct 20)*	5.0 - 7.5	5.0 - 7.5	60 - 65	135 - 140	1,108	989	103
Craig Macbeth Chief Finance Officer	2.5 - 5.0	2.5 - 5.0	40 - 45	85 - 90	749	669	69
Stacey Keegan Acting Chief Executive *(to Sep 20)* & Chief Nurse *(from Oct 20)*	7.5 - 10.0	22.5 - 25.0	25 - 30	60 - 65	457	283	169
Kerry Robinson Chief of Improvement, Performance & OD	0.0 - 2.5	0	20 - 25	0	223	190	30

Information provided by the NHS Pensions Agency

Note : Steve White and Christine Morris have taken their pensions so there are no figures to disclose.

Senior Managers Pension Entitlement 2019/20

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 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	Real increase in Cash Equivalent Transfer Value
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mark Brandreth Chief Executive Officer	2.5 - 5.0	2.5 - 5.0	55 - 60	125 - 130	989	882	86
Craig Macbeth Director of Finance	2.5 - 5.0	2.5 - 5.0	35 - 40	80 - 85	669	598	56
Sarah Bloomfield Director of Nursing *(to Oct 19)*	5.0 - 7.5	15.0 - 17.5	30 - 35	70 - 75	488	367	112
Nia Jones Director of Operations *(to Sep 19)*	0.0 - 2.5	0	15 - 20	0	183	156	22
Kerry Robinson Director of Performance *(from Oct 19)*	0.0 - 2.5	0	15 - 20	0	190	164	22

Information provided by the NHS Pensions Agency

Note: Steve White has taken his pension so there are no figures to disclose and Stacey Keegan was recharged from another organisation so the information is not available.

Payments for Loss of Office

There were no payments for loss of office recorded in 2020/21.

Payments to Past Senior Managers

No payments have been made to past senior managers during in 2020/21.

Staff Report

Staff Costs

Staff costs are shown in the table below. Costs have increased mainly due to pay awards, incremental drift and recognition of untaken annual leave.

	2020/21			2019/20
	Permanent £'000	Other £'000	Total £'000	Total £'000
Salaries & wages	57,340	169	57,509	53,186
Social security costs	5,150	-	5,150	4,922
Apprenticeship levy	253	-	253	247
Employer's contributions to NHS pensions	9,318	-	9,318	8,932
Pension cost – other	21	-	21	14
Termination benefits	21	-	21	31
Temporary staff		988	988	4,256
Total gross staff costs	**72,103**	**1,157**	**73,260**	**71,588**
Recoveries in respect of seconded staff	-1,399	-	-1,399	-802
Total staff costs	**70,704**	**1,157**	**71,861**	**70,786**
Of which:				
Costs capitalised as part of assets	*146*		*146*	*321*

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.

	2020/21			2019/20
	Permanent Number	Other Number	Total Number	Total Number
Medical & dental	137	2	139	135
Administration & estates	506	19	525	559
Healthcare assistants & other support staff	222	20	242	206
Nursing, midwifery & health visiting staff	290	11	301	296
Scientific, therapeutic & technical staff	187	5	192	205
Healthcare science staff	7		7	8
Total average numbers	**1,349**	**57**	**1,406**	**1,409**

Exit packages

All exit packages agreed in 2020/21 and 2019/20 are shown in the table below.

	2020/21			2019/20		
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	-	4	4	-	3	3
£10,001 - £25,000	-	-	-	-	1	1
Total number	**0**	**4**	**4**	**0**	**4**	**4**
Total cost	**£0**	**£21,000**	**£21,000**	**£0**	**£31,000**	**£31,000**

Analysis of the non-compulsory payments:

	2020/21		2019/20	
Exit package cost band	**Number of agreements**	**Value of agreements**	**Number of agreements**	**Value of agreements**
Contractual payments in lieu of notice	4	£21,000	4	£31,000
Total number of exit packages	**4**	**£21,000**	**4**	**£31,000**

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 2020/21 is shown below:

	Male	Female
Executive Directors	3	2
Non-executive Directors	5	2
Other senior managers	9	13
Other employees	547	1932
Total	564	1949

Staff Sickness Absence

In light of pressures caused by the public sector response to Covid-19, sickness absence figures for 2020/21 are not provided within this report. Information published by NHS Digital can be found at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff Equality and Diversity

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

The trust employed 2,514 staff at 31st March 2021. There has been a notable increase in staff numbers during 2020-21 due to additional staff recruited for the Vaccination Centres in Shropshire. The Trust has acted as the lead employer for the recruitment and employment of these additional staff.

The demographic profiles of our staff are shown below:

Age Range	Headcount	% Headcount
19 and below	20	1%
20 - 29 Years	242	13%
30 - 39 Years	383	21%
40 - 49 Years	415	23%
50 - 59 Years	497	28%
60 and above	241	13%
Total	1798	

Gender	Headcount	% Headcount
Female	1949	78%
Male	564	22%
Total	2513	

Ethnicity	Headcount	% Headcount
Any Other Ethnic Group	14	0.60%
Asian or Asian British	70	2.8%
Black or Black British	14	0.60%
Chinese	7	0.30%
Mixed - Any mixed background	15	0.60%
Not stated	274	10.9%
White - British	2007	79.9%
White - Other	112	4.5%
Total	2513	

Part Time/Full Time	Full Time	Part Time	% Full Time	Total
Female	541	1408	28%	1949
Male	323	241	57%	564
Total	864	1649		2513

Staff Turnover

In light of pressures caused by the public sector response to Covid-19, sickness absence figures for 2020/21 are not provided within this report. Information published by NHS Digital can be found at NHS workforce statistics - NHS Digital

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 2020-21 there were eight incidents reported to the HSE under the requirements of the RIDDOR regulations compared with five in 2019-20 and three in 2018-19. Six of the incidents resulted in staff sickness absence of more than seven days, two reports were as a result of Covid-19 outbreaks on the wards.

The Chief Nurse retained Board-level responsibility for health and safety, with the Health and Safety Committee being chaired by the Director of Estates and Facilities. The Trust employed a 0.4 WTE Health and Safety Advisor to assist with compliance with the requirements of section 7(1) of the Management of Health and Safety Regulations 1999.

The Health and Safety Committee met bi-monthly and included health and safety representatives from staff side unions in compliance with the Safety Representatives and Safety Committees Regulations,1977. A Health and Safety Working Group was established with a remit to manage operational level safety issues and to improve the safety culture of the Trust.

Staff Engagement

Culture and Leadership is one of the four strategic themes and its work streams 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'".

Countering fraud and corruption

The Trust has in place a Local Counter Fraud Specialist team who oversee 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. Both Lead and Support Local Counter Fraud Specialists at the Trust have access to the new fraud case management system, CLUE, which will assist them in the investigation and reporting of allegations.

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.

The Trust has transitioned to the Government Functional Standard for Fraud, Bribery and Corruption recently introduced by the Cabinet Office to help ensure consistency of approach across the public sector.

In line with national guidance the Trust employs a Managing Conflicts of Interest Policy 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.

In 2021, the counter fraud team conducted a review of the Trust's processes around Covid-19 related procurement and were able to provide positive post-event assurance.

Staff Survey Results

Further improvements were seen within the 2020 NHS Staff Survey. 96% of respondents would be happy with the standard of care provided if a friend or relative needed treatment and 79% of respondents would recommend the Trust as a place to work. 87% of responses agreed the care of patients/service users was the organisation's top priority.

Response Rate	2017	2018	2019	2020
	41.5%	44.9%	62%	57%

Our survey results have been shared with our colleagues. Our People Team and Organisational Development Team are working in collaboration to make sure we fully understand what this survey is telling us, and that we are using it to help provide direction to some of our existing improvement work. Key areas from this year's results are set out below.

Job satisfaction (recognition)

Question	2016	2017	2018	2019	2020	2019 Comparator average
(I am satisfied with) The recognition I get for good work	51.1%	51.2%	59.9%	61.7%	62.7%	61.2%
(I am satisfied with) The extent to which the organisation values my work	40.6%	43.3%	55%	53.4%	53.6	53.7

The Trust has made continued through the pandemic to ensure staff were recognised, and held a virtual/digital staff awards event and recognising and valuing staff contributions through the health hero award.

We listen

Question	2016	2017	2018	2019	2020	2019 Comparator average
I know who the senior managers are here	71.6%	78.6%	85.5%	82.5%	79.3	86.9%
Communication between senior managers and staff is effective	31.4%	39.4%	45.1%	41.8%	39.7	49.2%

We are going to do more during 2020/21 to understand how staff feel about the communication mechanisms we have in place, such as Chief Executive's Question Time, and consider other improvements to ensure we can bring about improvement.

We care about Health and Wellbeing

Question	2016	2017	2018	2019	2020	2019 Comparator average
Satisfied with the opportunities for flexible working patterns	52.3%	47.9%	56.2%	57.9%	60.9%	60.5%
Agrees the organisation takes positive action on health and wellbeing	36.3%	42.1%	34.1%	37.7%	36.3%	36.9%
Have experienced MSK problems as a result of work activities in the last 12 months	21.5%	20.5%	20.6%	21.7%	21.7%	26.6%
Have felt unwell as a result of work related stress in the last 12 months	28.8%	28.4%	31.8%	32.9%	35.5%	39.5%
Have come into work despite not feeling well enough to perform duties in the last 3 months	50.1%	50.2%	48.9%	45.5%	38%	40.2%

We will be doing more this year to address concerns that our people are worried about their health and wellbeing and particularly making sure that our people have access to appropriate psychological support.

Expenditure on consultancy - Off-payroll arrangements

The table below provides details of the Trust's off payroll engagements during 2020/21 and comparator data for 2019/20.

Off- payroll engagements as at 31 March 2020, for more than £220 per day and lasting more than six months	2020-21	2019-20
Number of existing engagements as at 31 March 2020	2	13
Of which		
have existed for less than one year at the time of reporting	1	8
have existed for between one and two years at the time of reporting	1	2
have existed for between two and three years at the time of reporting	0	1
have existed for between three and four years at the time of reporting	0	2
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 2020, for more than £220 per day and lasting more than six months	**2020-21**	**2019-20**
New Off- payroll engagements or those that reached six months duration between 1 April and 31 March 2020	1	8
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	1	8
Number of whom assurance has been requested	1	8
Of which		
Assurance has been received	1	8
Assurance has not been received	-	-
have been terminated as a result of assurance not being received	-	-
Off- payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April and 31 March 2020	**2020-21**	**2019-20**
Off- payroll engagements of board members, and/or senior officials with significant financial responsibility during the financial year	0	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	0	0

Mark Brandreth
Chief Executive Officer
14 June 2021

NHS Foundation Trust Code of Governance Disclosures

Statement of compliance with the NHS Foundation Trust Code of Governance

The 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.

TrThe 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.

Trust Code of Governance Continued

- 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

Vacancy
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

Victoria Sugden
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 and Elections

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	29 Jul 21*
Allen Edwards	Staff	3	7 Aug 19	6 Aug 22
Kate Betts	Staff	3	11 Apr 19	10 Apr 22
Public Governors (Elected)				
Colin Chapman	Shropshire	3	26 Oct 17	29 Jul 21*
Jan Greasley	North Wales	1	28 Jun 19	29 July 21*
Russell Luckock	West Midlands	3	26 Oct 17	29 Jul 21*
Sue Nassar	Shropshire	3	7 Aug 19	6 Aug 22
Victoria Sugden	Shropshire	3	7 Aug 19	6 Aug 22
Vacancy	Rest of England and Wales	3	-	-
Martin Coggon	North Wales	3	26 Oct 17	29 Jul 21*
William Greenwood	Powys	3	11 Apr 19	10 Apr 22
Katrina Morphet	Cheshire and Merseyside	3	26 Oct 17	25 Oct 20

* Governor tenures extended with Council of Governor agreement due to Covid-19 situation

During 2020/21 the Council of Governors approved the recommendation to suspend any election for a 12 month periods due to the on-going national pandemic with an election to be held in advance of July 2021. This impacted the following Governors:

- Colin Chapman
- Kate Chaffey
- Martin Coggan

In addition to the above, Russell Luckock's tenure would not have been eligible for re-election as per Section 13 of the constitutional rules. However, in the circumstances it was in the Trust's interests to extend his tenure to next July 2021 when the proposed elections will be held. It was recognised that this would be a technical breach of the Constitution but given the guidance from NHS England and NHS Improvement on the unprecedented situation, this was felt to be in the best interests of the organisation.

The Council also approved an extension of the tenure of the existing Lead Governor; Jan Greasley. Jan's role to July 2021 in order to maintain stability of the leadership of the Council of Governors.

The Trust has now held an election which concluded in May 2021.

Council of Governor Meetings

During 2020/21 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. It should be noted that the Executive Directors are not members of the Council and therefore attendance is not a requirement but on an adhoc basis to support specific agenda items:

Name	Council of Governors
Total 2020/21	**4**
Frank Collins, Chairman	4
Hilary Pepler, Board Advisor	2
Harry Turner, Non-Executive Director	4
Chris Beacock, Non-Executive Director	4
David Gilburt, Non-Executive Director	3
Paul Kingston, Non-Executive Director	4
Rachel Hopwood, Non-Executive Director	2
Mark Brandreth, Chief Executive Officer	2
Craig Macbeth, Chief Finance and Planning Officer	3
Shelley Ramtuhul, Trust Secretary	4
Stacey Lea Keegan, Chief Nurse and Patient Safety Officer	3
Steve White, Chief Medical Officer	3
Kerry Robinson, Chief of Performance, Improvement and Organisational Development	0

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 2020/21. In addition there were 1,170 staff members at the end of March 2021.

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Cheshire & Merseyside	348	348	350	351	352	353	352	354	352	351	349	353
North Wales	920	924	926	926	927	931	931	932	931	930	930	934
Powys	536	538	538	538	538	538	537	539	538	539	538	538
Shropshire	2,675	2,689	2,693	2,688	2,685	2,692	2,688	2,690	2,688	2,692	2,693	2,708
West Midlands	513	514	515	517	516	522	523	526	526	525	526	530
Rest of England & Wales	243	242	244	244	243	247	246	247	247	245	244	248
Out of Trust Area	39	40	40	40	40	40	40	40	40	58	65	40
Total	**5,274**	**5,295**	**5,306**	**5,304**	**5,301**	**5,323**	**5,317**	**5,328**	**5,322**	**5,340**	**5,345**	**5,351**

In 2015 the Trust set its Membership Strategy which aimed to achieve a 5% increase year on year. This was reviewed in July 2020 when it was agreed that the Trust had a stable membership profile and that a year on year increase rather than a specific % increase would be more appropriate.

For 2020/21 the Trust achieved a membership of 6504 was achieved compared to 6434 in 2019/20 and therefore there has been an increase in membership of 1%.

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 2020 the Trust is in segment 2. Latest segmentation information for all NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

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 THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

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

The NHS Act 2006 states that the Chief Executive Officer 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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, 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 and disclose any material uncertainties over going concern.

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 them 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.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Mark Brandreth
Chief Executive Officer
14 June 2021

ANNUAL GOVERNANCE STATEMENT 2020/21

Scope of responsibility

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

The purpose of the system of internal control

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

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The 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 2021 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.

During 2020/21 the Trust had to adapt it's risk management processes in order to respond to the impact of the pandemic and a number of interim changes were introduced as follows:

- Emergency response command and control model with daily meetings of the senior leadership team
- Covid-19 specific risk register which was reviewed regularly by the senior operational team
- Monthly briefings to the Chair and Non-Executive members of the Risk Management Committee
- Short term suspension of the Board Assurance Framework in recognition of the fast pace of risk management required and the changing objectives of the organisation.

The Trust has since reverted to its usual risk management processes and 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 was last reviewed in 2019 and is due for further review in 2022. The strategy has been distributed throughout 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 Officer

- 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

Chief Finance and Planning Officer

- 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

Chief Nurse and Patient Safety Officer

- Board lead for Quality and Safety (in conjunction with the Chief Medical Officer)
- 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

Chief Medical Officer

- 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 Chief Nurse and Patient Safety Officer)
- 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

Chief People Officer

- Effective matching of workforce to activity
- Leading and facilitating continuous professional development

- Develop the leadership capacity and capability

Chief Improvement, Organisational Development and Performance Officer

- 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
- 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 Chief Nurse and Patient Safety Officer for these aspects of the role
- The Trust's Data Protection Officer in accordance with the General Data Protection Regulation (GDPR)

Clinical Chairs / Managing Directors / Assistant Chief Nurses and Chief of Professions

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

Director of Digital

- As Senior Information Risk Owner (SIRO) ensuring that risks to data security are recognised and managed
- Lead Executive for Cyber Security

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 October 2019 and is next due for review in 2022.

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.

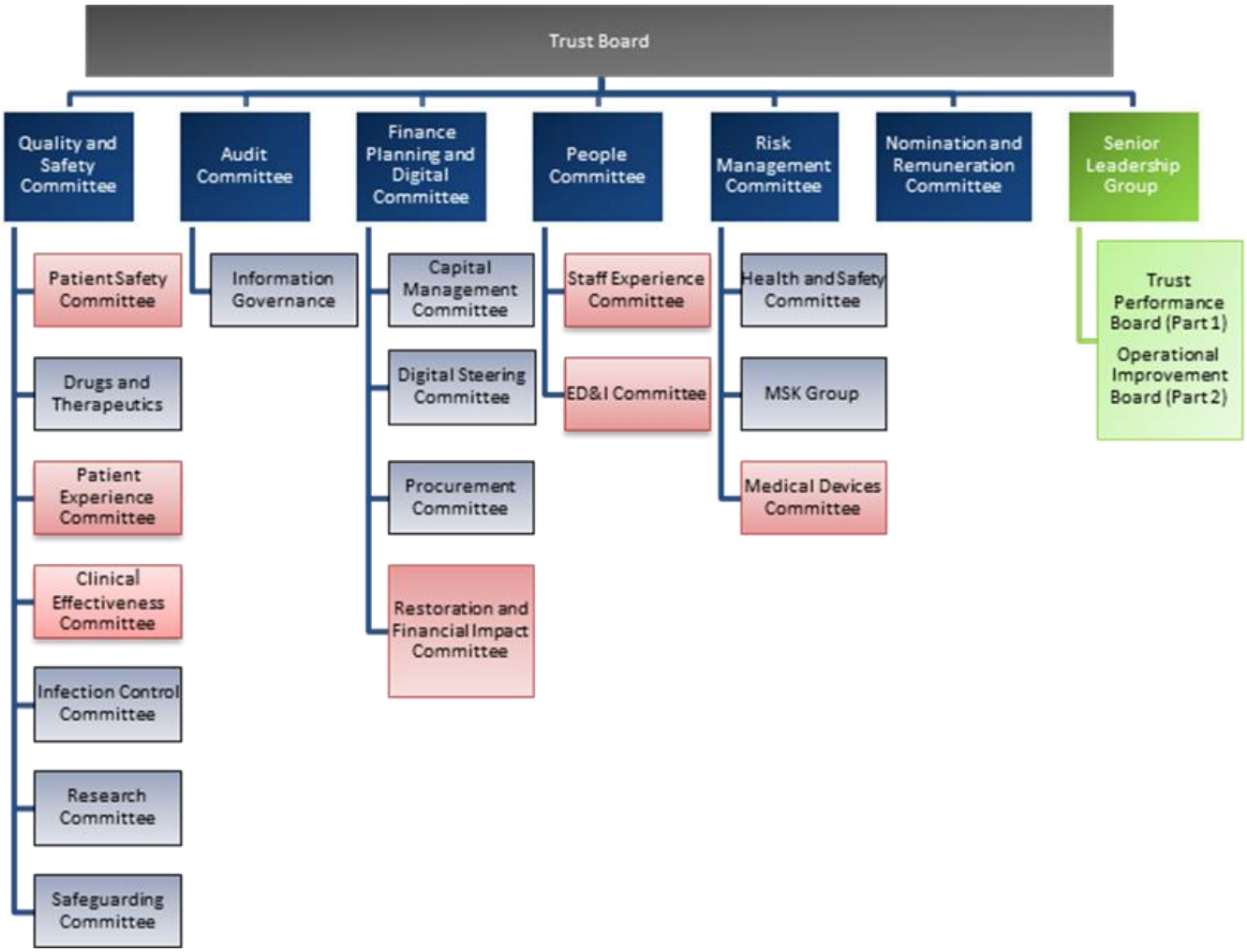
Governance Framework of the Organisation

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.

During the initial period of the first wave of the pandemic and during the second wave the Trust evaluated it's governance framework and reduced the frequency of meetings for a short period where possible in order to release management capacity. The meetings were however replaced with informal briefings with the Non-Executive Directors to ensure that independent oversight and scrutiny remained.

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 2020/21:



1. Green Operational meeting
2. Blue Assurance meetings
3. Pink New meetings which have been established in 2020/21
4. The Trust will schedule Joint Audit/QS and Joint Audit/Risk Meetings as and when required, this has strengthened governance across the Board.

In addition the Trust has held a Policy Committee quarterly throughout the year to oversee the ratification of Trust policies. This was in response to a CQC finding of policies being overdue for review but the work is now near completion and the Policy Committee is being stood down as a result.

The roles and responsibilities of the Board Committees are described more fully below and performance of these committees is evaluated on an annual basis with onward reports to the Audit Committee.

As outlined above the frequency of the meetings was for short periods reduced to release management capacity to work on the response to Covid-19, there did however remain oversight

from the Non-Executives during this time. Further, as a result of the pandemic, all face to face meetings ceased with all meetings, including the Board of Directors, being held virtually.

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 control 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

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

Policy Committee (Adhoc Committee meeting four times a year)

The Policy Committee reports progress to the Board with addressing the backlog of policies due for review. It is chaired by a Non Executive Director and attended by a number of Executives and Senior Managers. It is responsible for receiving and reviewing policies with a view to ratification. It ensures that there is consistency across all policies and that adequate expertise has been sought in their development before agreeing ratification.

Since the implementation of the Policy Committee the Trust has reviewed a number of documents and made progress with addressing the backlog. The Board of Directors has agreed to stand this committee down and policies that require a review are to be aligned with the sub-board committees. The committees will receive an assurance report on the policies aligned to the meeting.

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 and would usually run a number of workshops, these were however paused due to the pandemic with arrangement underway for the year ahead for a programme of virtual sessions.

.

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. In the event that attendance fell below expected levels this would be addressed on an individual basis.

Name	Board of Directors	Council of Governors	Quality and Safety Committee	Risk Management Committee	Audit Committee	Finance Planning and Digital Committee	People Committee	Policy Committee
Total 2020/21	10	4	10	5	7	10	5	3
Frank Collins, Chairman	10	4	*	*	*	*	*	*
***Hilary Pepler Trust Board Advisor**	10	2	10	*	*	*	4	*
Harry Turner, Non-Executive Director	10	4	*	4	5	*	3	*
Chris Beacock, Non-Executive Director	10	4	10	5	*	*	5	*
David Gilburt, Non-Executive Director	10	3	9	*	6	8	*	3
Paul Kingston, Non-Executive Director (From 1 Jan 2019)	10	4	8	*	5	*	5	3
Rachel Hopwood, Non-Executive Director	10	2	*	*	*	10	*	*
Mark Brandreth, Chief Executive Officer	5	1	2	2	*	1	*	*
Kerry Robinson, Chief Improvement, Performance and Organisational Development Officer	9	0	*	3	*	9	5	*
Craig Macbeth, Chief Finance and Planning Officer	10	3	*	4	5	10	3	*
Steve White, Chief Medical Officer	9	3	9	*	*	*	*	2
***Stacey Keegan, Chief Nurse and Patient Safety Officer**	10	3	9	4	1	3	3	0
Sarah Sheppard, Chief People	9	1	*	*	*	*	5	0

Officer								
Shelley Ramtuhul, Trust Secretary	10	4	8	5	4	6	4	3

Note: 5 of the meetings attended by Stacey Keegan were in her capacity as Interim Chief Executive Officer

Internal Audit

The Trust's internal auditors are BDO 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. The Trust is finalising its Quality Strategy for 2021onwards.

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 devised an action plan to address the

CQC recommendations and observations. Completion of this action plan has been overseen by the Quality and Safety Committee on a monthly basis with quarterly updates to the Board of Directors with all but two actions fully completed as referenced in the Annual Report. The outstanding actions relate to the introduction of an integrated electronic patient record for which the business case is being progressed during 2021/22. During 2019/20 a further CQC inspection was planned however this was paused following the Covid-19 pandemic and further information is awaited with regard to a future inspection.

Performance Data Quality

The Trust Board and each of its Committees reviews quality performance at each meeting and a data quality rating for each KPI is included within the 'heatmap' section of the performance report.

The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Blue No improvement required to comply with the dimensions of data quality
Green Satisfactory – minor issues only
Amber Requires improvement
Red Significant improvement required

Use of the Well-Led Framework

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 was developed to address all recommendations made by the CQC. The well-led elements were particularly focusing on policy management and staff training and these actions have been completed.

In June 2020 the Trust commenced a well led review however due to the Covid-19 pandemic, it was recognised that this was not a typical period for review. Currently the external reviewers are in the process of revisiting and testing their initial findings in order for a final report to be submitted to the Board of Directors.

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 2020 and is currently being updated for review in 2021.
- The Internal Auditors have undertaken the following specific reviews linked to governance:

Summary of Key Findings / Recommendations
Non RTT Activity
Overall, the Trust has controls in place that are designed sufficiently to ensure that waiting times for non-RTT activity are monitored, given that this is an unregulated activity. However, there are areas of improvement to create best practice and bring non-RTT monitoring and reporting in line with RTT activity, through setting formal thresholds and increasing the level of oversight. The auditors provided a 'moderate' assurance conclusion for both the control design and the control effectiveness.
Main Financial Systems

Overall, the Trust has financial systems in place that are designed effectively to ensure that no income or expenditure transactions are processed without appropriate approval, and a segregation of duties is maintained where required. Procedures around month-end financial reporting, cash flow monitoring and capital asset additions are being consistently applied. The auditors provided a 'substantial' assurance conclusion for both the control design and the control effectiveness.

DSP Toolkit

The Trust has been consistently completing the DSP Toolkit self-assessment return throughout the reporting period and we noted that where assertions have been completed, the work done has, to a large extent, been in line with the requirements of the Toolkit. However, in order to comply with the DSP Toolkit, the Trust is required to meet all mandatory sub-assertions, therefore further work will be required ahead of the year-end submission to address the areas of non-compliance identified as part of this audit. The auditors provided a 'moderate' assurance conclusion for both the control design and the control effectiveness.

Cyber Security

Overall, the Trust's ICT team has taken actions to design the configuration of its IT network perimeter security controls so that the exposure to a cyber-attack is reduced. However, having no antivirus clients installed could be exploited to gain unauthorised access to the IT network. In addition, a review of the migration plan found that there have been difficulties in migrating 8 servers that use unsupported Windows systems. These are common issues for NHS Trusts but present a significant risk, despite the patches that are currently being provided. The Auditors provided a moderate' assurance conclusion for both the control design and the control effectiveness.

Pressure Ulcers

Overall, the Trust had a comprehensive policy in place to prevent and treat pressure ulcers. However, there were inconsistencies identified within the documentation of patient notes for five cases reviewed. This is mainly due to the lack of education and training delivered across the Trust. Whilst the Trust policy contained extensive details on the prevention and treatment of pressure ulcers, it lacked instructions on training. Therefore, this should be updated once training schedules are in place. . The Auditors provided a moderate' assurance conclusion for both the control design and the control effectiveness.

Research Governance

Basic controls are in place to address the risks faced by the Trust, including Standard Operating Procedures (SOPs) on monitoring and auditing of the sponsored and hosted studies. We also noted that the Trust measures its performance against National Institute for Health Research (NIHR) High Level Objectives and the Research Strategy objectives. However, we noted that the Research Committee Terms of Reference has not been updated in the last 12 months, lessons learned on research studies have not been disseminated to relevant staff across the Trust, monitoring and auditing arrangements are not carried out in line with the SOPs and the audit sampling technique can be strengthened. The auditors provided a 'moderate' assurance conclusion for both the control design and the control effectiveness.

Data Quality

We were requested to undertake a Data Quality audit exercise with the information department. We were required to complete data quality assessments against 13 KPI's provided by the Trust. This review did not generate an internal audit opinion and testing was completed using the Trust workbook templates (provided by the Information Department). Some low priority recommendations have been made as a result of our work.

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.

Risks 2020/21

During 2020/21 the following risks were identified and cited on the Board Assurance Framework, these were closely associated with the challenges of Covid-19:

Caring for Patients

- Potential for increase harm to patients as waiting times increase
- Inability to respond quickly enough to rapidly changing infection control national guidance
- Inability to align the Capital Programme with the quickly changing operating environment and funding movements
- Capacity and resilience constraints within the Infection Control Team
- Infancy of the system's structure inhibits response
- Lack of designated Emergency Preparedness Resilience and Response resource

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
- Impact of Covid-19 on the workforce
- Inability to breakdown silo working from both an internal and external perspective

Caring for Finances

- Failure to achieve activity and income target within planned cost base
- Instability arising from fluctuations in tariff and uncertainty regarding future funding models due to the ambition to move away from PbR

Risks 2021/22

The Trust has established its strategy for 2021/22 to support its desired direction of travel over the next five years. The four key strategic aims for 2021/22 remain as follows:

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

It is however recognised that the key objectives identified for 2021/22 to underpin the strategy will require ongoing review to take into account the changing NHS landscape as the country hopefully moves out of Covid-19.

The key risks and issues facing the Trust for 2021/22 are reflective of the challenges the NHS is facing across the country. As part of the NHS response to the pandemic all elective activity was ceased and working practices had to change significantly in order to socially distance. These challenges are not over and the risks for the forthcoming year will be focussed on the delivery of the following two key areas:

- Restoring and recovering services for our patients
- Maintaining a safe environment for our staff and patients

The above are underpinned by the need to develop and implement new ways of working and it is recognised that risks relating to this will need to be considered and managed.

The sub-set of risks linked to the above are detailed on the Trust's Board Assurance Framework and Trust-wide Risk Register for ongoing review and management through the year. At the time of writing these are considered to be as follows:

Caring for Patients

- Insufficient core capacity to meet demand
- Potential for increase harm to patients as waiting times increase
- Inability to benchmark outcomes across all specialties
- Inability to respond quickly enough to rapidly changing infection control national guidance
- Management capacity inhibits engagement in the system
- Lack of designated EPRR resource

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
- Impact of Covid-19 on the workforce
- Lack of dedicated ED&I resource and expertise

Caring for Finances

- Failure to achieve activity and income target within planned cost base
- Instability to meet baseline activity due to heavy reliance on high proportions of out of job plan work
- Impact of the new system financial framework

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 Senior Leader 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.

The Trust has an established Strategy Board which meets 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 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 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 introduced a People Committee to increase oversight and assurance of the Trust's workforce strategy.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

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 Adaptation 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 2020/21 the Trust tracked its financial performance, including the economic, efficient and effective use of resources via the Finance Planning and Digital Committee and further the Board receives a monthly update on the Trust's financial performance.

Overview of Financial Performance

During an unprecedented year the Trust continues to focus on delivery of safe, high quality services for our patients, underpinned by robust business management. During 2020/21 a 'Covid-19 finance framework' was put in place across the NHS to simplify financial arrangements to support organisational responses to the pandemic.

The Trust's annual accounts provide full detail of the Trust's financial performance but to summarise; under the framework the Trust was required to control expenditure and deliver a breakeven position across the year, this was achieved successfully. In addition to this requirement the framework recognised two significant financial impacts during the pandemic which allowed the Trust to post a £4.5m surplus, these are £1.4m funding to recognise untaken annual leave during the year and £3.2m funding to recognise lost income from non NHS services. This puts the Trust in a healthy position in terms of cash for 2021/22 and allows for additional investment in the capital programme to improve care for patients.

It is important to note that the Shropshire, Telford and Wrekin Integrated Care System has significant financial issues with an underlying deficit target of £110m at the end of 2020/21and has been placed into formal recovery. As a partner in the system the Trust must continue to support improvement in the financial position and delivery of a sustainable financial plan, this will see impacts on our financial position in future years as we share some of this burden.

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. The Trust has in place the Chief Nurse as the Caldicott Guardian, and the Director of Digital as the Senior Information Risk Owner (SIRO). Further, the Trust Secretary is the Data Protection Officer.

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

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance DSPT score overall for 2020/21 has not yet been determined as the final submission date is 30 June 2021. For 2019/20 the Trust's score was **STANDARDS MET.**

During 2020/21 the Trust identified and reported no serious IG breaches.

Annual Quality Report

The Trust would ordinarily prepare a Quality Report to include in the Annual Report, however, due to the Covid-19 crisis there is no requirement for this to be included in the Annual Report and this will be published separately. The Trust is in the process of preparing its Annual Quality Report 2020/21 in line with relevant national guidance and this 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, Chief Nurse and Patient Safety Officer, Chief Medical Officer 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.

The Quality Account is subject to detailed review by the Chief Medical Officer and Chief Nurse and Patient Safety Officer, it is then approved by the Joint Audit and Quality and Safety Committee on behalf of 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 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 2021 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 2020/21 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, notwithstanding the challenges Covid-19 presented during 2020/21, 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.

Mark Brandreth, Chief Executive Officer
14 June 2021

ANNUAL ACCOUNTS 2020/21

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2021

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Foreword to the Accounts

These accounts, for the year ended 31 March 2021, 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 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Mark Brandreth**

Job title **Chief Executive & Accounting Officer**

Date **10 June 2021**

Consolidated Statement of Comprehensive Income

	Note	Group 2020/21 £000	Group 2019/20 £000	Foundation Trust 2020/21 £000	Foundation Trust 2019/20 £000
Operating income from patient care activities	3	106,855	111,205	106,855	111,205
Other operating income	4	12,418	7,764	12,127	7,199
Operating expenses	7	(112,870)	(114,422)	(112,686)	(114,045)
Operating surplus from continuing operations		**6,403**	**4,547**	**6,296**	**4,359**
Finance income	12	-	57	-	50
Finance expenses	13	(105)	(128)	(105)	(128)
PDC dividends payable		(1,502)	(1,747)	(1,502)	(1,747)
Net finance costs		**(1,607)**	**(1,818)**	**(1,607)**	**(1,825)**
Other gains	14	4	123	4	123
Surplus for the year from continuing operations		**4,800**	**2,852**	**4,693**	**2,657**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Revaluations	18	2,775	1,258	2,775	1,258
Total other comprehensive income for the period		**2,775**	**1,258**	**2,775**	**1,258**
Total comprehensive income for the period		**7,575**	**4,110**	**7,468**	**3,915**

All income and expenditure is derived from continuing operations and there are no minority interests in the Group.

The surplus delivered in 2020/21 includes unexpected income received late in the year.

Statement of Financial Position

	Note	Group 31 March 2021 £000	Group 31 March 2020 £000	Foundation Trust 31 March 2021 £000	Foundation Trust 31 March 2020 £000
Non-current assets					
Intangible assets	15	2,717	3,542	2,717	3,542
Property, plant and equipment	16	77,229	72,476	77,229	72,476
Receivables	21	1,245	1,288	1,245	1,288
Total non-current assets		**81,191**	**77,306**	**81,191**	**77,306**
Current assets					
Inventories	20	1,389	1,396	1,389	1,396
Receivables	21	7,582	5,777	7,473	5,687
Cash and cash equivalents	23	17,417	9,437	16,136	8,250
Total current assets		**26,388**	**16,610**	**24,998**	**15,333**
Current liabilities					
Trade and other payables	25	(14,195)	(10,209)	(14,185)	(10,205)
Borrowings	27	(1,428)	(1,189)	(1,428)	(1,189)
Provisions	29	(712)	(216)	(712)	(216)
Other liabilities	26	(1,072)	(94)	(1,072)	(94)
Total current liabilities		**(17,407)**	**(11,708)**	**(17,397)**	**(11,704)**
Total assets less current liabilities		**90,172**	**82,208**	**88,792**	**80,935**
Non-current liabilities					
Borrowings	27	(4,349)	(4,708)	(4,349)	(4,708)
Provisions	29	(1,001)	(894)	(1,001)	(894)
Total non-current liabilities		**(5,350)**	**(5,602)**	**(5,350)**	**(5,602)**
Total assets employed		**84,822**	**76,606**	**83,442**	**75,333**
Financed by					
Public dividend capital		36,108	35,467	36,108	35,467
Revaluation reserve		24,938	22,163	24,938	22,163
Income and expenditure reserve		22,396	17,703	22,396	17,703
Charitable fund reserve	19	1,380	1,273	-	-
Total taxpayers' equity		**84,822**	**76,606**	**83,442**	**75,333**

The notes on pages 96 to 136 form part of these accounts.

The financial statements on pages 91 to 95 were approved by the Board and signed on its behalf by:

Signed: 

Name: Mark Brandreth

Position: Chief Executive & Accounting Officer

Date: **10 June 2021**

Statement of Changes in Equity - Group

For year ended 31 March 2021	Group				
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Charitable fund reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**35,467**	**22,163**	**17,703**	**1,273**	**76,606**
Surplus for the year	-	-	4,631	169	**4,800**
Revaluations	-	2,775	-	-	**2,775**
Public dividend capital received	641	-	-	-	**641**
Other reserve movements	-	-	62	(62)	**-**
Taxpayers' and others' equity at 31 March 2021	**36,108**	**24,938**	**22,396**	**1,380**	**84,822**

For year ended 31 March 2020	Group				
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Charitable fund reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**33,719**	**20,905**	**15,046**	**1,078**	**70,748**
Surplus for the year	-	-	2,585	267	**2,852**
Revaluations	-	1,258	-	-	**1,258**
Public dividend capital received	1,748	-	-	-	**1,748**
Other reserve movements	-	-	72	(72)	**-**
Taxpayers' and others' equity at 31 March 2020	**35,467**	**22,163**	**17,703**	**1,273**	**76,606**

Statement of Changes in Equity - Trust

For year ended 31 March 2021	Foundation Trust			
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**35,467**	**22,163**	**17,703**	**75,333**
Surplus for the year	-	-	4,693	**4,693**
Revaluations	-	2,775	-	**2,775**
Public dividend capital received	641	-	-	**641**
Taxpayers' and others' equity at 31 March 2021	**36,108**	**24,938**	**22,396**	**83,442**

For year ended 31 March 2020	Foundation Trust			
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**33,719**	**20,905**	**15,046**	**69,670**
Surplus for the year	-	-	2,657	**2,657**
Revaluations	-	1,258	-	**1,258**
Public dividend capital received	1,748	-	-	**1,748**
Taxpayers' and others' equity at 31 March 2020	**35,467**	**22,163**	**17,703**	**75,333**

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 and Social Care 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 2020/21 £000	Group 2019/20 £000	Foundation Trust 2020/21 £000	Foundation Trust 2019/20 £000
Cash flows from operating activities					
Operating surplus		6,403	4,547	6,296	4,359
Non-cash income and expense:					
Depreciation and amortisation	7	4,298	3,070	4,298	3,070
Income recognised in respect of capital donations	4	(547)	(611)	(552)	(624)
(Increase) / decrease in receivables and other assets		(1,892)	2,006	(1,864)	1,994
(Increase) / decrease in inventories		7	(197)	7	(197)
Increase / (decrease) in payables and other liabilities		5,553	(385)	5,553	(385)
Increase in provisions		603	866	603	866
Movements in charitable fund working capital		15	(34)	-	-
Net cash flows from operating activities		**14,440**	**9,262**	**14,341**	**9,083**
Cash flows from investing activities					
Interest received		6	48	6	48
Purchase of intangible assets		(832)	(337)	(832)	(337)
Purchase of property, plant & equipment		(5,134)	(5,623)	(5,134)	(5,623)
Sales of property, plant & equipment		124	3	124	3
Receipt of cash donations to purchase assets		467	611	472	624
Net cash flows from charitable fund investing activities		-	7	-	-
Net cash flows used in investing activities		**(5,369)**	**(5,291)**	**(5,364)**	**(5,285)**
Cash flows from financing activities					
Public dividend capital received		641	1,748	641	1,748
Movement on loans from DHSC		(1,176)	(1,176)	(1,176)	(1,176)
Movement on other loans		1,059	-	1,059	-
Interest on loans		(108)	(130)	(108)	(130)
PDC dividend paid		(1,507)	(1,663)	(1,507)	(1,663)
Net cash flows used in financing activities		**(1,091)**	**(1,221)**	**(1,091)**	**(1,221)**
Increase in cash and cash equivalents		**7,980**	**2,750**	**7,886**	**2,577**
Cash and cash equivalents at 1 April - brought forward		**9,437**	**6,687**	**8,250**	**5,673**
Cash and cash equivalents at 31 March	23	**17,417**	**9,437**	**16,136**	**8,250**

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 the Trust shall meet the accounting requirements of the Department of Health & 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 2020/21, 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. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

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.

The Robert Jones & Agnes Hunt Orthopaedic Hospital Charity

The Trust is the corporate Trustee to the Robert Jones & Agnes Hunt Orthopaedic Hospital Charity, which is registered with the Charity Commission under registration number 1058878. 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.

Note 1 : Accounting Policies (continued)

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).

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.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard were employed. These are as follows:

- As per paragraph 121 of the Standard the Trust does not disclose information regarding 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 NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

Note 1 : Accounting Policies (continued)

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System/Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year-end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

The transaction price was based on the agreed tariff for the completed procedures, although this could 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 there were contract/invoice challenges, revenue was recognised to the extent that collection of consideration was probable. Where contract challenges from commissioners were expected to be upheld, the Trust reflected this in the transaction price and derecognised the relevant portion of income.

The Trust received income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agreed schemes with commissioners but they affected how care was provided to patients. That is, the CQUIN payments were not considered distinct performance obligations in their own right; instead they formed part of the transaction price for performance obligations under the contract.

In 2019/20, the Provider Sustainability Fund (PSF) enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds was accounted for as variable consideration.

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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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.

Grants and donations

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. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition of the benefit.

1.5 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments, such as social security costs and 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. The schemes are not designed in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as 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.

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.

Measurement

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

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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the service being provided. Assets held at DRC can be valued on an alternative site basis where this would meet the location requirements. 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.

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 when it meets the requirements set out in IAS 38.

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. Revaluations 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 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 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.

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

- 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 expenses 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 sale must be highly probable; and
- The asset is available for immediate sale in its present condition.

Following re-classification, the assets are measured at the lower of their existing carrying amount and their "fair value less costs to sell". Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment 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.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year-end.

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. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

Thereafter, the asset is accounted for as an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position, 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.

In addition, in 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

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 ONS.

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 22.43% 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

The Trust recognises a provision where it 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 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 & 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.

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 & 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, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

In accordance with the requirements laid down by the Department of Health & 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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1 : Accounting Policies (continued)

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 in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. 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.

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

1.25 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.

Note 1 : Accounting Policies (continued)

1.26 Critical Accounting Judgements and 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.

1. **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 desk-top valuation as at 31 March 2021 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 an increase in the carrying value of the Trust's land and buildings of £2.8m.

1.27 Early adoption of standards, amendments & interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

1.28 Standards, amendments & interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations, and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the Statement of Financial Position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the Statement of Financial Position, the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only, and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

Note 1 : Accounting Policies (continued)

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the Income and Expenditure Reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 for NHS bodies to 1 April 2022. Due to the need to re-assess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets and liabilities.

Other standards, amendments & interpretations

IFRS 17 Insurance Contracts – application will be required from 2023/24, but has not yet been adopted by the FReM. This is not expected to have an effect on the financial statements.

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	
	2020/21 £000	2019/20 £000
Foundation Trust income attributable to the Group	118,920	118,332
Charity income attributable to the Group	353	637
Total RJAH Group operating income	**119,273**	**118,969**
Foundation Trust surplus attributable to the Group	4,693	2,657
Charity surplus attributable to the Group	107	195
Total RJAH Group operating surplus	**4,800**	**2,852**
Foundation Trust net assets attributable to the Group	83,442	75,333
Charity net assets attributable to the Group	1,380	1,273
Total RJAH net assets	**84,822**	**76,606**

No material income attributable to the Group was received by the Charity from any single source during 2020/21 or 2019/20.

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	
	2020/21 £000	2019/20 £000
Acute services		
Block contract / system envelope income *(note 1)*	82,510	80,064
High cost drugs income from commissioners (excluding pass-through costs)	4,338	4,320
Other NHS clinical income	13,376	14,623
All services		
Private patient income *(note 2)*	1,467	5,239
Additional pension contribution central funding *(note 3)*	2,825	2,720
Other clinical income *(includes injury cost recovery scheme)*	2,339	4,239
Total income from activities	**106,855**	**111,205**

Note 1 - As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

Note 2 - The reduction in private patient income is due to activity being paused due to the pandemic. The Trust was reimbursed by NHS England for this lost income - see note 4.

Note 3 - The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 : Income from patient care activities (by source)

	Group & Foundation Trust	
	2020/21 £000	2019/20 £000
Income from patient care activities received from:		
NHS England	26,242	24,117
Clinical commissioning groups	53,302	53,339
Other NHS providers	43	342
Local authorities	1	1
Non-NHS: private patients	1,467	5,239
Non-NHS: overseas patients (chargeable to patient)	7	-
Injury cost recovery scheme *(note 1)*	778	813
Non-NHS: other *(note 2)*	25,015	27,354
Total income from activities	**106,855**	**111,205**

Note 1 - injury costs recovery scheme income is subject to a provision for impairment of receivables of 22.43% 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 (2020/21: £24,999k and 2019/20: £27,057k).

Note 3.3 : Overseas visitors (relating to patients charged directly)

	Group & Foundation Trust	
	2020/21 £000	2019/20 £000
Income recognised this year	7	-
Amounts written off in-year	7	-

Note 4 : Other Operating Income

	Group		Foundation Trust	
	2020/21 £000	2019/20 £000	2020/21 £000	2019/20 £000
Contract income				
Research & development (contract)	449	673	449	673
Education & training (excl. notional apprenticeship levy income)	1,764	1,212	1,764	1,212
Non-patient care services to other bodies	45	74	45	74
Provider sustainability fund income (PSF) *(note 1)*	-	372	-	372
Reimbursement and top up funding *(note 2)*	5,200	-	5,200	-
Sale of goods & services	443	1,247	443	1,234
Catering	153	536	153	536
Car parking	57	415	57	415
Other contract income *(note 3)*	1,631	1,585	1,631	1,598
Non-contract income				
Education & training - notional apprenticeship fund income	178	101	178	101
Receipt of capital grants & donations	547	611	552	624
Charitable and other contributions to expenditure	-	-	57	59
Consumables donated from DHSC for Covid response	1,296	-	1,296	0
Rental revenue from operating leases	302	301	302	301
Charitable fund incoming resources	353	637	-	-
Total other operating income	**12,418**	**7,764**	**12,127**	**7,199**

Note 1 - the PSF was a mechanism to allocate centrally held support to NHS provider organisations, based on the achievement of a number of performance targets.

Note 2 - under the Covid financial framework, the Trust received £2m funding from April to September 2020 to address the variable expenditure pressures of the initial pandemic response, and £3.2m funding to compensate for the loss of Non-NHS income during the year.

Note 3 - other contract income includes contributions to services, sponsorship income, and accommodation/room rental. In addition, funding for I/T schemes was received - £663k in 2020/21 and £800k in 2019/20.

Note 5 : Additional Information on Contract Revenue Recognised In The Period

	Group & Foundation Trust	
	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end (i.e. release of deferred income)	28	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	
	2020/21 £000	2019/20 £000
Staff and executive directors costs	71,091	69,811
Remuneration of non-executive directors	120	119
Supplies and services - clinical (excluding drugs costs)	12,799	20,096
Utilisation of consumables donated from DHSC for Covid response	1,127	-
Supplies and services - general	1,335	1,600
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	6,292	6,372
Inventories written down	207	161
Consultancy costs	817	389
Establishment	1,127	1,095
Premises *(note 1)*	6,426	4,413
Transport (including patient travel)	566	739
Depreciation on property, plant and equipment	3,333	2,907
Amortisation on intangible assets	965	163
Movement in credit loss allowance: contract receivables / contract assets	231	86
Increase/(decrease) in other provisions	582	605
Audit fees payable to the external auditor		
audit services - statutory audit	94	52
other auditor remuneration (external auditor only)	-	20
Internal audit costs	63	64
Clinical negligence	2,281	2,281
Legal fees	151	88
Insurance	105	82
Research and development	654	696
Education and training	487	490
Rentals under operating leases	919	1,070
Car parking & security	48	76
Losses, ex gratia & special payments	5	25
Other support services *(note 2)*	552	524
Other NHS charitable fund resources expended	179	372
Other	314	26
Total	**112,870**	**114,422**

Note 1 - the premises costs increase is mainly due to additional costs associated with the Covid response such as building works and I/T costs. There was also a significant amount of I/T expenditure relating to additonal funding received.

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 (2020/21 and 2019/20) of the "Audit services - statutory audit" line.

Note 7.2 : Other auditor remuneration

	Group	
	2020/21 £000	2019/20 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	12
Expenses	-	8
Total	**-**	**20**

The limitation on auditor's liability for external audit work, in accordance with their engagement letter, is £1m (2019/20: £1m).

Note 8 : Impairment of Assets

There was no impairment of assets.

Note 9 : Employee Benefits

Note 9.1 : Staff costs

	Group & Foundation Trust	
	2020/21 £000	2019/20 £000
Salaries and wages	57,509	53,186
Social security costs	5,150	4,922
Apprenticeship levy	253	247
Employer's contributions to NHS pensions	9,318	8,932
Pension cost - other	21	14
Termination benefits	21	31
Temporary staff (including agency)	988	4,256
Total gross staff costs	**73,260**	**71,588**
Recoveries in respect of seconded staff	(1,399)	(802)
Total staff costs	**71,861**	**70,786**
Of which		
Costs capitalised as part of assets	146	321

Note 9.2 : Retirements due to ill-health

During 2020/21 there was 1 early retirement from the Trust agreed on the grounds of ill-health (5 for 2019/20). The estimated additional pension liability of this ill-health retirement is £9k (£238k for 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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 1 April 2019 to 20.68% of pensionable pay.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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	
	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	302	301
Other	-	-
Total	**302**	**301**
Future minimum lease receipts due:		
- not later than one year;	307	300
- later than one year and not later than five years;	24	90
Total	**331**	**390**

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 £433k for 2020/21 (£425k in 2019/20). Other smaller leases relate to medical equipment (including a CT scanner and theatre equipment) I/T equipment and lease cars.

	Group & Foundation Trust	
	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	919	1,070
Total	**919**	**1,070**
Future minimum lease payments due:		
- not later than one year;	811	893
- later than one year and not later than five years;	2,485	2,619
- later than five years.	218	672
Total	**3,514**	**4,184**

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

Finance income represents interest received on assets and investments in the year.

	Group	
	2020/21 £000	2019/20 £000
Interest on bank accounts	-	50
NHS charitable fund investment income	-	7
Total finance income	**-**	**57**

Note 13 : Finance Expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	Group & Foundation Trust	
	2020/21 £000	2019/20 £000
Interest expense:		
Loans from the Department of Health and Social Care	105	128
Total finance costs	**105**	**128**

There was no interest payable in 2020/21 or 2019/20 under the Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015.

Note 14 : Other Net Gains

	Group & Foundation Trust	
	2020/21 £000	2019/20 £000
Gains on disposal of property, plant & equipment *(note 1)*	4	123
Total gains on disposal of assets	**4**	**123**

Note 1 - the gain in 2019/20 relates mainly to the disposal of the old MRI scanner.

Note 15 : Intangible Assets

All intangible assets are held by the Foundation Trust.

Note 15.1 : Intangible assets - 2020/21

	Group & Foundation Trust		
	Software licences	Intangible assets under development	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**3,923**	**132**	**4,055**
Additions	140	-	**140**
Reclassifications	128	(128)	**-**
Disposals / derecognition	(61)	-	**(61)**
Valuation / gross cost at 31 March 2021	**4,130**	**4**	**4,134**
Amortisation at 1 April 2020 - brought forward	**513**	**-**	**513**
Provided during the year	965	-	**965**
Disposals / derecognition	(61)	-	**(61)**
Amortisation at 31 March 2021	**1,417**	**-**	**1,417**
Net book value at 31 March 2021	**2,713**	**4**	**2,717**
Net book value at 1 April 2020	**3,410**	**132**	**3,542**

The minimum and maximum useful economic lives of the software licences are 2 years and 9 years respectively. Useful economic lives reflect the total life of an asset, not the remaining life.

Note 15.2 : Intangible assets - 2019/20

	Group & Foundation Trust		
	Software licences	Intangible assets under development	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**1,267**	**1,707**	**2,974**
Additions	1,006	75	**1,081**
Reclassifications	1,650	(1,650)	**-**
Valuation / gross cost at 31 March 2020	**3,923**	**132**	**4,055**
Amortisation at 1 April 2019 - brought forward	**350**	**-**	**350**
Provided during the year	163	-	**163**
Amortisation at 31 March 2020	**513**	**-**	**513**
Net book value at 31 March 2020	**3,410**	**132**	**3,542**
Net book value at 1 April 2019	**917**	**1,707**	**2,624**

Note 16 : Property, Plant & Equipment

All property, plant and equipment is held by the Foundation Trust.

Note 16.1 : Property, plant & equipment - 2020/21

	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 2020 - brought forward	**1,623**	**64,158**	**220**	**1,319**	**9,038**	**25**	**2,872**	**337**	**79,592**
Additions	-	2,497	-	721	1,874	-	219	-	**5,311**
Revaluations *(note 1)*	-	560	(6)	-	-	-	-	-	**554**
Reclassifications	-	174	54	(1,373)	1,145	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(70)	-	(709)	-	**(779)**
Valuation/gross cost at 31 March 2021	**1,623**	**67,389**	**268**	**667**	**11,987**	**25**	**2,382**	**337**	**84,678**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**159**	**10**	**-**	**5,107**	**25**	**1,556**	**259**	**7,116**
Provided during the year	-	2,092	12	-	890	-	327	12	**3,333**
Revaluations *(note 1)*	-	(2,208)	(13)	-	-	-	-	-	**(2,221)**
Disposals / derecognition	-	-	-	-	(70)	-	(709)	-	**(779)**
Accumulated depreciation at 31 March 2021	**-**	**43**	**9**	**-**	**5,927**	**25**	**1,174**	**271**	**7,449**
Net book value at 31 March 2021	**1,623**	**67,346**	**259**	**667**	**6,060**	**-**	**1,208**	**66**	**77,229**
Net book value at 1 April 2020	**1,623**	**63,999**	**210**	**1,319**	**3,931**	**-**	**1,316**	**78**	**72,476**

Note 1 - the revaluation is as a result of a desk-top revaluation of land and buildings by Avison Young.

Note 16.2 : Property, plant & equipment - 2019/20

	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 2019 - as previously stated	**1,623**	**62,461**	**220**	**513**	**9,047**	**25**	**1,871**	**337**	**76,097**
Additions	-	2,148	-	1,320	1,178	-	600	-	**5,246**
Revaluations *(note 1)*	-	(559)	-	-	-	-	-	-	**(559)**
Reclassifications	-	108	-	(514)	5	-	401	-	**-**
Disposals / derecognition	-	-	-	-	(1,192)	-	-	-	**(1,192)**
Valuation/gross cost at 31 March 2020	**1,623**	**64,158**	**220**	**1,319**	**9,038**	**25**	**2,872**	**337**	**79,592**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**-**	**-**	**-**	**5,629**	**25**	**1,326**	**238**	**7,218**
Provided during the year	-	1,976	10	-	670	-	230	21	**2,907**
Revaluations *(note 1)*	-	(1,817)	-	-	-	-	-	-	**(1,817)**
Disposals / derecognition	-	-	-	-	(1,192)	-	-	-	**(1,192)**
Accumulated depreciation at 31 March 2020	**-**	**159**	**10**	**-**	**5,107**	**25**	**1,556**	**259**	**7,116**
Net book value at 31 March 2020	**1,623**	**63,999**	**210**	**1,319**	**3,931**	**-**	**1,316**	**78**	**72,476**
Net book value at 1 April 2019	**1,623**	**62,461**	**220**	**513**	**3,418**	**-**	**545**	**99**	**68,879**

Note 1 - the revaluation is as a result of a desk-top revaluation of land and buildings by Avison Young.

Note 16.3 : Property, plant & equipment financing - 2020/21

	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 2021									
Owned - purchased	1,623	53,368	259	363	5,523	-	1,208	45	**62,389**
Owned - donated/granted	-	13,978	-	304	537	-	-	21	**14,840**
Net book value total at 31 March 2021	**1,623**	**67,346**	**259**	**667**	**6,060**	**-**	**1,208**	**66**	**77,229**

Note 16.4 : Property, plant & equipment financing - 2019/20

	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 2020									
Owned - purchased	1,623	50,338	210	1,319	3,465	-	1,316	54	**58,325**
Owned - donated/granted	-	13,661	-	-	466	-	-	24	**14,151**
Net book value total at 31 March 2020	**1,623**	**63,999**	**210**	**1,319**	**3,931**	**-**	**1,316**	**78**	**72,476**

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 reflect 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	7	48
Plant & machinery	2	31
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	5	35

Note 17 : Donations of Property, Plant & Equipment

Cash donations were received by the Foundation Trust for building refurbishments and to purchase medical equipment. All cash received was utilised for this purpose. Donations were received from:

The Headley Court Charity - £304k (first part of a £6m donation for the Veterans' Centre appeal)

The League of Friends - £108k

The Orthopaedic Institute - £55k

The RJAH charity - £5k

The Foundation Trust also received physical donations of medical equipment from:

DHSC - £72k (as part of the Covid response)

Roald Dahl's Marvelous Children Charity - £8k

Note 18 : Revaluations of Property, Plant & Equipment

For 2020/21, a desk-top revaluation of land and buildings was undertaken by Avison Young with an effective date of 31 March 2021. This resulted in an overall increase in value of £2,775k.

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 2021 £000	31 March 2020 £000
Unrestricted funds:		
Unrestricted income funds	1,140	1,037
Restricted funds:		
Other restricted income funds	240	236
	1,380	**1,273**

Note 20 : Inventories

All inventories are finished goods.

	Group & Foundation Trust	
	31 March 2021 £000	31 March 2020 £000
Drugs	145	194
Consumables	1,191	1,136
Energy	53	66
Total inventories	**1,389**	**1,396**

Inventories recognised in expenses for the year were £6,069k (2019/20: £10,743k). Write-down of inventories recognised as expenses for the year were £207k (2019/20: £161k).

In response to the Covid pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £1,296k of items purchased by DHSC. These items were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 21 : Receivables

Note 21.1 : Analysis of receivables

	Group		Foundation Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Current				
Contract receivables	7,143	5,034	7,143	5,064
Capital receivables	-	120	-	120
Allowance for impaired contract receivables	(696)	(473)	(696)	(473)
Prepayments (non-PFI)	844	887	844	887
Interest receivable	-	6	-	6
PDC dividend receivable	5	-	5	-
VAT receivable	124	25	124	25
Other receivables	51	58	53	58
NHS charitable funds receivables	111	120	-	-
Total current receivables	**7,582**	**5,777**	**7,473**	**5,687**
Non-current				
Contract receivables	1,084	1,156	1,084	1,156
Allowance for other impaired receivables	(243)	(252)	(243)	(252)
Prepayments (non-PFI)	51	83	51	83
Other receivables	353	301	353	301
Total non-current receivables	**1,245**	**1,288**	**1,245**	**1,288**
Of which receivable from NHS and DHSC group bodies:				
Current	4,240	2,216		
Non-current	353	301		

Note 21.2 : Allowances for credit losses

	Group & Foundation Trust		Group & Foundation Trust	
	Contract receivables 2020/21 £000	All other receivables 2020/21 £000	Contract receivables 2019/20 £000	All other receivables 2019/20 £000
Allowances as at 1 April - brought forward	**725**	**-**	683	-
New allowances arising	211	-	40	-
Changes in existing allowances	51	-	61	-
Reversals of allowances	(31)	-	-15	-
Utilisation of allowances (write offs)	(17)	-	-44	-
Allowances as at 31 March	**939**	**-**	**725**	**-**

Note 22 : Non-Current Assets Held for Sale

There were no non-current assets held for sale in either 2020/21 or 2019/20.

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	
	2020/21 £000	2019/20 £000	2020/21 £000	2019/20 £000
At 1 April	**9,437**	**6,687**	**8,250**	**5,673**
Net change in year	7,980	2,750	7,886	2,577
At 31 March	**17,417**	**9,437**	**16,136**	**8,250**
Broken down into:				
Cash at commercial banks and in hand	14	1,197	4	10
Cash with the Government Banking Service	17,403	8,240	16,132	8,240
Total cash and cash equivalents	**17,417**	**9,437**	**16,136**	**8,250**

Note 24 : Third Party Assets Held by the Trust

There were no third party assets held in either 2020/21 or 2019/20.

Note 25 : Trade & Other Payables

	Group		Foundation Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Current				
Trade payables	1,119	2,178	1,119	2,178
Capital payables	901	1,496	901	1,496
Annual leave accrual	1,688	-	1,688	-
Other accruals *(note 1)*	5,873	3,660	5,873	3,660
Receipts in advance and payments on account	-	3	-	3
Social security costs	804	729	804	729
Other taxes payable	738	623	738	623
Other payables *(note 2)*	3,062	1,516	3,062	1,516
NHS charitable funds: trade and other payables	10	4	-	-
Total current trade and other payables	**14,195**	**10,209**	**14,185**	**10,205**
Of which payables from NHS and DHSC group bodies:	1,437	1,265		

Note 1 - other accruals includes £1,782k to be repaid to Welsh commissioners and £980k system funding to be repaid.

Note 2 - other payables mainly includes outstanding pension contributions and payments to staff.

Note 26 : Other Liabilities

	Group & Foundation Trust	
	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	1,061	60
Deferred grants	11	34
Total other current liabilities	**1,072**	**94**

In 2020/21, the majority of these liabilities relate to funding for future recruitment and training (£410k), funding for spinal injuries activity, received late in the year when the beds were not occupied (£333k), and fees received from private patients in advance of treatment (£142k).

Note 27 : Borrowings

Note 27.1 : Analysis of borrowings

	Group & Foundation Trust	
	31 March 2021 £000	31 March 2020 £000
Current		
Loan from DHSC *(note 1)*	1,186	1,189
Salix loan *(note 2)*	242	-
Total current borrowings	**1,428**	**1,189**
Non-current		
Loan from DHSC *(note 1)*	3,532	4,708
Salix loan *(note 2)*	817	-
Total non-current borrowings	**4,349**	**4,708**
Total borrowings	**5,777**	**5,897**

Note 1 - the outstanding DHSC 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 2 - Salix is a government-funded organisation which provides interest-free loans to the public sector to improve energy efficiency.

Note 27.2 : Reconciliation of liabilities from financing activities

2020/21	Group & Foundation Trust		
	Loans from DHSC	Other loans	Total
	£000	£000	£000
Carrying value at 1 April 2020	**5,897**	**-**	**5,897**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,176)	1,059	**(117)**
Financing cash flows - payments of interest	(108)	-	**(108)**
Non-cash movements:			
Application of effective interest rate	105	-	**105**
Carrying value at 31 March 2021	**4,718**	**1,059**	**5,777**

2019/20	Group & Foundation Trust		
	Loans from DHSC	Other loans	Total
	£000	£000	£000
Carrying value at 1 April 2019	**7,075**	**-**	**7,075**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,176)	-	**(1,176)**
Financing cash flows - payments of interest	(130)	-	**(130)**
Non-cash movements:			
Application of effective interest rate	128	-	**128**
Carrying value at 31 March 2020	**5,897**	**-**	**5,897**

Note 28 : Finance Leases

There were no finance leases held in either 2020/21 or 2019/20.

Note 29 : Provisions for Liabilities & Charges

	Group & Foundation Trust				
	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**45**	**485**	**47**	**533**	**1,110**
Arising during the year	107	-	20	641	**768**
Utilised during the year	(36)	(16)	(29)	(15)	**(96)**
Reversed unused	-	-	(12)	(57)	**(69)**
At 31 March 2021	**116**	**469**	**26**	**1,102**	**1,713**
Expected timing of cash flows:					
- not later than one year;	37	20	26	629	**712**
- later than one year and not later than five years;	71	80	-	473	**624**
- later than five years.	8	369	-	-	**377**
Total	**116**	**469**	**26**	**1,102**	**1,713**

The pensions relate to NHS pensions payable to staff given early retirement prior to 1995, and an injury benefit for a previous employee of the Trust. 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 clinician pension tax reimbursement, outpatient backlog follow-up, employment tribunal claims, and the dismantling charges for the day case unit at the end of the lease.

Clinician pension tax reimbursement relates to a tax charge for work undertaken in 2019/20 by clinicians who are members of the NHS Pension Scheme, and have elected to have this paid by the Pension Scheme. The Trust will pay a corresponding compensated amount on retirement, which will in turn be funded by NHS England.

At 31 March 2021, £12,503k was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2020: £12,056k).

Note 30 : Contingent Assets & Liabilities

There were no contingent assets in 2020/21 or 2019/20.

	Group & Foundation Trust	
	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(11)	(30)
Gross value of contingent liabilities	**(11)**	**(30)**

Note 31 : Contractual Capital Commitments

	Group & Foundation Trust	
	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	187	1,301
Intangible assets	-	6
Total	**187**	**1,307**

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 arrangement), analysed by the period during which the payment is made:

	Group & Foundation Trust	
	31 March 2021 £000	31 March 2020 £000
Not later than 1 year	764	811
After 1 year & not later than 5 years	853	898
Total	**1,617**	**1,709**

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 Salix loan is interest free. The Foundation Trust therefore has low exposure to interest rate fluctuations. The charity has no borrowings.

Credit risk

As 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 2021 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

All at amortised cost under IFRS 9	Group		Foundation Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Trade & other receivables excl. non-financial assets	7,692	5,949	7,692	5,949
Cash & cash equivalents	16,136	8,250	16,136	8,250
Consolidated NHS Charitable fund financial assets	1,392	1,307	-	-
Total	**25,220**	**15,506**	**23,828**	**14,199**

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

All at amortised cost under IFRS 9	Group		Foundation Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
Loans from the Department of Health & Social Care	4,718	5,897	4,718	5,897
Other borrowings	1,059	-	1,059	-
Trade & other payables (excl. non-financial liabilities)	12,643	8,850	12,643	8,850
Provisions under contract	120	120	120	120
Consolidated NHS charitable fund financial liabilities	10	4		-
Total	**18,550**	**14,871**	**18,540**	**14,867**

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

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	Group		Foundation Trust	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
In 1 year or less				
In more than 1 year but not more than 5 years	14,035	10,138	14,025	10,134
In more than 5 years	4,709	5,032	4,709	5,032
	18,744	**15,170**	**18,734**	**15,166**

Note - this disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 34 : Losses & Special Payments

	Group & Foundation Trust			
	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	-	2	-
Fruitless payments and constructive losses	1	4	-	-
Bad debts and claims abandoned	40	16	150	37
Stores losses and damage to property	3	167	2	161
Total losses	**45**	**187**	**154**	**198**
Special payments				
Ex-gratia payments	39	40	87	25
Total special payments	**39**	**40**	**87**	**25**
Total losses and special payments	**84**	**227**	**241**	**223**

Losses and special payments are accounted for on an accruals basis, but exclude provisions for future losses.

Note 35 : 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:

Cheshire CCG
NHS England
NHS Resolution
Shrewsbury & Telford Hospitals NHS Trust
Shropshire CCG
Telford & Wrekin 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 Teaching 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 36 : Events After the Reporting Date

There were no events after the reporting date.

Note 37 : Adjusted Financial Performance

The table below shows the Foundation Trust's adjusted financial performance.

	Foundation Trust	
	2020/21	2019/20
	£000	£000
Surplus for the year	**4,693**	**2,657**
Remove capital donations/grants I&E impact	(15)	(102)
Remove net impact of consumables donated from other DHSC bodies	(129)	-
Adjusted financial performance	**4,549**	**2,555**
Less provider sustainability fund (PSF)	-	(372)
Less Covid reimbursement and top-up	(5,200)	
Adjusted financial performance, excluding PSF/top-up	**(651)**	**2,183**
Control total excluding PSF		(2,030)
Performance against the control total, excluding PSF		**153**

Independent auditor's report to the Council 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 the Foundation Trust's affairs as at 31 March 2021 and of the Group's and the 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 Group and the Foundation Trust statement of comprehensive income;
- the Group and the Foundation Trust statement of financial position;
- the Group and the Foundation Trust statement of changes in equity;
- the Group and the Foundation Trust statement of cash flows; and
- the related notes 1 to 37.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers;
- the table of pay multiples;
- the table of exit packages; and
- the table of pension benefits of senior managers.

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)), the Code of Audit Practice 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.

Conclusions relating to going concern
In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Foundation Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the Group and the Foundation Trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information
The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. 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.

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 course of 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 this gives rise to a material misstatement in the financial statements themselves. 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.

We have nothing to report in this regard.

Responsibilities of the accounting officer
As explained more fully in the statement of accounting officer's responsibilities, 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 they have been informed by the relevant national body of the intention to dissolve the Foundation Trust without the transfer of the Foundation Trust's services to another public sector entity.

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.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud
We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the Group and the Foundation Trust and its control environment, and reviewed the Group and the Foundation Trust's documentation of its policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the Group and the Foundation Trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the Group's and the Foundation Trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018, relevant employment legislation and clinical standards.

We discussed among the audit engagement team, including relevant internal specialists such as IT and industry specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following areas, and our specific procedures performed to address it, are described below:

- Recognition of NHS clinical revenue. We evaluated the recognition of income through the period, including year-end cut-off, and evaluated the results of the agreement of balances exercise. In doing so, we assessed the appropriateness of judgements made and the nature of provisions for disputes and the basis for the position adopted.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management and internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006
In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly 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

Use of resources

Under the Code of Audit Practice, we are required to report to you if we have not been able to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the Foundation Trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the Foundation Trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Respective responsibilities of the accounting officer and auditor relating to the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources
The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the Foundation Trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the Foundation Trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the Foundation Trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement 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; or
- proper practices have not been observed in the compilation of the financial statements.

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.

We have nothing to report in respect of these matters.

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 this matter.

Delay in certification of completion of the audit
We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report). We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

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 Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Mohammed Ramzan, CPFA (Key Audit Partner)
For and on behalf of Deloitte LLP
Statutory Auditor
Birmingham, United Kingdom
14 June 2021

Audit certificate issued subsequent to opinion on financial statements

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements
In our audit report for the year ended 31 March 2021 issued on 14 June 2021, we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 14 June 2021, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit
In our audit report for the year ended 31 March 2021 issued on 14 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Mohammed Ramzan, CPFA (Key Audit Partner)
For and on behalf of Deloitte LLP
Statutory Auditor
Birmingham, United Kingdom
10 September 2021