Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Annual Report and Accounts 2017–2018

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Annual Report and Accounts for the period of 1 April 2017 to 31 March 2018

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Contents

ANNUAL REPORT

INTRODUCTION

Statement of Chairman and Chief Executive

At Robert Jones and Agnes Hunt NHS FT we aspire to deliver world class patient care. As a high quality specialist orthopaedic hospital our core purpose is to care for our patients, our staff and our finances. We are extremely fortunate in having experienced and dedicated staff who are fully focussed in delivering excellence.

The following Annual Report details our performance for the 2017/18 financial year. The report outlines our key objectives and how we have progressed against these; it describes our governance arrangements, and provides detail on the important aspects of quality and finance which underpin our organisational achievements. The full performance report across all these areas is contained within this document.

There is so much from the last year that we can look back on with pride – not least the visit of HRH Princess Alexandra in July. The Princess came to officially open our £15.1 million theatre and oncology building, and also presented the inaugural Dame Agnes Hunt Nursing Medal to one of our staff, Sister Glenna Hardy as well as unveiling a sculpture in memory of popular hospital resident Percy the Peacock.

We were also delighted by the wonderful feedback we have received from our own patients over the past 12 months. In the Adult Inpatient Survey 2016, published in June last year, we were ranked as No 1 in the country for overall patient experience.

At the time of writing we have seen our own data for the 2017 report but are still waiting for the publication of the benchmarking report that will allow us to see how we compare this time. What we can say is that our own report makes, if anything, even better reading than a year ago and reflects the high regard in which we are held by our patients.

Just recently we were able to report truly sensational Patient Recorded Outcome Measures (PROMs). Our PROMs data showed us to be delivering greater health gains for hip and knee replacement patients than any of the other specialist orthopaedic providers. That truly is something to be proud of.

The year got off to a perfect start with the news last May that we had been taken out of breach of licence by our regulator, NHS Improvement. That was a significant milestone as we had worked so hard to get to that point.

One of the key contributors that had seen the organisation in breach in the first place was its performance in terms of access and waiting times. I'm pleased to say we have achieved a continued reduction in 52-week waiters and have also improved steadily against the Referral to Treatment (RTT) standard, with a year-end position of circa 91%.

We also had work to do around culture in the organisation. We took that challenge head-on with the Rebuilding Relationships Programme and by improving behaviours through embedding our values and cultural characteristics. As we take this work forwards, we will switch the emphasis a little to talking about what every member of staff can do to help 'Make The Difference' and really turn this into an extraordinary place to work.

The improvements we have made were evident in the results of our Staff Survey. This showed we had got better at learning from incidents and we have also made significant strides in improving the communication between senior managers and staff.

Our quality focus is essentially underpinned by robust and sound business management, which is demonstrated in our delivery of a surplus of £0.546 million in 2017/18. This surplus was in line with our control total set by NHS Improvement and therefore made us eligible for additional sustainability and transformation funding worth a further £1.807 m. This will provide a basis for our future growth and development, enabling re-investment to improve care for patients. In the current financial climate across the NHS it was quite an achievement, and one of which we are very proud.

Over the next 12 months, we will look to build on our recent successes and continue to grow. As part of the local health system we will look to continue to develop our services outside the walls of the hospital and with a real focus on preventative care and treatment. The current climate may be a challenging one, but we are confident that we are well equipped to meet those challenges and to thrive.

Frank Collins
Chairman

Mark Brandreth
Chief Executive

Highlights of the year

The Trust has, like many NHS organisations, had a challenging year but there have been many highlights:

- HRH Princess Alexandra returned to RJAH in July 2017 – 10 years to the day since her first visit – to officially open the £15.1 million theatre and oncology building.
- A rare treatment called Autologous Chondrocyte Implantation (ACI) – used on a type of arthritis in the knee and only currently available at RJAH – won approval for use on the NHS after 20 years of trials led by the late Professor James Richardson.
- RJAH signalled its commitment to patients who serve in military roles by signing up to the Armed Forces covenant.
- An investment of £500,000 was made to bring the hospital into the 21st century with 200 state-of-the-art beds installed across the site.
- The Trust was a finalist in the Provider Trust of the Year category at the HSJ Awards. Chief Executive Mark Brandreth was a finalist in the Chief Executive of the Year category at the same event.
- The Trust was ranked No 1 in the country for overall patient experience in the Adult Inpatient Survey 2016, which was published in June 2017.
- Our neuromuscular team were part of a North West Neuromuscular Network which was awarded 'Network of Excellence' status by Muscular Dystrophy UK.
- A fundraising project was launched in partnership with Horatio's Garden to raise more than £600,000 which will provide a stunning garden area for spinal injury patients.
- National award winners included Technical Instructor Derek Williams, who won the Care and Innovation Award at the Spinal Injuries Association (SIA) Rebuilding Lives Awards.
- Rebecca Warren, Ward Manager on the Midland Centre for Spinal Injuries, won the Outstanding QARANC Reservist Clinical Professional Development Award at the Cavell Awards.
- The Trust enlisted nearly 200 patients as part of the 100,000 Genomes Project – a Government funded programme using genetics to help improve knowledge and treatment of rare diseases.
- Research Associate Dr Charlotte Hulme showcased her work in Parliament as one of only 45 researchers – from over 600 who applied – selected to present at a prestigious event at the Palace of Westminster.
- The high standard of work experience offered to young people at RJAH was recognised with the Fair Train Work Experience Quality Standard bronze award.
- All sugar-sweetened drinks were phased out of the restaurant, shops and cafes at RJAH as part of an NHS-wide drive to promote healthy lifestyles.
- Everyone at RJAH was grateful to the 23 runners who took part in the London Marathon to support the hospital's own charity – raising an incredible £46,000 in the process.

PERFORMANCE REPORT

Overview of Performance

Statement from the Chief Executive

This section of the report provides an opportunity to highlight some of the considerable work that has been undertaken to enhance the Trust's services and the 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 2017-18. 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. We have seen another set of outstanding results in the latest Adult Inpatient Survey and our Patient Reported Outcome Measures set us apart as the leading specialist orthopaedic provider.

The next period is about focussing on quality and safety. We want to be compared with the best of the world. We have some work to do to realise this ambition but let us see how far we can go. As an Executive Team, we are focussed on being the safest specialist hospital.

Caring for Patients

A 20-year journey came to a successful conclusion in October 2017 when approval for Autologous Chondrocyte Implantation (ACI) to be used on the NHS was won. ACI is a treatment for a rare type of arthritis of the knee and was pioneered by Professor James Richardson. 'Prof' was delighted by this decision but sadly passed away in February 2018. We miss him.

Our commitment to our patients was also evidenced with the investment of £500,000 to replace every bed in the hospital. This was a significant piece of work but a necessary one as we look to deliver ever higher standards of patient experience.

Caring for Staff

We have continued with our focus on culture across the organisation in the past year. We took the challenge head-on with the continuation of our Rebuilding Relationships Programme and by improving behaviours through embedding our values and cultural characteristics.

At the time of writing we are waiting for the publication of our latest CQC report, but feedback from the inspectors highlighted improvements they saw in this area. As we take this work forwards, we will switch the emphasis to what every member of staff can do to help 'Make The Difference' and turn this into an extraordinary place to work.

The improvements we have made were evident in the results of our Staff Survey. This showed we had got better at learning from incidents and we have also made significant strides in improving the communication between senior managers and staff.

Caring for Finances

These are unprecedented times for the NHS. All around us, we see examples of the financial pressure bearing down on NHS organisations. Providers and commissioners alike are running up record-breaking deficits.

However, in 2017/18, we generated a surplus of £0.546 million and in doing so delivered the control total set for us by NHS Improvement. This resulted in the Trust being eligible for a further £1.807 million of funding, money that will help us stay solvent in the medium and long-term, it will help us stay vibrant and it will help us continue to grow.

Looking ahead

We cannot rest on our laurels. 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-focussed, 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; twelve operating theatres, including a day case surgery unit; and full outpatient and diagnostic facilities.

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

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

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

Brief History and Background

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

Sir Robert Jones

Dame Agnes Hunt

The Vision and Goals of the Trust

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

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

Key Issues and Risks

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

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

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

During 2017/18 the key risks facing the Trust have been in relation to its ability to safely meet its activity requirements and the impact of this on its financial plan. There has also been focus on continuing to shift the dial on staff engagement in recognition of the impact this has on the organisation as a place to work. At the time of the last annual report the Trust reported demonstrable progress being made to coming out of breach of licence but recognised there was still potential for failure to demonstrate compliance with licence requirements.

The Trust had previously had a significant risk around its RTT performance and had been in breach of licence, in part, in relation to this. In May 2017 the Trust successfully came out of breach of licence.

The key risks and issues facing the Trust for 2018/19 are as follows:

Caring for Patients

- Failure to improve performance in relation to the CQC core standards
- Inadequate or unsuccessful implementation of learning from incidents

Caring for Staff

- Potential inability to have the right workforce in the right place at the right time
- Communication between managers and the workforce fails to improve staff engagement

Caring for Finances

- Failure to achieve activity and income target within planned cost base

In addition the Trust recognises a risk from 2019/20 onwards with regard to the instability arising from fluctuations in the annual tariff.

Risk Management

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

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

The Trust's Risk Management Strategy is subject to annual review via the Risk Management Committee and approval at Trust Board and it was last reviewed in September 2017.

Going concern disclosure

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

The Directors having taken assurance from this and, having reviewed future plans and financial forecasts for a period of at least one year from the date of the approval of the accounts, have agreed the following statement: "After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts".

Performance Analysis

Trust Performance

The Trust's overall performance in 2017/18 has been good and feedback from patients on services continues to be excellent. Performance is monitored through a broad range of both externally and internally driven Key Performance Indicators (KPIs) covering three domains:

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

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

The Trust was inspected by the CQC in January 2018 but at the time of writing the inspection report was awaited. Prior to this the Trust was inspected in October 2015 following with the Trust was rated overall as 'Requires Improvement' with the caring element achieving 'Good'. The Trust developed a CQC Action Plan following the inspection in October 2015 and this has now been fully implemented. An internal audit of the action plan provided significant assurance on its implementation and the action plan was completed in April 2017. Since that time the Trust has worked closely with its local CQC team to ensure continuous improvement for its patients and staff.

Following the Trust being found in breach of its licence conditions, enforcement undertakings were imposed on the Trust in January 2016. To support delivery of these undertakings, the Trust implemented a RTT Recovery Plan and Integrated Governance Action Plan. At the time of writing the last annual report the process to remove some of the licence breach undertakings was underway and in May 2017 the Trust received notification that it had come out of breach of licence.

In March 2018, the Trust delivered 90.05% against the 92% 18 week Referral to Treatment open pathways target.

The Trust planned a control total surplus of £0.513 million for 2017/18 and delivered a surplus of £0.546 million excluding sustainability and transformation funding of £1.807 million.

Performance highlights across some of the key performance areas for the Trust during 2017/18 were as follows:

Caring for Patients

- The Trust continued to deliver exceptionally low rates of hospital acquired infections; there have been no cases of hospital acquired MRSA Bacteraemia since 2006 and no cases of C. Difficile during the year. The Trust has taken further steps in the prevention of transmission of MRSA in ward environments by investing in a hydrogen peroxide deep clean.

- The Trust has also this year seen the development and launch of the Quality Improvement strategy, setting out the Trusts Quality aims for the next 5 years and the Patient Experience strategy, ensuring that we continue to be the best that we can be in relation to the experience of our patients

- The National Inpatient Survey 2017 results published by Picker Institute shows that the Trust achieved a response rate of 58.5% against a national average of 38.3% and the respondents scores indicate the Trust is significantly better than average in 56 out of the 60 applicable questions. The final benchmarked report is due for publication in May 2018. The last benchmarked report received by the Trust was in May 2017 and this confirmed that 824 patients had responded with 97% saying their care was seven out of ten or higher. Further the Trust was noted to have performed better than most other Trusts in 9 out of the 10 applicable sections of the survey. Other highlights from the survey were that 97% of patients had complete faith in their doctors and 95% said they were treated with respect and dignity. Cleanliness also scored well with 100% saying their room or ward was very or fairly clean.

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

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

- At March 2018, the Trust had two 52 week waiters[1] and RTT performance stood at 90.05% compared to 91.37% in March 2017.

Caring for Finances

- The Trust overachieved against the baseline control total surplus by £33k giving a year end surplus of £0.546 million. This rises to a surplus of £2.353 million when Sustainability and Transformation Funding (STF) worth £1.807m is included. The STF income is made up of £0.592m core income earned in full through delivery of the control total and £1.215m bonus/incentive STF earned as part of a national allocation of unearned STF from other Trusts notified at the year end. This position was supported by an efficiency programme which realised £4.1 million efficiencies in year.

[1] There was a deviation in national reporting due to subsequent validation. Throughout the year the Trust had reported one 52 week waiter but a second 52 week waiter (relating to the financial year 2017-18) was reported and treated in May 2018.

- The Trust was allocated an agency ceiling target of £1,617k in 2017/18. Agency spend was closely monitored and managed across the year, however pressures on bed capacity coupled with difficulties in recruitment of theatre nurses and medical consultants in the latter half of the year have resulted in the Trust exceeding the target by £91k with expenditure totalling £1,708k.

Caring for Staff

- The Trust achieved a Staff Survey response rate of 41.5% (575 members of staff) and results were benchmarked against other Acute Specialist Trusts. Results were considerably better than 2016 with key headlines as follows:
    - Friends and Family test scores showed 75% would recommend the Trust as a place to work and 93% would recommend for treatment and care
    - Engagement scores are slightly above average when compared with other acute specialist trusts
    - Work continues on developing an open culture, improving communication particularly between managers and staff and improving our leadership capacity and capability
    - Key areas of improvement relate to learning from our mistakes up by 11% and communications between senior managers and staff with improvements up to 10%

Activity Analysis

The number of patients treated has remained broadly stable in 2017/18. The data for GP referrals has been refreshed retrospectively to align with that reported in the Trust's integrated performance report to ensure consistency both in reporting throughout the year and the Annual Report.

Patient Activity Figures 2017/18

Activity	Division	14/15	15/16	16/17	17/18
Outpatients	Surgical	78,792	84,531	86,129	81,858
	Medical	23,893	25,862	30,255	29,332
	Total	**102,685**	**110,393**	**116,384**	**111,190**
Planned Inpatient Stays	Surgical	12,701	12,765	12,484	12,220
	Medical	1,967	2,087	2,477	2,761
	Total	**14,668**	**14,852**	**14,961**	**14,981**
Non Elective Stays	Surgical	366	289	298	301
	Medical	484	422	359	356
	Total	**850**	**711**	**657**	**657**
GP Referrals	Surgical	15371	14240	13882	14227
	Medical	7127	7965	8160	8484
	Total	**22498**	**22205**	**22042**	**22711**

Financial Analysis

The Trust was set a control total surplus of £513k for 2017/18. Despite a number of in-year operational pressures arising from a shift in case mix complexity the Trust achieved this target and therefore became eligible for additional sustainability and transformation funding (STF) from NHS Improvement. This contained a core element of £592k and a further and unplanned bonus element of £1,215k which was a share of the unclaimed national sustainability fund. The total control total surplus for the year including sustainability funding was £2,353k.

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

	2017/18 £'000
Accounting surplus for the year	1,821
Add back capital donations/grants impact	532
Control total surplus (including STF)	**2,353**
Less STF	-1,807
Control total surplus (excluding STF)	**546**
Control total target	-513
Over achievement against control total	**33**

This strong financial performance has improved our financial resilience and will enable future investments back into services. It was supported by a programme of cost improvements which realised £4.1 million savings in year from operating more efficiently (2016/17 £3.5 million).

A full set of the Annual Accounts is included at the end of the Annual Report and further analysis of the Trust's financial performance is included in the Directors report. The Charitable Funds accounts have been consolidated with the Trust's accounts but in order to give a true and fair view of the Trust's position these have been excluded from the tables and narrative in this report.

A breakdown of the surplus for 2017/18 is given in the table below.

	2017/18 £'000
Operating income	107,511
Operating expenses	-103,967
Net finance costs	-1,723
Surplus	**1,821**

The Trust had a year-end cash balance of £4.2 million, which is a small decrease on the previous year's balance of £4.6 million. The reduction is linked to outstanding STF owing which is expected to be paid by July 2018.

Capital Programme

The Trust invested £2.4 million in the capital programme for 2017/18, compared to £5.3 million in 2016/17 and includes donations of £22k from the RJAH Charity and the League of Friends.

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

- Replacement of beds in the hospital with modern beds providing benefits to both patients and staff.
- Refurbishment of the outpatients department to improve patient experience and address environmental issues.
- Theatre and recovery equipment to enable an additional theatre in the Menzies Unit to be utilised, thereby facilitating sessions in theatre to accommodate the recruitment of additional consultants.
- Fire risk reduction work to reduce the likelihood of a fire and improve safety if a fire starts.
- Medical gas plant upgrade to support the Menzies theatres.

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

- Estates backlog maintenance - this includes maintenance of areas such as roofing, car parks, cosmetic improvements and replacement of ageing infrastructure.
- Medical equipment - this includes replacement of ageing medical equipment and investment in additional equipment to support service improvement.
- Information Technology (IT) - this includes investment in new technologies and ways of working as well as routine replacement of hardware and software, and cyber security.

Capital Scheme	2017/18 £'000
Bed replacement	498
Medical equipment	445
Backlog maintenance (including fire risk work)	336
I/T investment	212
Menzies theatre equipping	176
Outpatient development	164
Office reconfigurations	155
Generator & medical gas plant upgrade	146
Theatre & tumour unit	120
Project management & fees for future capital schemes	169
Total capital expenditure	**2,421**

The Environment and Sustainability

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

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

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

In response to this, through the Trust's Sustainability Working Group, the Trust revisited and refreshed its own Sustainable Development Strategy ensuring that whilst delivering outstanding patient care remains the Trust's primary focus, it is committed to embedding sustainability across the organisation, understanding that it must play its part and tackle the challenges of sustainability because of the longer term impact on the health and wellbeing of service users, employees, visitors and the wider community.

The strategy focuses on five key areas of commitment:

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

The Trust's development and oversight of the delivery of this Sustainability Strategy agenda will be managed through the Finance Planning and Investment Committee. The Trust has both a named executive and non-executive director for sustainability.

The targets set for the Trust are:

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

As compliance tightens around water safety Estates and Facilities are undertaking increasing numbers of water flushing exercises; in an effort to reduce the likelihood of issues related to water borne bacteria. The effect has been to marginally increase water use. Alongside flushing the Estates Department has worked hard to minimise water use and is still achieving its 2020 National Target figure.

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

The below table demonstrates the progress made against the National 2015 and 2020 Sustainability target, plus the Trust's own Sustainability Strategy target. It should be noted that due to the use of CHP the Trust's gas usage has increased but its electric usage has decreased.

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

Key:

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

Social, Community and Human Rights

The Trust continues to have strong links with the local community, which are enhanced by its public governors. It has an active apprentice scheme and in 2017-18, 21 staff commenced an apprenticeship qualification with the Trust.

The Trust also provided work experience placements for 220 local youngsters and held an "Operating Theatre Live" event for 16-18 year olds.

We have played an active role in our local community working with 41 members of staff acting as health ambassadors supporting careers fairs, training programmes and other community events

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

Conclusion of the Performance Report

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

Mark Brandreth

Chief Executive Officer

24 May 2018

ACCOUNTABILITY REPORT

Directors Report

The report includes the following:

- Meet the Board
- Delivery of the 2017/18 strategic plan
- Looking ahead : vision for the Trust for 2018/19
- The strategic priorities for 2018/19
- 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 2017 to 31 March 2018. The directors' report incorporates an analysis of the delivery of the 2017/18 strategic plan during that period and the vision for 2018/19.

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

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

Frank Collins Chairman

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

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

Frank currently serves as non-executive director/chairman to a range of healthcare related companies, is a trustee of a local charity and interim Chair of North Bristol NHS Trust.

Mark Brandreth – Chief Executive

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

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

Alastair Findlay Non-Executive Director

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

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

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

David Gilburt
Non-Executive Director

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

David 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.

Hilary Pepler
Non-Executive Director

Hilary is the Chair of the Trust's Quality and Safety Committee as well as a member of the Audit and Finance Planning and Investment Committees. In addition, Hilary also acts as the Trust's Non-Executive Safeguarding lead.

Hilary brings a wealth of clinical, managerial and executive experience. She started her NHS career as a nurse, working primarily within Community Health Services; she then moved into managerial roles, working as the Director of Human Resources at the Royal Liverpool University Hospital. In 1993 she became a Trust Chief Executive, working in Chester, Liverpool and the North East Wales Trust.

Following her retirement in 2007 Hilary has worked as a volunteer with the National Trust.

Chris Beacock
Non-Executive Director

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

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

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

Harry Turner
Non-Executive Director

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

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

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

Steve White
Medical Director

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

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

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

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

Bev Tabernacle
Director of Nursing/ Deputy Chief Executive

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

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

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

Craig Macbeth
Finance Director

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

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

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

Nia Jones
Director of Operations

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

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

Nia became Director of Operations in August 2017

Changes to the Board of Directors

During 2017/18 the following changes have been made to the Board of Directors:

Starters

Director	Date of Change
Nia Jones, Interim Director of Operations.	1 April 2017
Nia Jones became substantive Director of Operations	1 August 2017
Craig Macbeth, Director of Finance	1 April 2017

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 these are also published on the Trust's website.

Cost allocation and charging guidance

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

Modern Slavery Act 2015

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

Delivery of the 2017/18 Strategic Plan

During 2017/18 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 22 objectives with a clearly defined measurable for each. The table below provides a position statement against each of the objectives (as at 31 March 2018)

Caring for patients			
1. Delivering timely access to patient care			
	Annual Objective	**Measure**	**Position**
1.1	Sustain the delivery of our access and waiting times.	• By Q3 deliver Access to Service – English to 92% open pathway performance for patients waiting 18 weeks or less to start their treatment.	The Trust closed the year at 90.05% open pathway performance for patients waiting 18 weeks or less to start their treatment.
1.2	Reduce on the day cancellations.	• At March 2018 show a year to date on the day cancellations less than the year to date March 2017 position.	The number of on the day cancellations changed from 106 reportable and 293 non-reportable, giving a total 399 in 16/17, to 123 reportable and 321 non-reportable giving a total of 444 in 17/18.
1.3	Reduce delayed discharges	• At March 2018 show a year to date delayed discharges less than the year to date March 2017 position.	The Trust has been working hard to ensure work in relation to reducing delayed discharges is a priority. The number of days of delayed discharges has reduced from 2,963 in 16/17, to 2,111 in 17/18, a reduction of 852 days, a reduction of 29% A number of processes have been reviewed and improved. The delayed discharge CQUIN has been achieved.
1.4	Participate in the local health economy STP development, particularly the development of MSK services.	• Develop a stakeholder engagement plan to position RJAH as a key lead in the development of MSK services.	The development of MSK services is progressing well, as per regular Board updates. Regular executive attendance at STP Partnership Board meetings is in place. The Trust has attendance at the following STP groups; • STP Programme Delivery • Independent impact assessment. • STP Finance • One public estate • Estates, Transport & Back Office • Digital Enablement

2. Delivering outstanding outcomes and experiences			
2.1	Continually improve the CQC inpatient survey result.	• As per the published survey results in May 2018 demonstrate incremental improvement in our performance.	The historical comparisons section of the Picker Inpatient survey for 17/18 demonstrates our continued improvement. The Trust also maintains our number one position for patient experience.
2.2	Demonstrate improvement in our NJR performance	• At March 2018 utilising the NJR performance reporting, measurement of outcomes to have improved against March 2017 report.	As presented at March Board our 16/17 provisional scores show improvements across hip and knee replacements and revisions as follows; • Primary hip replacement from 20.847 to 22.155 • Primary knee replacement from 17.027 to 17.854 • Revision hip replacement from 11.163 to 13.847 Revision knee replacement from 8.505 to 10.96
2.3	Sustain a friends and family test score above 98%	• For the financial year 2017/18 show a Friends and Family score above 98% each month.	2017/18 exited the year with a friends and family test score of 99.17% with the score throughout 2017/17 being above 98% each month
3. Achieving outstanding patient safety			
3.1	Improve learning from incidents.	• At March 2018 utilise the year to date number of incidents and near misses reported in totality to have shown a decrease in similar type incidents against the same measurement the previous financial year.	We are continuing to embed the process of learning from incidents. We have a revised Serious Incident policy in place which strengthens clinical involvement in the process and we are underway with our changes to Datix and the governance team structures. A safety summit was held in July 2017, from which work has commenced in relations to Human Factors training in line with our quality strategy. Learning triangles are circulated to all areas on a monthly basis. At the end of March 2018 there were no open serious incidents and the Trust has not had a never event for over 12 months.
3.2	Develop a dashboard for safety which reflects SOA common values.	• Revised dashboard in place.	Dashboard has been developed and is awaiting NOA publication.
3.3	Develop an open culture	• Improvement in 2017 staff survey score for all indicators relating to errors, near misses or incidents against 2016 score.	The scores improved as follows; In the last month have you seen any errors, near misses, or incidents that could have hurt … • Staff improved from 88% to 89%

			• Patients improved from 84% to 87% The last time you saw an error, near miss or incident that could have hurt staff or patients, did you or a colleague report it? • Improved from 89% to 92% My organisation treats staff who are involved in an error, near miss or incident fairly • Improved from 47% to 55% My organisation encourages us to report errors, or near misses or incidents • Improved from 87% to 89% When errors, near misses or incidents are reported, my organisation takes action to ensure they do not happen again • Improved from 61% to 70% We are given feedback about changes made in response to reported errors, near misses and incidents • Improved from 45% to 56% Raising concerns about clinical practice • Would you know how to report it remained static at 95% • Feeling secure to raise is improved from 62% to 63% Confident organisation would address improved from 55% to 58%
Caring for staff			
4. Being an extraordinary place to work			
4.1	Streamline and improve quality of appraisals for staff.	• Improvement in 2017 staff survey scores for quality of appraisals measured against 2016 score.	In response to the questions; • 'it has helped me to improve how I do my job' an improvement from 62% to 65% • 'It helped me agree clear objectives for my work' an improvement from 77% to 80%

			• 'It left me feeling that my work is valued by my organisation' an improvement from 68% to 74% • 'The values of my organisation were discussed as part of the appraisal process' an improvement from 74% to 78% 'Were any training, learning or development needs identified' an improvement from 56% to 61%
4.2	Demonstrate year on year improvement of staff survey results.	• Improvement in 2017 staff survey score for staff engagement measured against 2016 score.	The staff engagement score improved from 3.89 in 2016 to 3.96 in 2017.
4.3	Embed values and behaviours.	• Improvement in Pulse survey scores from baseline of March 2017 scores.	Throughout the period that the pulse surveys were running we saw improvement as presented in the IPR at Board, together with the improvement within the staff survey results.
4.4	Reduce voluntary turnover.	• At March 2018 show a year to date voluntary turnover rate less than the year to date March 2017 position.	The voluntary staff turnover has reduce from 8.88% in March 2017 to 7.57% in March 2018.
4.5	Develop a workforce plan to include succession planning.	• By March 2018 to have agreed through Patient and staff committee a workforce plan.	The workforce plan is currently in development but is yet to be agreed.
4.6	Develop leadership capacity and development.	• Development and roll-out of leadership programmes.	The Rebuilding Relationships bite-sized training modules have been successfully rolled out, with the sixth module recently released. The second year of Releasing Potential saw 33 applications for 16 places. Service improvement programme commences in quarter four.
Caring for finances			
5. Spending our money wisely			
5.1	Achieve our control total of £1.1m surplus.	• At March 2018 delivering the planned surplus for financial year 2017/18.	Our financial control total for the year has been met.
5.2	Achieve an income and expenditure margin of at least 1%	• At March 2018 deliver at least 1% income and expenditure margin for financial year 2016/17.	By meeting our financial control total for the year we have delivered the required margin.

5.3	Continuously develop progress against the Carter Model Hospital	• As per the published specialist model hospital data, to have developed an action plan for improvement by March 2018.	Quarterly meetings are established where model hospital information is reviewed and action plans established for outlying areas.
5.4	Develop an investment portfolio programme.	• At March 2018 to have agreed through Finance, Planning and Investment committee a programme of work to create an investment portfolio to support the delivery of our strategic intentions.	The development of our capital investment prioritisation process has been finalised providing a standardised method of assessment criteria which now provides oversight of all likely capital investments. A staged by year plan is now in place to inform the investment portfolio.
Regulatory			
6. Delivering undertakings and not being in breach of licence			
6.1	Removal from breach of license.	• Undertaking and removal by NHSI by Q2.	Trust removed from breach of licence in Q1.
6.2	Preparedness to respond to a CQC inspection for improved rating.	• Regular review of CQC inspection preparedness demonstrated through action plan updates at Quality and Safety committee.	Action plans have demonstrated preparedness to CQC inspection. A successful CQC inspection was undertaken in January 2018. This was followed by the 'Well Led' inspection.

Looking ahead for 2018/19

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

The next fiscal year will focus on building on the great work of 2016/17 and 2017/18. It will involve looking at those performance targets that have not been achieved in 201718 and what actions need to be taken to achieve these. The Trust will ensure that patient safety and quality standards are maintained and at the fore of its business.

In summary our strategy is;

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

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

The Corporate Objectives for 2018/19

Caring for Patients		
Achieving outstanding patient safety		
Annual Objective	**Delivered by**	**Responsible Director**
100% delivery of WHO checklist.	This will be measured through the Trust WHO audit compliance process, which considers both quantitative and qualitative measures.	Medical Director & Director of Nursing
Improved learning from incidents.	As measured through the staff survey question "we are given feedback about changes made in response to reported errors, near misses and incidents".	Medical Director & Director of Nursing
Provision of a continuously improving paediatric service.	Refresh our service model to ensure it continues to meet the relevant standards.	Director of Nursing & Medical Director
Delivering outstanding outcomes and experience		
Annual Objective	**Delivered by**	**Responsible Director**
Increased capture and use of patient reported outcome measures (PROMs).	Delivery of an improved, standardised method to capture PROMs with incorporated reporting for improving service delivery.	Medical Director & Director of Strategy
Utilising real time patient experience data.	Implementation of a method to capture real time patient experience, with evidenced use to improve services.	Director of Nursing
Reduce the number of rescheduled episodes.	As measured through the Picker Inpatient survey question "planned admission: admission date changed by hospital" & to be determined measure for outpatients.	Director of Operations
Delivering timely access to patient care		
Annual Objective	**Delivered by**	**Responsible Director**
Sustain the delivery of our access and waiting times	Deliver the commissioner standards as per agreed 2018/19 contractual arrangements.	Director of Operations
Deliver an outpatient capacity model	Design and delivery of an outpatient capacity model to provide a method of outpatient planning.	Associate Director of Performance
Generate greater understanding within our workforce of MSK self-management and non-surgical pathways.	As measured through the difference in results of a perception survey delivered in April 2018 and March 2019.	Director of Operations & Director of Strategy
Caring for staff		
Being an extraordinary place to work		
Annual Objective	**Delivered by**	**Responsible Director**
Implement the behavioural standards framework.	Improvement in 2018 staff survey scores for harassment, bullying and discrimination.	Director of Strategy
Develop a strategic workforce plan	Delivery of a three to five year workforce plan.	Director of People
Improve the level of communication and engagement between managers and our workforce.	Continued improvement in 2018 staff survey scores for questions in relation to 'your managers'.	Director of Strategy & Director of People

Caring for finances		
Spending our money wisely		
Annual Objective	**Delivered by**	**Responsible Director**
Deliver our financial control total for 2018/19.	Deliver the planned financial control total for financial year 2018/19.	Director of Finance
Understand and reduce clinical variation.	Utilising GIRFT measurements provide the range of areas of clinical variation; produce an action plan for reducing variation evidenced through the GIRFT measurements.	Medical Director & Director of Operations
Develop and implement an operational transparency model.	Evidence the implementation of real time data use to drive operational management and decision making.	Director of Operations & Associate Director of Performance
Meeting the requirements of our regulators		
Annual Objective	**Delivered by**	**Responsible Director**
Continue to improve performance in relation to the CQC core standards.	An audited CQC action plan incorporating both response to past inspections together with preparation for 2018.	Director of Nursing
Maintain our Single Oversight Framework (SOF) score.	As demonstrated by the March 2019 score in comparison with March 2018.	Director of Finance
Develop a register of accreditations.	Maintenance of accreditations, e.g. HTA licences, fire safety, etc.	Trust Secretary

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 2017/18 the Trust paid 93% of the number of invoices and 95% of the value of invoices within the target.

	2017/18		2016/17	
	Number of invoices	Value in £000s	Number of invoices	Value in £000s
Total invoices paid	33,546	62,128	34,190	63,939
Invoices paid within target	31,031	59,088	32,406	61,683
Percentage paid within target	93%	95%	95%	96%

Quality Governance

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

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

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

The Trust has in place a robust governance framework to underpin the delivery of enhanced quality and further detail on this framework is contained within the Trust's Annual Governance Statement which can be found at page 68 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 2017/18

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 looks 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. Key quality risks identified are:

- Inadequate or unsuccessful implementation of learning from incidents
- Inability to deliver our access and waiting time targets
- Failure to improve performance in relation to the CQC core standards
- Failure in data quality
- Failure in clinical quality or safety controls

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 have set out our Quality aims for the next 5 Years.

Our Quality Aims

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

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

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

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

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

Always Events

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

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

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

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

Listening to Patients and Carers

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

The table below shows overall patient feedback in 2017/18 compared to 2016/17:

Feedback	2017/18	2016/17	Diff from 2017/18 to 2016/17
Complaints	78	105	-27
Local resolution	32	29	3
PALS concerns	434	496	-62
PALS info requests	839	722	117
Compliments	4979	4269	710

Key Highlights

CQC Action Plan

During January 2018, the CQC carried out an inspection of the Trust and at the time of writing the inspection report was awaited. Prior to this, the Trust was inspected by the CQC in October 2015. At this time, the Trust was given an overall rating of Requires Improvement, with the breakdown of ratings show in the table below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

In response to the inspection report from October 2015, the Trust put in place a robust action plan to address the areas for improvement highlighted by the CQC. Completion of this action plan was monitored by the Quality & Safety Committee and all actions were signed off as complete in April 2017.

Inpatient Survey

Patients are asked to answer the Friends and Family Test (FFT) question: "How likely are you to recommend our ward/clinic to friends and family if they needed similar care or treatment" on the day

of discharge or after they have attended a clinic appointment. They are invited to rate the Trust against options ranging from "extremely likely" to "extremely unlikely".

The Trust collects the FFT data via the Trust current comment cards and electronically using volunteers to collect the data using iPads.

For April 17–March 2018, Trust results continue to be very high with 99% of the 10176 patients asked would recommend the Trust.

The RJAH achieved an average monthly rank of 5th out of 154 NHS Trusts in England, making the Trust one of the top performing NHS Trusts in the country.

- This is higher than the national score in England of 96%
- 36% of inpatients provided a response

	FFT score	Promoters - Extremely Likely	Passive – Likely	Detractors – Not at All	Detractors – Neither Likely nor Unlikely	Detractors – Unlikely	Don't Know
Inpatients	99.2%	4994	210	4	22	6	7
Outpatients	98.9 %	4520	302	4	28	13	9

Patient Feedback

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

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

In 2017 as part of the implementation of the Patient Experience Strategy the Trust has invested in a 'Real time' patients experience system. This will be fully rolled out and implemented in 2018/19.

Friends and Family Question

The National Friends and Family Test, the Trust has given all inpatients the opportunity to say whether or not they are "extremely likely" to recommend the hospital to their family and friends if they required similar treatment. (the 'extremely likely' category being the response which generates a positive figure for the Trust: the response of only 'likely' is neutral to a trust's score).

Patients have the opportunity to participate in the Friends and Family test and give comments by postcard.

The table below shows the percentage of patients that would recommend the Trust.	Mar-2016	Jun-2016	Sep-2016	Dec-2016	Mar-2017	Jun-2017	Sep-2017	Dec-2017	Mar-2018
ENGLAND (INCLUDING INDEPENDENT SECTOR PROVIDERS)	96%	96%	96%	95%	96%	96%	96%	96%	*
ENGLAND (WITHOUT INDEPENDENT SECTOR PROVIDERS)	95%	95%	95%	95%	96%	96%	96%	95%	*
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	100%	100%	100%	100%	99%	99%	99%	100%	*

*Data not yet published

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

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

Stakeholder Relations

Stakeholder relationships have continued to be supportive and positive during 2017/18. We meet with commissioners from the various commissioning parties throughut the year and Shropshire CCG have 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 monthly meetings in place to share intelligence regarding their consultation events. They have also undertaken one enter and view visit on the spinal injuries unit.

Sit and See Observations

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

Since April 2017-March 2018 there have been on average 8 observations per month across wards and departments of which 98% were positive.

There are 23 active Sit & See Observers, of which 7 are Patient volunteers or Trust Governors.

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

- Ensure privacy and dignity is maintained
- Communication to patients, i.e. being updated on waiting times or introduction or welcome to department.
- Facilities issues i.e. temperature of ward, cluttered environment or replenishing hand gels.

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

The Trust has fulfilled its principle 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 good and services for any other purposes.

Private practice complements the NHS services provided at 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

24 May 2018

Remuneration Report

This report includes details regarding “senior managers” 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 Remuneration Committee (Trust Chairman, Mr Frank Collins)

The membership of the Remuneration Committee is as follows:

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

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

The Remuneration Committee met six times during the year, and approved changes to the senior management structure to strengthen the Board of Directors as follows:

- Deputy Chief Executive (with effect from May 2017)
- Director of Operations (with effect from August 2017)
- Associate Director of Performance
- Director of HR (due to commence 9th April 2018)

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

All of the members of the Committee attended all meetings with the exception of Mr Harry Turner who gave apologies for August 2017 and Mr Alistair Findlay who gave apologies for August 2017 and March 2018.

Senior Managers' Remuneration Policy

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

The Executive and Associate Directors' Remuneration framework, which was not subject to formal consultation, is agreed by the Committee and determines remuneration of the Chief Executive and Executives directly accountable to the Chief Executive. This Framework was reviewed and updated at the Remuneration Committee of August 2017.

National Context

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

Pay Comparators

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

Ranges for each post are agreed based on this information.

Performance Related Pay and Assessment Process

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

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

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

Performance related pay will not be consolidated for a period of 12 months, and is not therefore pensionable for this period. After 12 months, performance related pay will be consolidated into the Directors' 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 Remuneration Committee.

Future Policy

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

Service Contracts 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 is 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 Treasure guidance 'Managing Public Money' where appropriate.

Statement of Consideration of Employment Conditions

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

Annual Report on Remuneration

Service Contracts

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

Officer	Start date	Unexpired term	Notice period
Collins, F Chairman	1 February 2015	31 January 2021	N/A
Beacock, C Non-executive Director	4 July 2016	3 July 2019	N/A
Davis, I Non-executive Director left 31 October 2016	1 November 2013	N/A	N/A
Findlay, A Non-executive Director	1 November 2013	31 October 2019	N/A
Gilburt, D Non-executive Director	1 December 2015	30 November 2018	N/A
Peplar, H Non-executive Director	30 November 2012	28 November 2018	N/A
Turner, H Non-executive Director	1 January 2017	31 December 2020	N/A
Brandreth, M Chief Executive	1 April 2016	N/A	6 months
Tabernacle, B Director of Nursing/ Deputy Chief Executive	1 January 2016	N/A	6 months
White, S Medical Director	1 June 2012	N/A	6 months
Macbeth, C Finance Director	1 April 2017	N/A	6 months
Jones, N Director of Operations	1 April 2017 (Interim) 1 August 2017 (Substantive)	N/A	6 months

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 Manager's Remuneration

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

Senior Managers Remuneration 2017/18							
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	10 - 15			10 - 15			10 - 15
David Gilburt Non Executive Director	10 - 15			10 - 15			10 - 15
Hilary Pepler Non Executive Director	10 - 15			10 - 15			10 - 15
Harry Turner Non Executive Director	10 - 15			10 - 15			10 - 15
Mark Brandreth Chief Executive	140 - 145	6,100	5 - 10	155 - 160		22.5 - 25	180 - 185
Craig Macbeth Director of Finance	95 - 100	6,800	0	100 - 105		52.5 - 55	155 - 160
Bev Tabernacle Director of Nursing	95 - 100	5,500	0	100 - 105		42.5 - 45	145 - 150
Nia Jones Director of Operations	80 - 85	3,100	0	80 - 85		40 -42.5	120 - 125
Steve White Medical Director *Note 3*	170 - 175	0	30 - 35	200 - 205		37.5 - 40	235 - 240

Notes

1. Taxable benefits relate to either a lease car or a car allowance.

2. Pension related benefits are based on the HMRC approved calculation and assume a pension will be drawn for 20 years from retirement. This excludes employee contributions.

3. The Medical Director's salary includes £100 - £105k relating to clinical duties. A clinical excellence award of £30 - £35k is included in the annual performance related bonus column.

Senior Managers Remuneration 2016/17

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 (from Jul 16)	5 - 10			5 - 10			5 - 10
Ian Davis Non Executive Director (until Oct 16)	5 - 10			5 - 10			5 - 10
Alastair Findlay Non Executive Director	10 - 15			10 - 15			10 - 15
David Gilburt Non Executive Director	10 - 15			10 - 15			10 - 15
Hilary Pepler Non Executive Director	10 - 15			10 - 15			10 - 15
Harry Turner Non Executive Director (from Jan 17)	0 - 5			0 - 5			0 - 5
Mark Brandreth Chief Executive	140 - 145	6,100	0	145 - 150		172.5 - 175	320 - 325
John Grinnell Deputy Chief Executive & Chief Finance Officer	125 - 130	4,600	0	130 - 135		55 - 57.5	190 - 195
Bev Tabernacle Director of Nursing	95 - 100	4,600	0	95 - 100		25 - 27.5	125 - 130
Kim Barrow Director of Operations	90 - 95	4,600	0	95 - 100		97.5 -100	195 - 200
Steve White Medical Director *Note 3*	165 - 170	0	25 - 30	195 - 200		77.5 - 80	275 - 280

Notes

1. Taxable benefits relate to either a lease car or a car allowance.

2. Pension related benefits are based on the HMRC approved calculation and assume a pension will be drawn for 20 years from retirement. This excludes employee contributions.

3. The Medical Director's salary includes £100 - £105k relating to clinical duties. A clinical excellence award of £25 - £30k is included in the annual performance related bonus column.

Governor and Director Expenses

During 2017/18 the Trust had six Non-Executive Directors and five Executive Directors in post. In addition the Trust had a maximum of 15 Governors in post at any one time. The following table provides details of any expenses claimed by either Directors or Governors during the reporting period and provides comparative data for the previous year. The majority of the expenses relate to travel. Any Directors of Governors who have not made any claims for the years reported are not cited in the table.

Name	Role	2017/18	2016/17
Directors			
Frank Collins	Chairman	£2,271	£4,794
Chris Beacock	Non Executive Director	£596	£662
Ian Davis	Non Executive Director	£0	£742
Alastair Findlay	Non Executive Director	£1,236	£1,566
David Gilburt	Non Executive Director	£1,621	£1,164
Harry Turner	Non Executive Director	£3,568	£0
Mark Brandreth	Chief Executive	£880	£1,131
John Grinnell	Deputy Chief Executive	£0	£433
Craig Macbeth	Director of Finance	£202	£0
Kim Barrow	Director of Operations	£84	£355
Bev Tabernacle	Director of Nursing	£1,816	£1,301
Steve White	Medical Director	£270	£712
Governors			
Martin Coggon	Governor (Public) North Wales	£64	£0
Peter David	Governor (Appointed) RJAH Voluntary Services Committee	£34	£54
Jan Greasley	Governor (Public) North Wales	£138	£174
Katrina Morphet	Governor (Public) Cheshire & Merseyside	£175	£0
Gareth Pritchard	Governor (Public) North Wales	£17	£205
Julie Santy-Timlinson	Governor (Public) Rest of England and Wales	£0	£161
Linda Ward	Governor (Public) North Wales	£1,551	£658
Total		**£14,523**	**£14,112**

Fair Pay Multiple

The HM Treasury FReM requires disclosure of the median remuneration of the Trust's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director (including that paid for work as other than a director). Directors are those defined as senior managers earlier in this report).

The calculation is based on full-time equivalent staff of the Trust at the reporting period end date on an annualised basis.

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

	2017/18	2016/17
Mid point of banded remuneration of highest paid director	202,500	197,500
Median remuneration of all staff	23,597	23,363
Ratio	8.6	8.5

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

Information provided by the NHS Pensions Agency

Note : Steve White is over normal retirement age in the existing scheme so a 17/18 CETV calculation is not applicable.

Senior Managers Pension Entitlement 2016/17							
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 2017 (bands of £5,000)**	**Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)**	**Cash Equivalent Transfer Value at 31 March 2017**	**Cash Equivalent Transfer Value at 31 March 2016**	**Real increase in Cash Equivalent Transfer Value**
	£'000	**£**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mark Brandreth Chief Executive	7.5 - 10.0	17.5 - 20.0	40 - 45	110 - 115	631	498	133
John Grinnell Deputy Chief Executive & Chief Finance Officer	2.5 - 5.0	2.5 - 5.0	30 - 35	75 - 80	400	352	48
Bev Tabernacle Director of Nursing	0.0 - 2.5	5.0 - 7.5	30 - 35	100 - 105	574	531	43
Kim Barrow Director of Operations	5.0 - 7.5	2.5 - 5.0	20 - 25	20 - 25	254	185	69
Steve White Medical Director	2.5 - 5.0	12.5 - 15.0	60 - 65	190 - 195	1479	1312	167

Information provided by the NHS Pensions Agency

Payments for Loss of Office

No payments have been made during 2017/18 for loss of office

Payments to Past Senior Managers

No payments have been made to past senior managers during 2017/18

Staff Report

Staff Costs

Staff costs are shown in the table below. Costs have increased mainly due to pay awards, additional theatre costs associated with case mix changes, and a reclassification of agency costs.

	2017/18			2016/17
	Permanent £'000	Other £'000	Total £'000	Total £'000
Salaries & wages	46,392	258	46,650	43,278
Social security costs	4,387	-	4,387	4,020
Apprenticeship levy	213	-	213	
Employer's contributions to NHS pensions	5,474	-	5,474	5,180
Pension cost - other	3	-	3	-
Termination benefits	24	-	24	-
Temporary staff		4,403	4,403	1,439
Total gross staff costs	**56,493**	**4,661**	**61,154**	**53,917**
Recoveries in respect of seconded staff	-941	-	-941	-701
Total staff costs	**55,552**	**4,661**	**60,213**	**53,216**
Of which:				
Costs capitalised as part of assets	*112*		*112*	*112*

Average number of employees

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

	2017/18			2016/17
	Permanent Number	Other Number	Total Number	Total Number
Medical & dental	118	5	123	116
Administration & estates	471	24	495	460
Healthcare assistants & other support staff	175	17	192	193
Nursing, midwifery & health visiting staff	270	17	287	271
Nursing, midwifery & health visiting learners	0	0	0	1
Scientific, therapeutic & technical staff	167	6	173	163
Healthcare science staff	10	0	10	10
Total average numbers	**1,211**	**69**	**1,280**	**1,214**

Exit packages

Exit packages agreed in the period 2017/18 are shown in the table below. All costs relate to contractual payment in lieu of notice. There were no exit packages for 2016/17.

	2017/18		
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages**
<£10,000	-	5	5
£10,001 - £25,000	-	1	1
Total number of exit packages	**0**	**6**	**6**
Total resource cost (£)	**-**	**£24,000**	**£24,000**

Staff gender distribution

A breakdown of the number of persons who were directors of the Trust, senior managers and other employees during 2017/18 is shown below:

	Male	Female
Executive Directors	2	3
Non-executive Directors	5	1
Other senior managers	2	5
Other employees	378	1227
Total	387	1236

Staff sickness absence

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

2017/18			2016/17		
Average FTE 2017	**FTE Days Lost 2017**	**Average Sick Days per FTE 2017**	**Average FTE 2016**	**FTE Days Lost 2016**	**Average Sick Days per FTE 2016**
1,214	9,339	7.7	1,160	8,456	7.3

Note: FTE = Full Time Equivalent

Staff Equality and Diversity

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

The trust employed 1623 staff at 31st March 2018.

The demographic profiles of our staff are shown below:

Age Range	Headcount	% Headcount
19 and below	25	1.54%
20 - 29 Years	242	14.91%
30 - 39 Years	342	21.07%
40 - 49 Years	420	25.88%
50 - 59 Years	442	27.23%
60 and above	152	9.37%
Total	1623	

Gender	Headcount	% Headcount
Female	1236	76%
Male	387	24%
Total	1623	

Ethnicity	Headcount	% Headcount
Any Other Ethnic Group	11	0.68%
Asian or Asian British	48	2.96%
Black or Black British	6	0.37%
Chinese	2	0.12%
Mixed - Any mixed background	7	0.43%
Not stated	131	8.07%
White - British	1333	82.13%
White - Other	85	5.24%
Total	1623	

Part Time/Full Time	Full Time	Part Time	% Full Time	Total
Female	501	735	41%	1236
Male	285	102	74%	387
Total	786	837	48%	1623

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

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

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

Staff Engagement

During 2017-18 we conducted a series of pulse checks, as well as other information gathering exercises, with our staff aimed at looking at our culture. This demonstrated some positive features of the culture

It also demonstrated some areas for us to work on to improve our culture. During 2017-18 the programme focused on rebuilding relationships, the Trust recognised that to rebuild relationships with staff it needed to enable our leaders, create an enabling infrastructure and give an active commitment to having frequent, open conversations with all staff. For 2018-19 the Trust has developed a 5 Year People Plan to help take this work to the next stage based on 'Making the Difference'. This programme is made up of 11 projects covering the following areas:

Countering fraud and corruption

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

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

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

Staff Survey results

Overall the 2017 staff survey results are considerably better than in 2016. 93% of respondents would be happy with the standard of care provided if a friend or relative needed treatment and 75% of respondents would recommend the Trust as a place to work.

Our overall engagement score was slightly above average in comparison with other acute specialist trusts.

The response rate and top and bottom ranked key finding scores are detailed below.

Response Rate	2016		2017		Trust Change
	Trust	National Average	Trust	National Average	
	42%	44%	41.5%	45%	-0.5%

Top 5 ranked key finding scores				
Key Finding (* indicates the lower the score the better)	**2017**	**2016**	**Change**	**Average**
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months*	28%	29%	1%	35%
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month*	21%	22%	1%	27%
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	86%	5%	88%
KF16. Percentage of staff working extra hours*	66%	67%	1%	75%
KF24. Percentage of staff / colleagues reporting most recent experience of violence	80%	82%	-2%	70%

Bottom 5 ranked key finding scores				
Key Finding (* indicates the lower the score the better)	**2017**	**2016**	**Change**	**Average**
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	86%	90%	-4%	92%
KF10. Support from immediate managers	3.73	3.65	.08	3.81
KF13. Quality of non-mandatory training, learning or development	4.00	3.89	.11	4.08
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	48%	52%	-4%	54%
KF5. Recognition and value of staff by managers and the organisation	3.44	3.40	.04	3.53

Our survey results have been shared with our staff and the detail will be shared with divisional and corporate teams who will develop local action plans to improve results. Progress will be monitored through divisional performance review meetings and Quality and Safety Committee. The survey is one element of our ongoing work to continue to develop our leadership capacity and capability and support our cultural change programmes.

Expenditure on consultancy - Off-payroll arrangements

The table below provides details of the Trust's off payroll engagements during 2017/18 and comparator data for 2016/17.

Off- payroll engagements as at 31 March 2018, for more than £220 per day and lasting more than six months	2017-18	2016-17
Number of existing engagements as at 31 March 2018	11	7
Of which		
have existed for less than one year at the time of reporting	4	4
have existed for between one and two years at the time of reporting	5	2
have existed for between two and three years at the time of reporting	1	1
have existed for between three and four years at the time of reporting	1	0
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 2018, for more than £220 per day and lasting more than six months	2017-18	2016-17
New Off- payroll engagements or those that reached six months duration between 1 April and 31 March 2017	6	4
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	6	4
Number of whom assurance has been requested	2	4

Of which		
Assurance has been received	2	2
Assurance has not been received	0	2
have been terminated as a result of assurance not being received	0	(1 no longer works at the Trust and the other is pending)

Off- payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April and 31 March 2018.	**2017-18**	**2016-17**
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
24 May 2018

NHS Foundation Trust Code of Governance Disclosures

Statement of compliance with the NHS Foundation Trust Code of Governance

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

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

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

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

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

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

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

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

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

Meet the Trust's Council of Governors

The Council of Governors consists of fourteen Public Governors, two Staff Governors and two Stakeholder Governors.

Katrina Morphet
Public Governor – Cheshire and Merseyside

Jan Greasley
Public Governor - North Wales - Lead Governor

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

Allen Edwards
Staff Governor

Kate Chaffey
Staff Governor

Peter David
Governor - Stakeholder

Russell Luckock
Public Governor - West Midlands

Sue Nassar
Public Governor - Shropshire

Mrs Gill Pitcher
Public Governor - Shropshire

Colin Chapman
Public Governor - Shropshire

Linda Ward
Public Governor - Powys

Martin Coggon
Public Governor – North Wales

Karen Calder
Stakeholder Governor

Karina Wright
Stakeholder Governor

Council of Governors Terms of Office

Type of Governor	Constituency	Term of Office Yrs	Appointed / Elected	Date Term in Office Ends
Stakeholder Governors				
Karen Calder	Shropshire Council	3	1 Jun 16	31 May 19
Karina Wright	Keele University	3	22 Nov 17	21 Nov 20
Peter David	Voluntary Services Committee	3	23 Sep 15	22 Sep 18
Staff Governors				
Kate Chaffey	Staff	3	26 Oct 17	25 Oct 20
Allen Edwards	Staff	3	1 Aug 16	31 Jul 19
Public Governors				
Colin Chapman	Shropshire	3	26 Oct 17	25 Oct 20
Jan Greasley	North Wales	3	1 Aug 16	31 Jul 19
Russell Luckock	West Midlands	3	26 Oct 17	25 Oct 20
Sue Nasser	Shropshire	3	1 Aug 16	31 Jul 19
Gill Pitcher	Shropshire	3	1 Aug 16	31 Jul 19
Julie Santy-Tomlinson	Rest of England and Wales	3	1 Aug 16	31 Jul 19
Martin Coggon	North Wales	3	26 Oct 17	25 Oct 20
Linda Ward	Powys	3	1 Aug 16	31 Jul 19
Katrina Morphet	Cheshire and Merseyside	3	26 Oct 17	25 Oct 20

During 2017 the Trust held Governor elections in order to fill vacancies. The following table sets out the vacancies and the recruitment that took place.

Governor Elections

Elections took place in September 2017, the results of which were as follows:

Results of the Governor Elections Sept 2017		
Constituency	Number of vacant posts	Elected Governor
Staff Governors		
Staff	2	Kate Chaffey
Public Governors		
Shropshire	1	Colin Chapman
North Wales	1	Martin Coggon
Cheshire and Merseyside	1	Katrina Morphet

Membership

The Trust reviews its membership on quarterly basis with a report being presented to the Council of Governors. This report looks at the number of members and analysis 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 2017/18. In addition there were 1115 staff members at the end of March 2018.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Cheshire & Merseyside	313	313	313	313	315	317	321	322	323	322	323	323
North Wales	840	842	842	847	845	851	862	866	870	872	872	878
Powys	489	491	492	492	493	495	502	505	506	503	506	509
Shropshire	2,397	2,404	2,405	2,409	2,417	2,421	2,449	2,458	2,463	2,472	2,474	2,490
West Midlands	461	463	463	463	466	467	468	471	471	471	472	474
Rest of England & Wales	210	210	210	211	214	213	213	218	220	221	222	224
Out of Trust Area	32	32	32	32	35	35	37	37	37	37	37	37
Total	**4,742**	**4,755**	**4,757**	**4,767**	**4,785**	**4,799**	**4,852**	**4,877**	**4,890**	**4,898**	**4,906**	**4,935**

In 2015 the Trust set its Membership Strategy which aimed to achieve a 5% increase year on year. For 2017/18 this represented a total membership target of 6140 against which an actual membership of 6050 was achieved. This represents a 4.6% increase in membership.

The Trust has continued to hold members surgeries during 2017-18, held in the hospital's main foyer as a way of drawing attention to membership. Moving forward into 2018-19 the Trust will be looking for new ways to increase membership and will refresh the Membership Strategy.

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 2018 the Trust is in segment 2. Latest segmentation information for all NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and Use of Resources

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

Area	Metric	2017/18 Plan	2017/18 Outturn
Financial sustainability	Capital service capacity	2	2
	Liquidity	3	1
Financial efficiency	Income & expenditure margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	1	4
Overall scoring			**3**

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

Statement of the Chief Executive's responsibilities as the accounting officer of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust.

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Robert Jones and Agnes Hunt Orthopaedic Hospital NHS 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 Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health 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 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 and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the 69 NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed

Chief Executive Date: 24 May 2018

ANNUAL GOVERNANCE STATEMENT 2017/18

Scope of responsibility

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

The purpose of the system of internal control

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

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, 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 Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for the year ended 31 March 2018 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 staking individual responsibility for the safety of themselves, their colleagues or patients to Executive Director responsibility for strategic risks or the Non-Executive responsibilities for robust challenge of effective risk management and assurance of adequate control.

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

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

Chief Executive

- Accounting Officer
- Maintain a sound system of internal control
- Prudent and economic administration of the organisation

Director of Finance

- 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 Trusts operational targets and objectives

Director of Nursing and Quality

- Board lead for Quality and Safety (in conjunction with the Medical Director)
- Sound Clinical Governance
- Professional Leadership of Nursing Staff and Allied Health Professionals

- Patient and Public involvement
- DIPC (Director of Infection Prevention and Control)
- Information Governance, Caldicott Guardian
- Oversight of risk management process
- Accountable Officer for controlled drugs
- Health and Safety management and compliance with statutory requirements

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Medical Director

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

Director of People

- Organisational Development Strategy
- Effective matching of workforce to activity
- Learning and facilitating continuous professional development
- Develop the leadership capacity and capability

Directors of Operations

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

Director of Strategy and Planning

- Ensure the Trust is positioned to achieve its strategic aims and objectives.
- Strategic leadership for the Trust's Information Management and Technology infrastructure and services
- As Senior Information Risk Owner (SIRO) ensures that risks to data security are recognised and managed
- Lead for the Clinical Services Strategy (in conjunction with the Medical Director)
- Strategic leadership for the development of the Trust's estate

Trust Secretary

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

Clinical Leads / Senior Managers

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

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

The Risk and Control Framework

Risk Management Strategy

The Trust's Risk Management Strategy sets out the framework and systems for implementation of risk management and governance in the Trust. This strategy was reviewed and updated by the Board of Directors in July 2017.

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

During September 2017 the Trust undertook a well led self-assessment in line with the new guidance on the well led framework. This covered all aspects of leadership in line with the CQC Key Lines of Enquiry but in terms of governance and internal controls, we found that positive steps had been taken to improve the Trust's risk management processes and the BAF had been reviewed to optimise its use as a risk management tool and ensure that it was embedded as a dynamic document reviewed regularly by the Executive Team and the Board. We identified that as the STP develops it was important to ensure there were clear governance arrangements and that partnership risks were reflected more overtly. We have acted on these findings and updated the BAF further.

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.

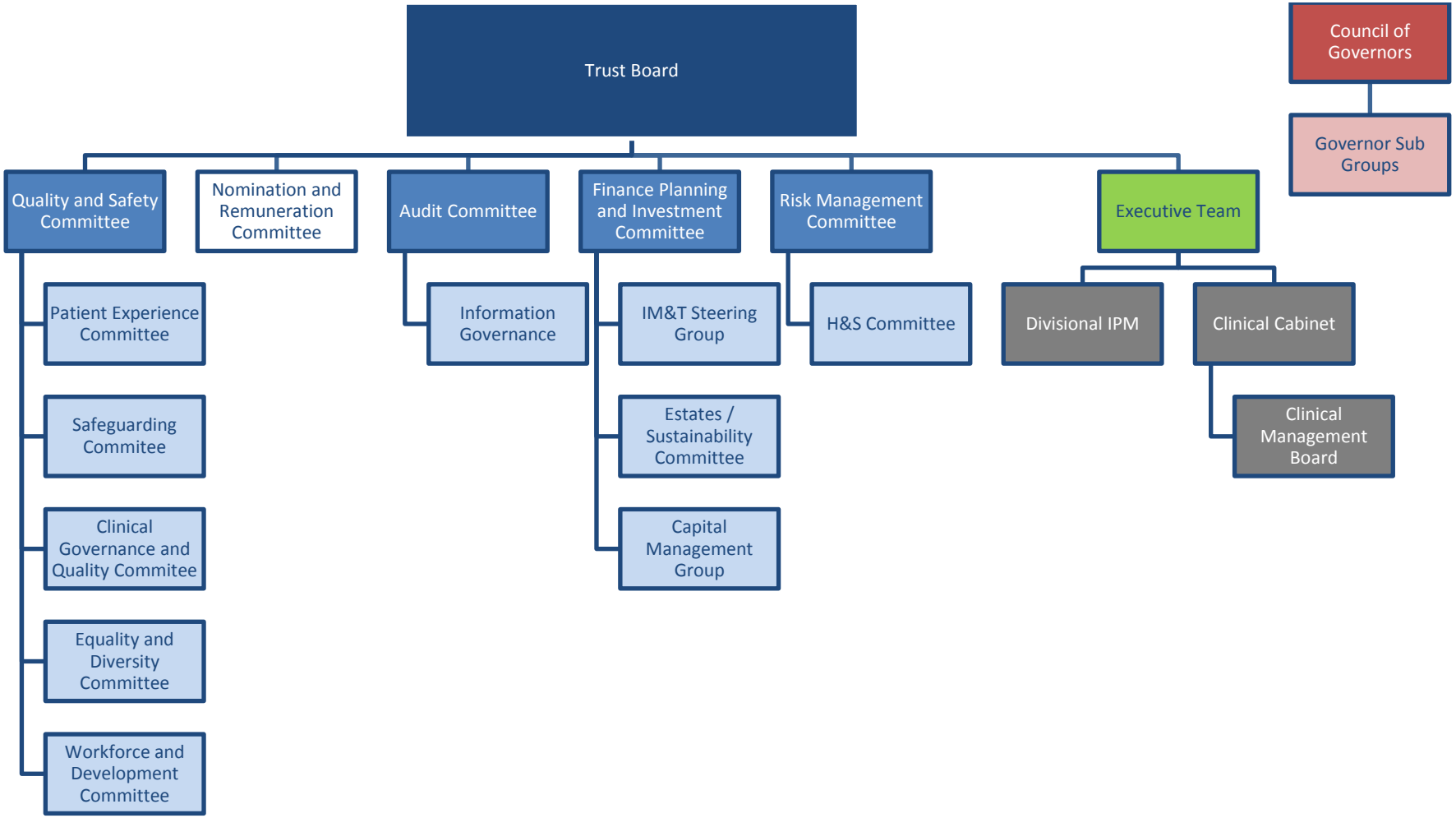
The Trust is committed to ensuring that any potential risks are mitigated to the lowest possible level and where possible negated altogether. The use of both internal and external expertise, as required, to decide on the most appropriate treatment of identified risks.

Governance Framework of the Organisation

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

Board Assurance Structure

The Board of Directors leads on integrated governance and delegates key duties and functions to its committees whilst retaining certain decision making powers on strategy and aspects of financial management. The diagram below sets out the committee structure in place:



The roles and responsibilities of these committees are described more fully below:

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 is comprised of the Trust Chairman, Chief Executive Directors 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 oversee the annual audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal controls with respect to risk management in place. An annual Head of Internal Audit Report is presented to the Audit Committee.

Quality and Safety Committee

The Quality and Safety Committee is accountable to the Board and is responsible for ensuring effective clinical governance throughout the Trust. It assists the Board in obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. It works with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes and controls in place throughout the Trust to:

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

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

Finance Planning and Investment Committee

The Finance Planning and Investment 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

This Committee is chaired by a Non-Executive Director and attended by a further two Non-Executive Directors 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.

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

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

Internal Audit

During 2017-18 the Trust used KPMG as its internal auditors who met mandatory NHS Internal Audit Standards and provided appropriate independent assurance to the Audit Committee, Chief Executive and Board. They primarily provide an independent and objective opinion to the Trust on the degree to which risk management, control and governance processes support the achievement of the Trust's objectives. During 2017-18 the Trust's internal audit contract came up for renewal and following a tender process BDO UK LLP were appointed and will therefore be the Trust's internal auditors for the forthcoming year.

External Audit

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

Quality Governance

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

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

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

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

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

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

The Robert Jones 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 January 2018 but at the time of writing the inspection report had not been received. Prior to this, the Trust was last inspected by the CQC in October 2015. At this time, the Trust was given an overall rating of Requires Improvement and a robust action plan to address the areas for improvement was devised. Completion of this action plan was monitored by the Quality & Safety Committee and all actions were signed off as complete in April 2017.

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 May 2017.
- The Internal Auditors have undertaken the following specific reviews linked to governance
    - CQC Compliance
    - Board Assurance Framework and Risk Management
    - Serious Incident Management
    - Safer Surgery
    - Data Quality
    - IT Governance
    - STAR

With the exception of the Serious Incident Management Audit, these audits received substantial assurance with minor recommendations which largely reflected known issues. The Serious Incident Management Audit was given a split assurance to reflect both the historical performance (partial assurance) and the design of the new policy and processes going forward (substantial assurance).

Principal Risks

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

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

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

Risks 2017-18

During 2017/18 the following risks were identified and cited on the Board Assurance Framework:

- Inadequate or unsuccessful implementation of learning from incidents
- Failure to identify and delivery cost improvements and QIPP
- Failure to improve performance in relation to the CQC core standards
- Inability to sustain the delivery of our access and waiting times
- MSK service integration fails to deliver expected benefits
- Failure to shift the dial on staff engagement
- Failure to achieve required staffing levels in key areas
- Instability arising from fluctuations in the annual tariff

In addition, the Trust's Strategic plan recognised that the major strategic risk was national tariff volatility. As a predominantly single specialty hospital the Trust's financial sustainability is more sensitive to material shifts in the tariff than hospitals with a broader portfolio. The Trust worked closely with the National Orthopaedic Alliance to work with NHS Improvement in informing future pricing models.

Risks 2018-19

The Trust has established its strategy for 2018-19 to support its desired direction of travel over the next five years. The four key strategic aims for 2018-19 remain as follows:

- MSK
- Specialist Services
- Operational Excellence
- Culture and Leadership

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

Caring for Patients

- Failure to improve performance in relation to the CQC core standards
- Inadequate or unsuccessful implementation of learning from incidents

Caring for Staff

- Potential inability to have the right workforce in the right place at the right time

- Communication between managers and the workforce fails to improve staff engagement

Caring for Finances

- Failure to achieve activity and income target within planned cost base

In addition the Trust recognises a risk from 2019/20 onwards with regard to the instability arising from fluctuations in the annual tariff.

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

As described in the sections above, the Trust has in place effective governance structures with clear responsibilities delegated to each Executive Director and Board Committee. Furthermore, within the Risk Management Strategy and the Terms of Reference for each Board Committee, the Trust has clear reporting lines between the Board, its sub committees and the Executive Team to ensure an integrated approach is maintained.

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

NHS Pension Scheme

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

Equality Diversity and Human Rights

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

Emergency Preparedness and Civil Contingency

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

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 2017/18 the Trust tracked its financial performance, including the economic, efficient and effective use of resources via the Finance Planning and Investment Committee and further the Board receives a monthly update on the Trust's financial performance.

Overview of Financial Performance

The Trust's annual accounts provide full detail of the Trust's financial performance but to summarise, the Trust planned a control total surplus of £0.513 million for 2017/8 and overachieved against this with a surplus of £33k. This resulted in a year end surplus of £0.546 million. This achievement of the financial plan entitled the organisation to a pot of Sustainability and Transformation Funding (STF) of £1.807 million giving a combined control total surplus including STF of £2.353 million.

This position was supported by a programme of cost improvements which realised £4.1 million savings in year compared to £3.5 million in the previous year.

The Trust's financial performance for 2017/18 provides assurance of the financial controls it has in place and the economic, efficient and effective use of its resources.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the Trust, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The Trust has an established information governance management framework and continues to develop information governance processes and procedures in line with the information governance toolkit. The Trust`s Information Governance status is the subject of ongoing review by the Information Governance Committee which is responsible for reviewing policy and monitoring compliance with Department of Health Guidelines. This process is overseen by the Audit Committee which also has a role in ensuring that all serious data governance risks or incidents are brought to the attention of the appropriate Board Committee. Two Directors have complementary roles in assuring data governance; the Director of Nursing as the Caldicott Guardian, and the Director of Strategy and Planning as the Senior Information Risk Officer (SIRO). During 2017/18 the Trust has introduced a Data Protection Officer in anticipation of General Protection of Data Regulations coming in from May 2017 and this role will be fulfilled by the Trust Secretary.

The Trust has self-assessed against the NHS Digital Information Governance Toolkit 2017/18 version 14.1 which assesses performance with Department of Health information governance policies and standards and scored 80% achieving an overall rating of Satisfactory. This assessment involved 45 requirements of which the Trust achieved the top level score of 3 for 17 of them.

During 2017/18 there were no HSCIC Information Governance Toolkit defined Level 2 Reportable Incidents from information submitted by the Trust.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS

Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Annual Quality Report 2017/18 has been developed in line with relevant national guidance and is supported internally through the Board Assurance Framework. The majority of the content of the Quality Report is subject to the various foundation trust policies and procedures which ensure the quality of care provided.

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

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

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

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

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

Review of Effectiveness

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

The Trust's Head of Internal Audit provides an annual opinion on the assurance framework and for the financial year to 31 March 2018 this can be summarised as follows:

' Our overall opinion for the period 1 April 2017 – 31 March 2018 is that significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control '

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 2017/18 all the Executive Directors have completed appraisals which have included reflections on the discharging of their duties as Directors.

Conclusion

There are have been no significant internal control issues identified and my review confirms that the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives

Signed
Chief Executive Date: 24 May 2018

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Quality Account 1 April 2017 – 31 March 2018

Table of contents

Contents

INTRODUCTION

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

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

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

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

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

Foreword from the Director of Nursing and Medical Director

We are aligned to the requirements of national strategy in that quality is at the core of all we do. During 2017 we revised our Quality Strategy to strengthen our aim to continue delivering outstanding patient care to every patient, every day. This strategy sets out our clear vision so that both staff and patients understand our aims and goals, what we consider high quality services look like and what part they can play in helping us achieve this. We pride ourselves in the high quality of the services we deliver and this is reflected in the feedback we receive from our patients.

In order to continuously drive quality improvements we recognise the need to be able to respond promptly and effectively to patient and staff feedback. During 2018-19 the Trust will see the roll out of an electronic patient feedback system which will provide real time intelligence of patient experiences. By using this information, analysing trends and themes and working with our staff, we strongly believe we can make a greater difference to the experience of our patients.

As we move into 2018-19 our focus will be the implementation of our Quality Strategy and this will be underpinned by a robust service improvement framework with work already underway through our Service Improvement Champions to make this happen. The Trust will continue to work hard to ensure that providing quality care is at the heart of everything we do, every day.

Bev Tabernacle
Director of Nursing

Mr Steve White
Medical Director

PART 1

Statement on Quality from the Chief Executive

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust launched a revised vision statement in 2017-18 – stating that it aspired to deliver world class patient care. This ambitious but achievable vision is supported by the Trust's five-year Quality Strategy, which ensures that quality and patient safety are at the heart of everything we do.

These Quality Accounts set out our key achievements in 2017-18, as well as sharing our priorities for 2018-19 and we hope that this will provide our patients, their families and carers with confidence in the quality of our services.

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

The Trust has continued to use the "safety thermometer" to monitor incidents of harm to patients in the course of their hospital treatment and has consistently scored over 98% of patients having received "no new harms" whilst at the Trust, which exceeded the target of 95%. Learning from all patient safety incidents is promoted throughout the Trust with examples of good practice shared at a variety of meetings. The Staff Survey 2017 provided clear evidence that we are doing better at reporting and learning from errors and near misses.

The staff survey also found that 93% of staff would recommend the hospital to their family and friends – a score that ranked us as joint first in the country against this measure. Staff are very proud of the service that they deliver, giving patients even more confidence in the care and treatment provided by the hospital.

The Trust has continued to use a ward based nursing assessment process, 'STAR' (Sustaining quality Through Assessment and Review) to provide assurances with regard to 14 standards based upon national recommendations. This has been developed to be more team and multidisciplinary focused through the development of 5 STAR. Two of our wards have successfully retained this status in 2017-18 while another Ward achieved this status for the first time.

We came out of breach of licence with our regulator, NHS Improvement, in May 2017. This reflected the hard work we have done to improve both access and waiting times and to develop a better staff culture within the organisation. I am pleased to say we have achieved a continued reduction in 52-week waiters and have also improved steadily against the Referral to Treatment (RTT) standard, with a year-end position of around 91% against the 92% target.

Feedback from our patients also shows we have been getting it right. Last June we saw Adult Inpatient Survey results that showed us to be No 1 in the country in terms of overall patient experience. The results of the latest Inpatient Survey also look very impressive, and

whilst we do not at the time of writing have the benchmarking data to see if we have retained our No 1 status, I think we can be confident that we will be there or thereabouts.

Just recently we were able to report excellent Patient Recorded Outcome Measures (PROMs). Our PROMs data showed us to be delivering greater health gains for hip and knee replacement patients than any of the other specialist orthopaedic providers. That truly is something to be proud of.

We were also delighted to welcome HRH Princess Alexandra to RJAH in July 2017 to officially open our £15.1 million theatre and oncology building. This building includes four new clean air Theatres, a High Dependency Unit and an Admission on Day of Surgery Unit, as well as a new dedicated Bone Cancer Centre with inpatient and clinic facilities and a flexible multiuse ward.

Quality is at the heart of every decision we take and, with the significant contribution of staff from across the hospital, we will strive to keep improving in 2018/19 to deliver ever higher levels of patient experience.

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

Mark Brandreth
Chief Executive

PART 2

Priorities for improvement

Our Quality Priorities for 2018/19

Deciding on our quality priorities for the coming year

This part of the report describes the areas for improvement that the Trust has identified for the forthcoming year 2018-19. The quality priorities have been derived from a range of information sources consulting with key staff and including our Council of Governors. We have also been guided by our performance in the previous year and the areas of performance that did not meet the quality standard to which we aspire.

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

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

Patient Safety

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

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

Rationale: During 2017-18 a number of reviews were undertaken following the transfer of patients from other hospitals. This identified that in order to maintain the delivery of safe care improvements in the process of transfer were needed and the introduction of a Transfer Passport has been established as the solution for this.

Measures:

- 100% implementation of the Transfer Passport for patients transferred from another hospital for care at RJAH.

Board Sponsor: Bev Tabernacle, Director of Nursing.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

2. 100% completion of the WHO Safety Checklist

Objective: To improve patient safety and avoid preventable incidents related to surgery such as wrong site surgery.

Rationale: The WHO Safety Checklist is aimed entirely at avoiding preventable incidents and it is therefore expected that 100% compliance with this is demonstrated in our Theatres. Historical serious incidents have be contributed to or caused by a non-compliance with the WHO safety checklist. Despite improved completion rates a recent CQC inspection highlighted that the practice around completion is not to the standard the Trust would expect and therefore it is only right that this should be an area of focus.

Measures:

- To be measured through the Trust's WHO audit compliance process which considers both quantitative and qualitative measures.

Board Sponsor: Bev Tabernacle, Director of Nursing.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

Clinical Effectiveness

3. Implementation and monitoring of behavioural characteristics

Objective: Implement the behavioural standards framework.

Rationale: Take the Trust values and the cultural ambition to create a defined set of behavioural dos and don'ts that can be taken on by all projects; performance management, recruitment, induction, etc.

To agree a programme to develop the Trust's behaviours. The programme of development will include wide spread workforce and patient engagement, covering;

- Focus groups
- Workshops
- Engagement surveys
- Staff side involvement

A fully planned set of launch activities to ensure behaviours are embedded and sustained

Measures:

- Level of awareness amongst all workforce
- > 95% compliance success rate in appraisals across the Trust.
- Level of involvement of Clinicians in the definition and launch
- Reduction in number of grievances
- Developed and embedded approach to inclusion

- Involuntary turnover
- Improved results in this area through staff survey

Board Sponsor: Kerry Robinson, Director of Strategy and Planning.

Oversight Committee: The Workforce Development Group and Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

Patient Experience

4. 95% of clinical staff have undertaken management of deteriorating patient training

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

Rationale: Clinical deterioration can occur at any stage of a patient's treatment or illness, but patients are more vulnerable during medical or surgical interventions. Patients who are at risk of deteriorating may be identified before a serious adverse event occurs by monitoring changes in physiological observations recorded by healthcare staff. The interpretation of these changes and timely institution of appropriate clinical management once physiological deterioration is identified is of crucial importance to minimise the likelihood of serious adverse events, including cardiac arrest and death.

Measures:
- 98% with NEWS compliance
- 95% clinical staff have undertaken Managing the deteriorating patient training
- 10% reduction in unplanned admissions to HDU

Board Sponsor: Bev Tabernacle, Director of Nursing.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

5. Improved collection and use of patient feedback

Objective: To implement an electronic solution to enable the collection of real time patient feedback

Rationale: The Trust recognises the significant role patients play in improving its services. Every instance of patient feedback is an opportunity to improve services and care going forward and ultimately improve the patient experience. At present the Trust's collection of patient feedback is a manual process and which can impact on the Trust's responsiveness. Through the collection of real time patient feedback the Trust can take remedial action or make improvements more promptly.

Measures:
- Roll out of system to capture real time patient experience data

- Evidence of improvements to services linked to the patient experience data through Divisional Quality Reports to the Quality and Safety Committee.
- Introduction of a triangulated PICC report on patient experience (**P**ALS, **I**ncidents, **C**omplaints and **C**laims)

Board Sponsor: Bev Tabernacle, Director of Nursing.

Oversight Committee: Quality and Safety Committee, this will ensure sure both Executive and Non-Executive oversight of progress against the measures outlined. Progress will also be presented to the Council of Governors on a Quarterly basis.

Statements of Assurance from the Board

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

Review of Services

During 2017-18, The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provided three NHS services, in musculo-skeletal surgery, medicine and rehabilitation.

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

The income generated by the relevant health services reviewed in 2017-18 represents 100% of the total income generated from the provision of NHS services by The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for 2017-18.

Participation in Clinical Audit

During 2017-18, 2 National clinical audits and 2 national confidential enquiries covered NHS services that the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provides.

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

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

- National Audit of Rheumatoid Arthritis
- National Joint Registry
- Elective Surgery (National PROMS Programme)
- Reaudit National comparative audit bedside transfusion practice (National)
- National Confidential enquiry-Chronic Neurodisability
- National Confidential enquiry-Mental Health
- National Confidential enquiry-Cancer in Children, Teens and Young Adults ***(No data submitted to date although the figures have not yet been finalised)***

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

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

The national clinical audits and national confidential enquiries that The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was eligible to participate in and for which data collection was completed during 2017-18 are listed below alongside that number

of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

	Eligible to participate	% cases submitted
National Joint Registry	Yes	N/A*
Elective Surgery (National PROMS Programme)	Yes	N/A
National Confidential enquiry-Chronic Neurodisability	Yes	100%
National Confidential enquiry-Perioperative Diabetes	Yes	100%

*there was a delay in the Trust submitting the data although this has since been rectified.

The reports of 20 local clinical audits were reviewed by the provider in 2017-18 and The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the actions set out in below to improve the quality of healthcare provided.

	Audit Number	Title of Audit	Action Points
1	16/17_014	Reaudit of NICE Guidance CG 172-Myocardial Infarction-Secondary prevention following a Myocardial Infarction	As there was full compliance following the previous audit there was no actions to take forward from this reaudit. We will reaudit in 12 months to ensure we still meet full compliance of NICE Guidance
2	16/17_001	Audit of Outcome data collection for hand and upper limb unit	1. Sharing of Knowledge and findings-Results to be circulated to all Hand and Upper limb consultants, Eric Robinson-Quality Outcomes Manager, Jo-anne Bidmead-Pre-op assessment unit manager and Mr S White-Medical Director. 2. Data to be presented at the next HULU meeting on Friday 30th June 2017
3	16/17_013	Pneumonia in Adults-NICE Guidance CG 191	1. Discuss the findings at lunch time meeting ensuring all concerned are informed of action. Also send an email to all staff members stressing the non-compliance to NICE Guidance and a spot check will take place in August to ensure this will be compliant. CURB-65 score to be documented on EPR for every patient 2. Ensure all staff members are aware of the antibiotics Trust guidelines and they know the management of pneumonia and antibiotics. 3. Discuss the findings at lunch time meeting ensuring all concerned are informed that all patients should have blood/sputum cultures sent for moderate and severe pneumonia 4. Spot check interim audit to be conducted in August 2017 with a reaudit to be undertaken in February 2018

4	16/17_039	Compliance of CCG Guidelines for Carpal Tunnel Syndrome	1. Present the findings of this audit to all consultants and all concerned at the next HULU meeting and stress the need for more effective documentation of objective signs in the Non NCS group 2. Circulate the report findings to all hand consultants and Mr Potter ahead of the next HULU meeting. Audit report to be put on the agenda for the next meeting as a presentation by Mr Kelly
5	16/17_036	Accuracy of discharge information to GPs	1. Re-education and re-enforcement of doctors obligation to provide correct information-to be carried out at Dr's induction days 2. Ask Medical Director to address all doctors in the Trust by a written letter and electronic communication 3. Ask IT if the discharge date to be generated on discharge and added to Medicine reconciliation
6	16/17_012	Reaudit of Pre-operative Chest X-Ray reports 2016	1. Avoid allocating radiographs to radiologists who are on leave to ensure chest x-rays are reported in a timely way 2. Continue to put pre-operative CXRs for reporting as a no. 5 for immediate or urgent reporting
7	16/17_015	Audit of treatment of heart failure NICE Guidance 187	1. Improve documentation of patient records particularly with regards to initiation of drugs 2. All patients with clinical heart failure should have 2D echo done either at RJAH or referred to GP 3. All patients conditions should be communicated to the GP
8	16/17_037	Reaudit of Appropriateness and effectiveness of the care provided to diabetics for surgery	1. Staff on pre-op clinic to measure and record HbA1c levels on EPR and synopsis 2. Booking clerks to liaise with the surgeons and theatre co-ordinators to place all Diabetic patients within first third of all day operating lists 3. Record hourly BMs in the anaesthetic charts and making plans for post-op management of diabetes
9	17/18_019	Adequacy and accuracy of recording drug allergy status	1. Remind doctors at Trust Induction to complete the drug allergy status in the discharge summaries 2. Speak to IT to see if the drug allergy box on the discharge summaries are made a compulsory option to complete like the date of discharge box 3. Explore the option of auto-filling the drug allergy box once the medication reconciliation has been completed by pharmacist
10	13/14_066	National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis	No local action plan identified and poor results were identified however ongoing work is being carried out within the Rheumatology department. There is a reaudit due to start early May 2018

11	14/15_028	Audit of outcomes for revision arthroplasty to a primary arthroplasty device	No actions needed as standards were met. A follow up audit in 5 years will determine if any further work needs to be undertaken on this.
12	15/16_005	The use of ODEP rated implants for Hip and Knee Replacements	1. From this data set there is more spread in the ODEP rating of the acetabular shells implanted in comparison to femoral stems- the use of acetabular shells should be reviewed
13	17/18_002	Plain Film radiographs with GP referrals to elective lower limb orthopaedics	1. Reduce outpatient waiting times by encouraging GP referrals to include plain-film radiographs by sending a letter to CCG with recommendations to GPs 2. Publish audit findings
14	17/18_049	VTE prevention in patients undergoing shoulder replacement procedures at RJAH-A compliance audit	1. Circulate report findings to all upper limb consultants 2. Establish actions to take forward following the HULU meeting
15	17/18_020	Audit of the baseline and follow-up DXA reporting	1. Ensure the second page of report is always included in the details of WHO criteria for diagnosis of osteoporosis and type of DXA scanner used. 2. Advice on further investigations advised for secondary causes of osteoporosis-Discuss amongst the metabolic team to decide how to approach this 3. Incomplete reporting of indication for scan; significant changes in height. Weight since last scan; reasons for exclusion of data and recommendation for time of next scan-Disseminate audit report to team with reminder of need to meet these standards
16	17/18_021	Acute Kidney Injury Audit	1. Inform doctors to use urine dipstick in all patients with AKI 2. All patients with AKI should have a documented reason to identify the cause if known 3. To continue monitoring U&Es in patients with AKI
17	17/18_016	Reaudit of Delirium among in-patients NICE Clinical Guidance 103	1. Inform pre-op clinic, and nursing staff on wards to screen confusion >75 years 2. Inform GPs about confusion state at discharge 3. Delirium screening for in-patients with confusion to be used such as CAM 4. Doctors and pharmacists to sign box on drug chart to acknowledge drug check. Also scan drug chart into EPR
18	16/17_028	Reaudit of Comparative audit of bedside transfusion practice	1. Training medical staff and registrars-Induction training stressing the importance of needing 2 signatures for blood labels 2. Nursing and practitioner e-learning training-Bi-annual training e-learning training provided for Nurses and practitioners 3. Information Distribution-Create newsletters and updates and distribute accordingly

19	16/17_031	Resuscitation Equipment Provision Audit	1. Re-design the resuscitation Pictorial Guidance 2. Monthly check of progress aligned to Month End by communication to departmental leads
20	17/18_030	Reaudit into admissions onto Alice Ward	Completion of the ASA documentation-Anaesthetist team dealing with the patient and Junior Doctors to be encouraged to complete on EPR

There were 21 Service Evaluation projects reports reviewed by the provider in 2017-18.

	Project Number	Project Title	Action Plans
1	15/16_014	Use of antibiotics and the prevalence of antibiotic-associated diarrhoea in patients with spinal cord injuries: an international, multicentre study	No local actions were needed to be undertaken regarding this evaluation.
2	15/16_011	Sexual Disorder among men with Spinal Cord Injury	1. MDT to be informed about the results of the evaluation in the MCSI Clinical Governance meeting to raise awareness about patient expectations as noted in comments and implement changes 2. Educate patients about the effects of SCI on sexual function during their patient education session and progress meeting
3	16/17_002	Quality of data entry into national SCI database: ASIA scoring and ASIA impairment scale	1. Nominate a person who will be responsible for the quality of data entry into database 2. Incorporating the current ISNCSCI chart into the database by meeting with the national database team 3. Explore the possibility of incorporating the ISNCSCI algorithm calculator into national database by meeting with the national database team
4	17/18_023	Reaudit of Quality of data entry into National SCI database: ASIA Scoring and ASIA impairment scale	1. Reinforce training to members of multidisciplinary team about ISNCSCI and algorithm calculators 2. Check the accuracy of data before entering into database
5	16/17_025	Are lead gowns and other X-Ray protection equipment available in theatre fit for purpose and use?	1. Have a named person who takes responsibility for reviewing, organising repair work and replacing gowns used in theatre 2. Condition of the gowns should be checked along with the annual safety check 3. Guidelines in place for storing gowns
6	00331	The natural history of disc prolapse	No actions needed following this evaluation
7	16/17_018	Study of inhaled anaesthetic agents used at RNOH and RJAH to compare and identify good practice	1. Email all anaesthetists the report for their information 2. Ensure low flow anaesthetic machines are available in all areas required
8	15/16_050	Ultrasound guided MSK Injections in Rheumatology Evaluation	1. To repeat the outcome analysis by employing other validated pain and functional outcome measures via pain and EQ5D score; also outcomes to be

			assessed at longer durations than 1 week 2. Whole department to undertake an evaluation of their injection techniques and to compare the results to the ultrasound department
9	16/17_029	Reaudit of patient satisfaction in Muscle clinics	1. Communication to patients if there is a delay in waiting times and to avoid double bookings 2. Reception staff to obtain patient permission for visitors to be present in the clinic rooms
10	00378	Minimally invasive transsartorial approach for periacetabular osteotomy	No actions needed as deemed safe and successful in minimizing tissue trauma
11	15/16_033	Reaudit of DMD in adolescence: Assessment of Outpatient services	1. Inpatient/overnight stay seating-Discussion re: Neuromuscular centre purchase appropriate high chairs 2. Teenage appropriate waiting area-Teenage focus group. Arrange all transfers groups and services such as morbidity etc
12	15/16_028	7-14 year follow up of ZMR Revision Hip Replacement	No recommendations/actions were needed
13	16/17_007	The validation of the Royal Stoke Pharmacy workforce calculator	No recommendations/actions were needed
14	00399	Genex Synthetic Bone Graft: Is it safe? Does it work?	No recommendations/actions were needed
15	17/18_015	MRI request form completion evaluation	1. Design a new request form with more information that is needed 2. Contact all clinicians via email informing them of the importance of correctly filling in the form in the presence of the patient. Make sure old request cards are removed and new ones available in all clinical areas
16	15/16_024	Evaluation of recorded outcome of radiographic requests	1. Share results of the audit to Chief Executive and Medical Director in order that the issue of the legal requirements under IR(ME)R are revisited 2. Letter to be sent to all consultants by the medical director making them aware of the contents of the audit 3. Undertake a further audit to investigate the patients who have received no comment on EPR
17	00300	Radiographic Marker Evaluation	1. Radiographers to be made aware of the actual percentage of images that have physical markers and should be encouraged to use them more often 2. Improve the awareness of having a physical marker visible in the primary beam 3. Further investigation should be done to determine if anything can be done to reduce the disparity between grid and non-grid work
18	17/18_014	Introduction of the Edmonton Frailty Score to improve patient outcomes Service Evaluation	1. Use of the Edmonton Frailty assessment as a standard part of the Pre-op assessment process for all patients who are visually assessed as frail.

			2. Use of the Edmonton Frailty assessment as a standard part of the Pre-op assessment process for all patients with Dementia and include it on all patients who score as moderate to severe impairment during dementia
19	16/17_026	Advanced Care Planning in the RJAH Neuromuscular Service	Continue to monitor the Advanced Care Plan on a monthly basis to ensure our standards are kept and will reaudit in 12 months' time from June 2017
20	16/17_020	Evaluation of the West Midlands Critical Care Network Transfer form in HDU	1. Discuss the completion of the form with the ward manager to ensure all sections are complete and ask the ward manager to inform the staff 2. Share and discuss the findings with all staff concerned 3. To encourage more staff to attend the transfer course 4. Discuss evaluation with the Lead Consultant Anaesthetist in HDU to ensure awareness of completing all sections of the form
21	17/18_027	Reaudit of ward in-patient satisfaction survey	1. Patients being disturbed by light and noise on 2 wards at night. Ward managers to put requirements in place to minimise noise and light at night 2. Some staff members were deemed as unhelpful-Ward managers to address these issues 3. 33% of patients said staff did not introduce themselves-Ward managers to address this by ensuring 'hello my name is' being used 4. Share all comments from patients with ward managers, matrons, CG divisional leads via email 5. Share report with Patient Panel at the March 2018 meeting 6. To monitor improvements needed via the Patient Experience Strategy and Always Events as these are similar themes 7. 30% of call bells not being answered within 2 minutes of patient ringing them-Ward manager to address and improve timings

Participation in Clinical Research

Research at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continues to flourish. The total number of Health Research Authority approved (including Ethical approval) studies active during 2017-18 was 66, of which 52 are National Institute for Health Research (NIHR) recognised, a rise of 62% (32 to 52) on 2016-17. These studies fall into 5 of the 7 NIHR speciality areas including cancer for the first time. They include commercially, academic and RJAH sponsored studies.

The number of patients receiving relevant health services provided or subcontracted by Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2017-18 that were recruited during that period to participate in research approved by a research ethics committee and recognised by the NIHR was 737.

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

During 2017-18 research at RJAH contributed to 18 publications, which shows our commitment to transparency and desire to improve patient outcomes and experience.

CQUIN framework

A proportion (2.5%) of The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and its Commissioners through the CQUIN (Commissioning for Quality and Innovation) payment.

The current CQUIN schemes are for a two year period in line with the NHS standard contract period of 2017-19. The national drive behind developing two year schemes was to give greater certainty and stability on CQUIN goals.

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

1. Clinical Quality and transformational indicators

2. Supporting local areas
    a. Sustainability & Transformational Plans
    b. Local Financial Sustainability

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

Indicator	Indicator Name
1a	Improvement of health and wellbeing of NHS staff
1b	Healthy food for NHS staff, visitors and patients
1c	Improving the uptake of flu vaccinations for frontline clinical staff
2a	Timely identification of patients with sepsis in emergency departments and acute inpatient settings
2b	Timely treatment of sepsis in emergency departments and acute inpatient settings
2c	Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.
2d	Reduction in antibiotic consumption per 1,000 admissions
Scheme 6	Advice & Guidance
Scheme 7	E-referrals
Scheme 8a	Supporting proactive and safe discharge
9	Achievement of Control Total
10	Ongoing collaboration as part of the STP
A1	Spinal Surgery: Network / Outcomes / Governance
A2	End of Life Care
A3	Paediatric Networked Care

The total income conditional upon achieving quality improvement and innovation goals at the end of 2017/18 was £1,398K compared to £1,240K in 2016/17

Further improvement targets have been set for 2018/19 to further implement the initiatives introduced during 2017/18.

CQC registration

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration is without conditions. The Care Quality Commission has not taken any enforcement action against The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2017/18.

During January 2018, the CQC carried out an inspection of the Trust and at the time of writing the inspection report was awaited. Prior to this, the Trust was inspected by the CQC in October 2015. At this time, the Trust was given an overall rating of Requires Improvement, with the breakdown of ratings show in the table below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

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

In response to the inspection report from October 2015, the Trust put in place a robust action plan to address the areas for improvement highlighted by the CQC. Completion of this action plan was monitored by the Quality & Safety Committee and all actions were signed off as complete in April 2017.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2017-18.

Secondary Uses Service Submission

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode

Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

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

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

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

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

- Raise the awareness and profile of data quality, developing within the Trust a positive culture, through encouraging best practise and promoting new processes, and ensuring that all staff recognises that they have a responsibility for ensuring a high standard of Data Quality. Offering help, support and advice to departments and staff.
- Make certain that the six data quality principles are incorporated across the Trust and used to promote a strong Data Quality culture ensuring that: Accuracy, Validity, Reliability Timeliness, Relevance, Completeness are embedded to drive forward the Data Quality Policy.
- Continue to provide a robust Audit framework that is closely monitored and updated as new key performance indicators are agreed with key stakeholders, with the aim of ensuring the data is of an agreed acceptable level regarding the six data quality principles and incorporating the data quality score into the Integrated Performance Report (IPR). Also setting of internal KPI's in areas of concern, to help monitor, review and recognise to then enable us to mitigate, improve and report on data quality offering support to areas
- Improve the Data quality in relation to 18 week referral to treatment time (RTT) through audit, validation and education of both clinical and non-clinical teams, providing support and advice when needed.
- To prepare for the new Data Security and Protection Toolkit ensuring continued compliance for all data quality standards.

Information Governance

The Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance Assessment Report score overall for 2017/18 was 80% and was graded green ('Satisfactory'). When conducting the self-assessment, the Trust achieved the top level score of 3 for 17 of the 45 requirements.

Clinical coding error rate

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust was not subject to the Audit Commission's Payment by Results clinical coding audit during 2017-18.

An audit of 200 sets of case notes was carried out by an external company (JW Clinical Coding Limited) as part of the Information Governance process. The figures again far exceed the recommended 95% accuracy for primary diagnoses and procedures and 90%

accuracy for secondary diagnoses and procedures required for Information Governance purposes at Level 3, an extract from the report summary is shown below:

Primary diagnosis correct	Secondary diagnosis correct	Primary procedures correct	Secondary procedures correct
98.50%	**94.90%**	**97.58%**	**98.18%**

Seven Day Working

The seven day services programme has been designed to ensure patients that receive high quality consistent care across all seven days of the week.

As an elective centre the Trust does not receive emergency admissions in the same way as an Acute Hospital and is aware of emergency admissions in advance which enables the Trust to ensure appropriate multi-disciplinary teams are in place.

The Trust is already offering a seven day service in respect of the elective surgery and outpatient services it delivers with consultant led clinics and procedures conducted throughout the entire week.

NHS Outcomes Framework: Review of performance against mandated indicators

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

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

Mortality

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

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

During 2017-18 nine patients of Robert Jones and Agnes Hunt Orthopaedic Hospital died. This comprised the following number of deaths which occurred in each quarter of that reporting period: four in the first quarter; one in the second quarter; two in the third quarter and two in the fourth quarter.

By 31 March 2018, eight case record reviews and one investigation have been carried out in relation to the nine deaths.

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

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

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

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

Notwithstanding the information above, through the case record reviews and investigations the Trust identified an opportunity to improve liaison between the wards and critical care around the planning of limits for treatment this has prompted discussion between the MCSI lead and HDU lead for providing opinion on treatment limits planned.

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

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

0 representing 0% of the patient deaths during 2016-17 are judged to be more likely than not to have been due to problems in the patient care.

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

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

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has introduced a Learning from Deaths Policy during 2017-18 and intends to ensure its ongoing implementation during 2018-19.

Helping people recover from episodes of ill health or following injury

Readmission Rates

During 2017/18 the percentage of patients aged 0-15 years old, readmitted to the hospital within 28 days of discharge was 0% (as at 1 January 2018) and for 16+ years old it was 0.63%. For 2016/17 we are unable to show a comparison of our peer group data due to the removal of the provider access to the SUS data.

	Readmission rate for 0-15 year olds	Readmission rate for 16+ years old
2015-16	0.17	0.76
2016-17	0.78	0.63
2017-18	0 (as of March)	0.8 (as of March)

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

- No comparative data is now available
- Data is submitted and checked on a monthly basis as part of regular performance reporting.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken action to improve this percentage by:

- Improved understanding of readmission rates linked to infection
- Continued discharge planning at pre-operative appointments

PROMS data

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

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

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

The table below summarises the Trust's performance as reported in the year 2017/18 for hip and knee replacements as the only PROMS procedures offered by the Trust and provides a comparator to the national average and the highest and lowest scores nationally. Data is also provided for previous years with the publication dates as follows:

- 2014-15 Final Release - August 2016
- 2015-16 Final Release - August 2017
- 2016-17 Provisional - covering April - March 17 - Published February 2018

The Trust's data published in February 2018 shows that the Trust achieves good outcomes for its patients, particularly given the complex nature of the procedures it carries out.

Primary Hip Replacement

	EQ5D Index			Oxford Score		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
National Average	0.436	0.438	0.445	21.443	21.607	21.799
Highest Score	0.524	0.510	0.537	24.652	24.755	25.068
Lowest Score	0.331	0.321	0.310	16.291	16.884	16.427
Robert Jones and Agnes Hunt	0.414	0.414	0.451	20.616	20.847	22.155

Revision Hip Replacement

	EQ5D Index			Oxford Score		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
National Average	0.277	0.283	0.291	12.751	13.206	13.504
Highest Score	0.375	0.374	0.362	15.524	16.209	16.508
Lowest Score	0.185	0.224	0.239	8.796	9.358	10.256
Robert Jones and Agnes Hunt	0.235	0.236	0.339	8.797	11.163	13.847

Primary Knee Replacement

	EQ5D Index			Oxford Score		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
National Average	0.315	0.320	0.324	16.116	16.365	16.547
Highest Score	0.418	0.398	0.404	19.581	19.970	19.876
Lowest Score	0.204	0.198	0.242	11.430	11.955	12.508
Robert Jones and Agnes Hunt	0.321	0.316	0.318	16.844	17.027	17.854

Revision Knee Replacement

	EQ5D Index			Oxford Score		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
National Average	0.261	0.258	0.273	12.314	11.98	12.36
Highest Score	0.334	0.335	0.297	16.763	14.157	13.875
Lowest Score	0.186	0.190	0.157	8.574	8.328	8.615
Robert Jones and Agnes Hunt	0.186	0.190	0.252	8.574	8.505	10.96

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

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

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

- Continuing to review both national and local data to identify any areas where improvements can be made.
- Considering other specialities that can be included

Staff Survey

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

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

Staff who would recommend the Trust to their family or friends	2015 %	2016 %	2017 %
National Average (All Trusts)	69	69	59
Highest	96	95	96
Lowest	38	45	42
Robert Jones and Agnes Hunt	93	93	93

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

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

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

- Continuing to support staff to have a positive experience and work across the hospital.
- Undertaking pulse checks during 2017/18 for a more up to date view on staff opinion and enabling focused action to be taken to improve staff morale
- Agreement of a Five Year People Plan

Ensuring that people have a positive experience of care

Responsiveness to Inpatient's Personal Needs

We await the final CQC benchmark report for the 2017 survey due to be published in June 2018.

	2012/13	2013/14	2014/15	2015/16	2016/17
National Average	68.1	68.7	68.9	69.6	68.1
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	79.0	81.6	79.8	82.0	82.5
Highest	84.4	84.2	86.1	86.2	85.2
Lowest	57.4	54.4	59.1	58.9	60.0

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

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

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

- Implementation of its Patient Experience Strategy
- Improved patient involvement in the investigation of its incidents

Patient Friends and Family Test

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

The Trust has been collecting FFT data monthly via the Trust current comment cards and electronically using volunteers to collect the data in real time using iPads.

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

	2015/16	2016/17	2017/18
National Average	96%	96%	96% (to Feb 18)
Highest Score	100%	100%	100% (to Feb 18)
Lowest Score	75%	75%	75% (to Feb18)
Robert Jones and Agnes Hunt	99%	100%	99% (to Feb18)

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

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

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

- Refresh of the Patient Panel, appointment of three co-chairs ensuring the move forward with co-production with our patients
- Implementation of a new Patient Experience Strategy

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

VTE Assessment

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

The Trust has in place a robust system of audit to measure compliance with the VTE assessment process. Further, any incidence of DVT or PE is subject to a full root cause

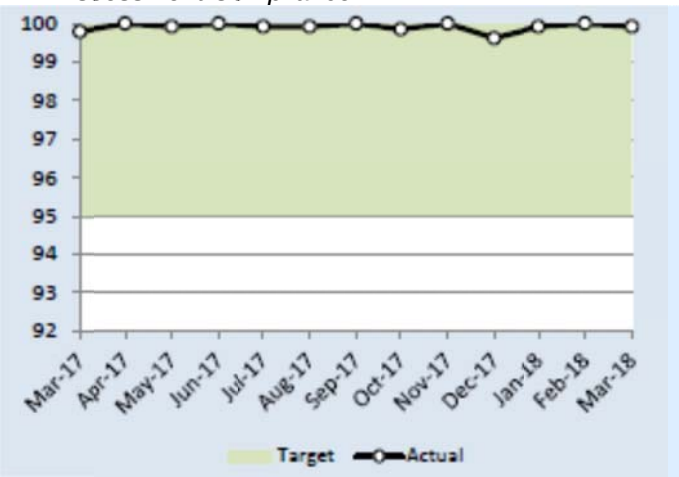
analysis review to ensure that learning is taken. The Quality and Safety Committee receives regular reports on the Trust's work on VTE prevention.

The chart below outlines the percentage compliance for VTE assessments for the year (up to Dec 2017) and the preceding two years:

	2015-16	2016-17	2017-18
Average	95.83%	95.75%	95.3%
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	100%	100%	99.9%
HIGHEST	100%	100%	100%
LOWEST	76.60%	71.42%	66.2%

Performance for the year 2017-18 by month was as follows:

VTE Assessment Compliance



RJAH has maintained the required percentage of VTE assessments completed. The Trust monitors this through the monthly performance reports. During 2017-18 the Trust commissioned the internal auditors to review its VTE data quality. This resulted in recommendations regarding the capture of the data and this resulted in a strengthening of the Trust's data capture.

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

- The Trust has in place a clinical lead for VTE who champions the VTE process amongst the clinical staff
- Regular audits are undertaken to check compliance with follow up actions where required
- The Quality and Safety Committee receives regular reports on compliance with VTE assessments.

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

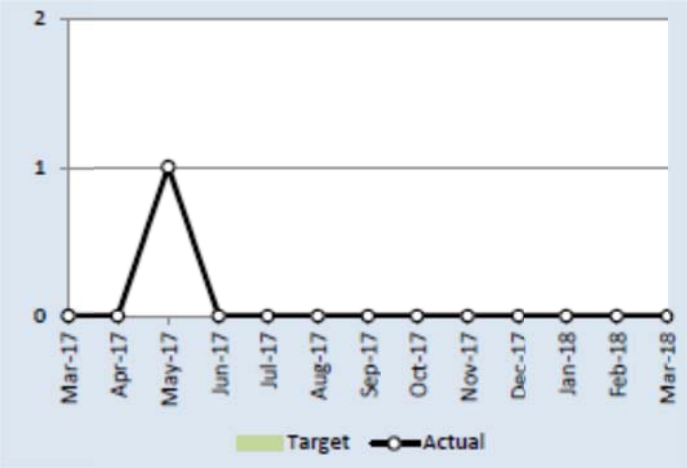
- Implementation of documentation audits to ensure the completion of the necessary risk assessments are further implemented

C.difficile Infections

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

The Trust has had no attributable cases of C Difficile for the year 2017/18. This was against a target issued by NHSE of 2. The case referenced below was reported but subsequently found to not be attributable to the Trust.

Number of C.Difficile Infections



	2013-2014	2014-2015	2015-16	2016-17	2017-18
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	1.9	3.8	0.0	0.0	0.0
HIGHEST	37.1	62.2	24.3	82.7	*
LOWEST	0.0	0.0	0.0	0.0	*

* Benchmark data next due for publication July 2018

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

- Data is reported and monitored on a monthly basis.

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

- Continuing to carry out regular audits and monitoring instances of non-compliance

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

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

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

Patient Safety Incidents Reported per 1000 Bed Days

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

Patient Safety - Severe Harm / Death

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

Serious Incidents

In 2017/18 the Trust reported eight serious incidents as defined by the NHS England Serious Incident Framework. All of these incidents have had Root Cause Analysis completed and reports prepared for presentation and agreement at Quality and Safety Committee. In addition, all our serious incidents have been reviewed by the Clinical Commissioning Group to ensure they are in line with the NHSE Framework.

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

- Pressure sore category 3
- Unexpected Death
- Falls
- Medication

In comparison, during 2016/17 the Trust reported 18 serious incidents of which 3 were never events.

Never Events

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

In 2017-18 there were 0 never events. This compares to 2016-17 when there were 3 never events. All three never events in 2016-17 related to wrong site surgery, two related to wrong level spinal surgery and one related to an incision being made on the wrong finger. All were reported in line with the NHSE never event framework and investigated and reported to NHSi and the CQC.

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

- The Trust has undertaken reconfiguration work on Datix to ensure more accurate capture of themes and trends in the categories of incident
- The Trust has introduced a new serious incident management framework

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

- Wider dissemination of learning triangles as the output from incident reporting
- Feedback to all staff who report incidents
- Introduction of the Action module in Datix to capture and better track the learning from incidents
- Communication to key groups regarding the serious incident management framework

PART 3

Review of Quality

Summary of Performance Status for Quality Priorities Set for 2017/18

In line with the Trust's Quality Improvement Strategy, and in discussion with the Board of Directors, Council of Governors and other relevant stakeholders (including the Patient Panel and commissioners), the Trust identified the following three key priorities for 2017/18:

- Safety: Learning from Incidents
- Effectiveness: Reduce on the day avoidable cancellations
- Patient Experience: Patient experience of the pre-op pathways

Progress made for quality priorities 2017/18

In our Quality Account for 2017/18, we chose three areas to focus on for our quality improvement priorities.

The following section gives a detailed account of the progress we have made for each of the priority areas and how the improvement work will be maintained in the coming year. In this section, we also discuss the quality priorities that we will be taking forward into 2016/17 and those that we will be retiring from the Quality Accounts.

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

Safety

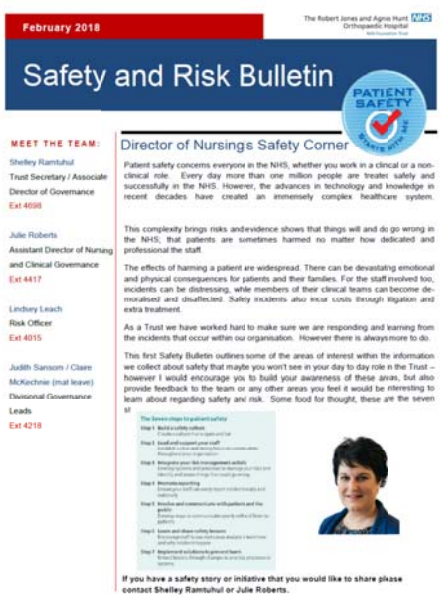
Priority One: Learning from Incidents 

We said that we would ensure that learning from incidents is both embedded and sustained across the Trust. We said the way we would measure this would be through the following:

- Implementation of a Safety Bulletin
- Hold a Patient Safety Summit for Clinical Staff
- 80% of complaints have an action plan.

In July 2017 the Trust held its first Patient Safety Summit which was attended by senior management, clinical staff and stakeholders such as the CCG, Governors and CQC. The session was well attended and focused on the human factors involved in serious incidents. This has been further followed up with more in depth human factors training for clinical staff.

In February 2018 the Trust issued its first Safety and Risk Bulletin. This introduced the Clinical Governance Team and covered topics such as:


February 2018

Safety and Risk Bulletin

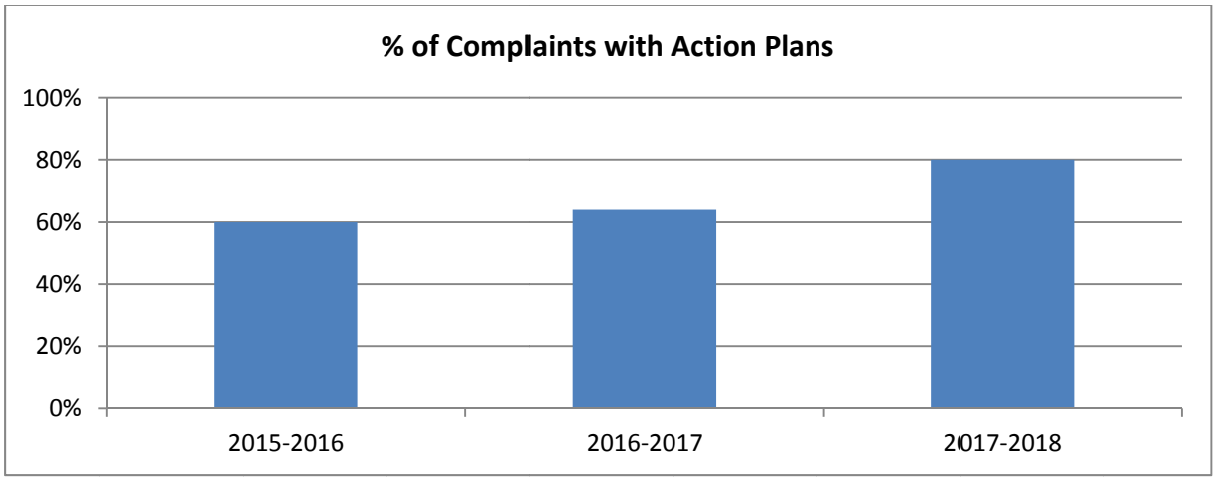
MEET THE TEAM:

Director of Nursings Safety Corner

If you have a safety story or initiative that you would like to share please contact Shelley Ramtuhul or Julie Roberts.

- Changes to the list of never events
- RIDDOR definitions
- Incident Management
- Stop before you block campaign
- HSIB Wrong Prosthesis investigation
- NHS Resolution update
- Datix updates and training dates
- Duty of candour
- Saying sorry

The Trust recognises the opportunity patient feedback provides to identify areas for improvement and it is for this reason it committed to increasing the percentage of complaints with resultant action plans. The graph below shows how performance in this area has improved with the target of 80% of complaints having action plans being achieved for 2017-18.



Effectiveness

Priority Two: Reduce on the Day Avoidable Cancellations

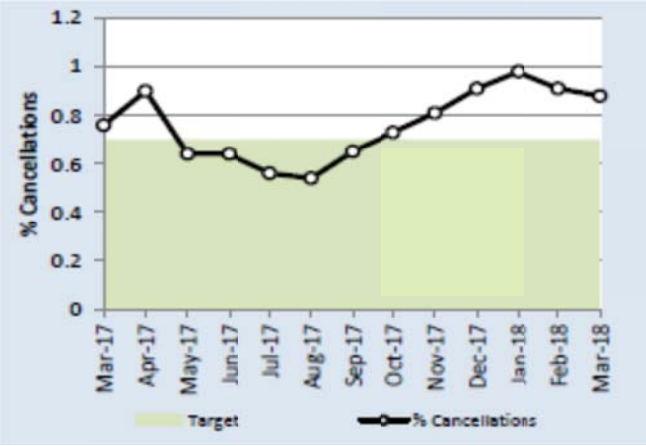
We said we would develop processes and systems that ensure that on the day avoidable cancellations are reduced. We said that we would measure this by developing a baseline and then work to reduce this by 5% for the financial year.

This priority has been particularly challenging and whilst good progress was made initially in 2017-18 the performance worsened over the winter months as a result of a combination of adverse weather, seasonal illness and high activity levels.

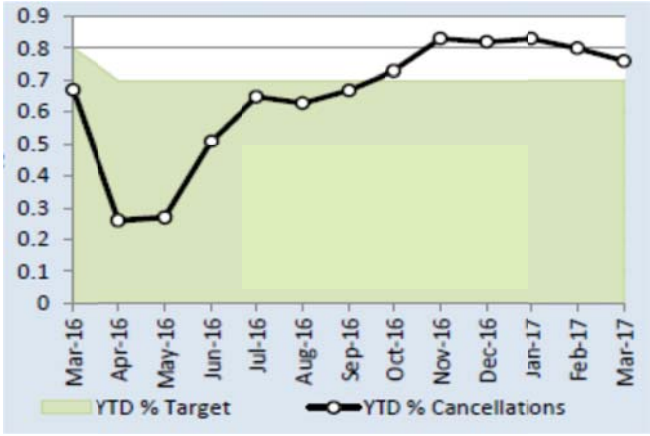
During 2017-18 the Trust had 123 reportable on the day cancellations which equates to 0.88% compared to 106 in 2017. With regard to non-reportable cancellations, the Trust had 321 which equates to 2.29%.

It is important to note that whilst the cancellations themselves are a disappointment, the Trust did re-book all cancellations within 28 days throughout 2017-18 and therefore delays were kept to a minimum. The Trust has not achieved its aim of reducing its reportable cancellations and has therefore decided to carry this priority forward to 2018-19.

Reportable Cancellations

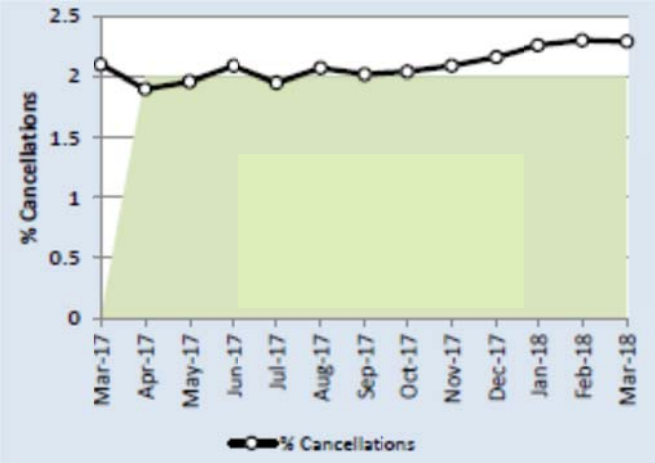


Source: Integrated Performance Report March 2018



Source: Integrated Performance Report March 2017

Non Reportable Cancellations



Priority Three: Quality of Appraisals

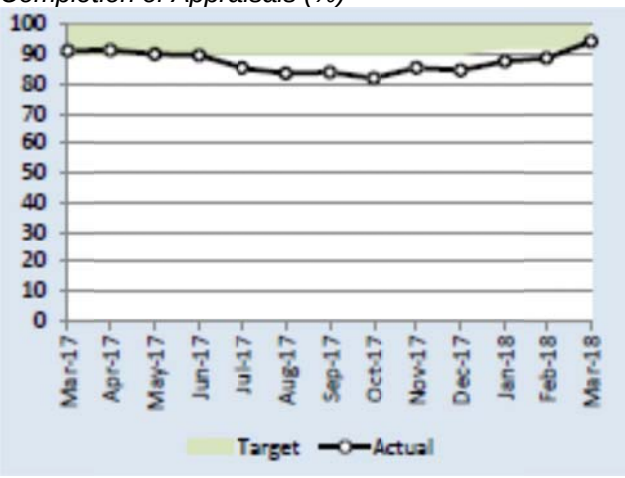
We said we would develop a process which measures the Quality of the appraisal process from RJAH staff. We said we would measure this in the following way:

Measures:

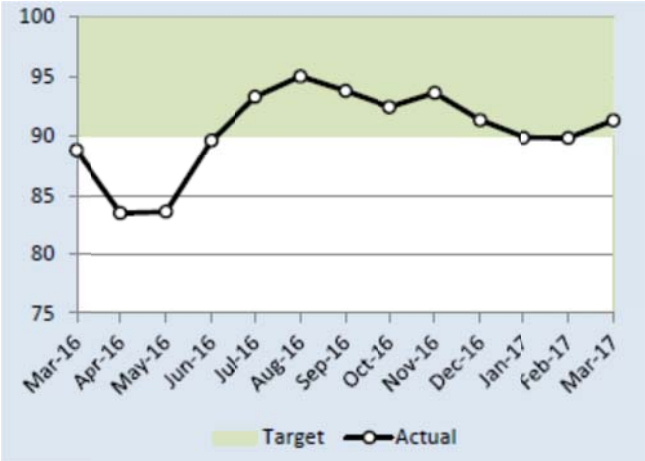
- Reviewing the appraisal process to ensure the measure of Quality is recorded.
- Ensuring that incident reporting rates for consultants are included in the appraisal process
- The Key Finding Score for Quality of Appraisals in the national staff survey to improve to be in line with the national average for Specialist Trusts

The number of staff who have received an appraisal has decreased slightly during the summer of 2017 but steadily improved to exceed the target figure by year end.

Completion of Appraisals (%)



Source: Integrated Performance Report March 2018



Source: Integrated Performance Report March 2017

The Staff Survey Results for 2017 demonstrated improvement of the quality of appraisals in the response rate to the following questions about the appraisal process:

- 'it has helped me to improve how I do my job' an improvement from 62% in 2016 to 65% in 2017
- 'It helped me agree clear objectives for my work' an improvement from 77% in 2016 to 80% in 2017
- 'It left me feeling that my work is valued by my organisation' an improvement from 68% in 2016 to 74% in 2017
- 'The values of my organisation were discussed as part of the appraisal process' an improvement from 74% in 2016 to 78% in 2017.
- 'Were any training, learning or development needs identified' an improvement from 56% in 2016 to 61% in 2017

Patient Experience

Priority Four: Decreasing the number of delayed discharges across the Trust

We recognised the good progress made during 2016-17 on improving the number of delayed discharges across the organisation but felt there was more to be done to sustain this to ensure that our patients were not unnecessarily staying in hospital longer than they required. For 2017-18 we set ourselves an ambitious target of reducing delayed discharges by 10% on the 2016-17 baseline.

In 2015-16, the Trust's discharge transfers of care metric averaged 2.87% which was below the target set by the Department of Health. In 2016-17 the Trust averaged above the national target of 3.5% at 5.41% which also meant the Trust continued to average above its own target of 2.5%.

The majority of the Delayed Transfer of Care's (DTOC's) were in the Medicine Division. This includes The Midlands Centre for Spinal Injuries (MCSI) and Sheldon Ward, a general medical ward providing fifteen rehabilitation beds and eight beds, which can be split between rheumatology and patients requiring further rehabilitation and physiotherapy.

In response to the increasing number of delayed discharges, a project group was set up to review the national good practice in discharge planning and to work jointly with commissioners and stakeholders to reduce the number of delayed discharges.

The objectives were :

- to improve patient experience
- reduce delays associated with completion of assessments
- reduce delays with sourcing equipment
- reduce delays with sourcing nursing and residential care

NHS England invested in 0.52 WTE Resettlement Officer posts to support the project. A QIPP was agreed to reduce the number of English delayed discharge beds by 16%.

A dashboard was put in place for the team to monitor progress against Clinical Commissioning Groups (CCG) split by the reason for delay for all patients.

The number of days of delayed discharges has reduced from 2,963 in 16/17, to 2,111 in 17/18, a reduction of 852 days, a reduction of 29%

Local Quality Indicators *

In addition to the Quality Priorities for 2017-18 the Trust has selected a number of local quality indicators. These remain the same as those reported in 2016-17 but in addition there is information included on the Patient Experience Strategy and Patient Safety Walkabouts which were introduced in 2017-18.

Safety

Falls

Patients who have fallen prior to admission to hospital or who present at hospital following a fall are at high risk of falling whilst an inpatient. This is due to the increased incidence of confusion, confounding medical conditions and environmental factors. (Fonda et al 2006). Reducing the risk of these falls can be achieved by identifying those at risk of falling and implementing a multidisciplinary multifactorial management and intervention strategy, whilst maintaining a patient's right to dignity, privacy, independence and their right to make informed choices about the risks they take.

The Trust has continued with its falls collaborative work which aims to reduce the amount of falls if possible, but certainly to reduce the number and severity of harm.

The continued work which is being undertaken shows a sustained reduction across all clinical areas of the trust.

Summary of actions/preventative measures taken:

Polypharmacy and anaesthetic review – communication of information gathered at pre-op. All patients are measured for frailty, pain and their risk of a fall. Their anaesthetic and medications are prescribed accordingly on the enhanced recovery charts. Representative coloured stickers are placed on the patients pathway documentation and prescription chart to alert staff.

Immediate post fall follow-up – the development of a new post fall assessment tool and action plan has improved consistency of data recorded and monitored through the Datix

system. The assessment incorporates information gathered from the patient and a multidisciplinary 'huddle' enables clarification as to why the patient fell and what lessons can be learnt to avoid it happening again. Actions taken can be for the individual patient and/or can be appropriate to wider changes being made to the environment or routine.

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

Intentional Rounding - as a result of the review documentation has been changed to embrace individual needs especially in relation to the time if the rounding. This has part way addressed the number of patient's falling immediately before or after mealtimes. Further monitoring and actions are required to further reduce falls during these times.

Bay Nursing – cohorting 'at risk' patients in one nursing bay - initially implemented on Sheldon Ward which reduced the number of falls to below the mean. Due to this success Bay Nursing has been cascaded to other appropriate wards.

A review and update of the Trust Fall Prevention Policy was undertaken to ensure it reflected the findings of the collaborative. A Fall Change Package is being produced. This will summarise the group of identified ideas for changes which when applied reliably to patient care, may reduce the likelihood of a patient sustaining a fall. The change package will assist teams to improve their processes for managing the risks and implement and monitor fall prevention strategies and will become an integral part of the daily routine. Each clinical area will now take ownership of the change package from the collaborative and will continue to undertake further tests of change that may assist in reducing falls further.

The work of the collaborative links with the Trust's Quality Strategy and is an integral component of the STAR assessment (Sustaining Quality Through Assessment and Review). Ludlow Ward has recently maintained their 5 Star award. The following illustrates some of the actions implemented which was presented to CQC at their recent visit to the trust:

How we reduce the risk of falling on the ward:

- Toilet tagging
- At a glance information on patient board
- Safety huddles
- Team working
- Intentional rounding
- Risk assessment pre-operative and post operative
- Blue band

Call Bells

- Minimise falls by always making sure patients have the call bells to hand;
- **Single side rooms** mean we can't see all the patients at the same time;
- Having call bells to hand or beirg within easy reach means patients are more likely to ring than get up unsupervised;
- Staff also make sure they tell patients to ring, every time we are in the rooms we say before we leave "if you need anything ring this bell".
- Bells in the bathroom and showering areas are also to hand.

Intentional Roundings (new times)

- We complete the intentional roundings every two hours, checking on patients to make sure they have everything to hand.
- We have just updated our rounding forms to suit different times on the ward.
- **All** staff have been made aware of what needs to be checked and ticked before being signed..

Signs in rooms and toilet areas

- Updated signs tell patients to ring their bell, wait for a staff member to come, stay seated and stay safe!
- The colour of the background of the sign was changed to make it stand out more than the old forms (black writing on white);
- Recently moved posters in the toilets to eye level, but are asking patients where is the best place for them, as they know where to look.

High falls on boards and **blue bands**

- Name boards in each room now say if a patient is at high risk of falling, and what equipment they are using;
- Board also records physiotherapist advice: e.g. safe on crutches or need a bit longer and more practice with the frame. Some patients stay on frames and need more supervision than others;
- The content of the boards is a big help in reducing the risk of falling as all staff are aware of what the patient needs are.

High falls on boards and **blue bands**

- Blue bands indicate if a patient is a high risk of falling, and remind staff and the MDT that they need to be more aware of the risk when they are either getting out of bed, or walking.
- Risk assessments carried out for all patients to identify who is at most risk, e.g. if a patient falls quite regularly at home we know to put them in a room closer to the nurses station to keep a closer eye on them

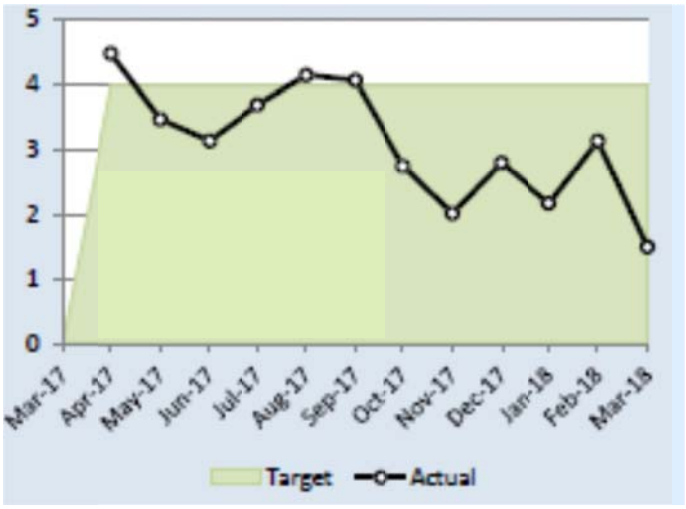
Staff will continue to monitor falls within the trust especially looking for ways in which improvements in communication of patient's risk factors can be made so that their journey will be as safe as possible.

Further analysis of falls data by surgical procedure commenced in January 2018. This will identify whether patients who have undergone a specific surgical procedure are any more

likely to sustain a fall. The results will determine what actions may be tested and implemented accordingly.

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

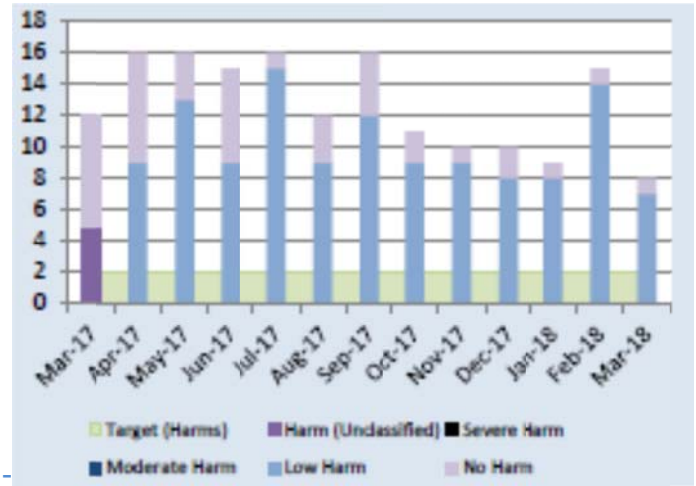
Inpatient Falls per 1000 Bed Days 2017-18



Source: Integrated Performance Report March 2018

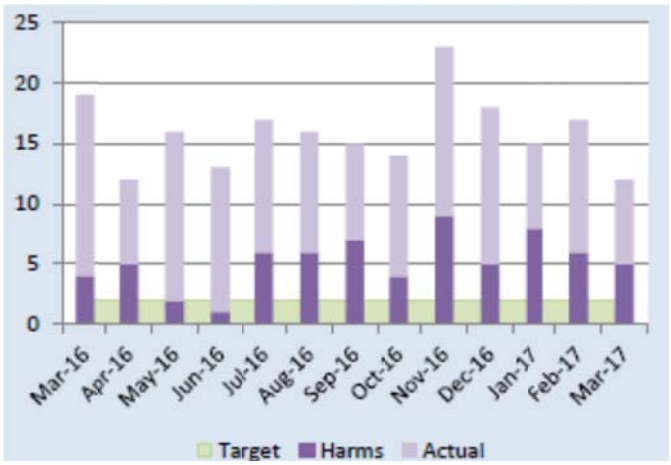
It is important to not only look at the rate of falls but also any harm that may have been caused as a result of a fall. The data below reflects the harm of each fall and reflects that for the duration of 2017-18 there have been no moderate or severe harms to patients as a result of falling.

Falls Harms2017-18



Source: Integrated Performance Report March 2018

Falls Harms2016-17



Source: Integrated Performance Report March 2017

Medication Incidents

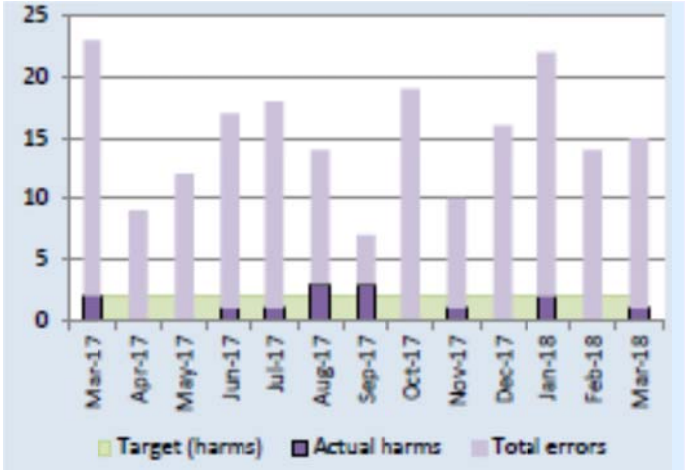
Medication incidents and an organisational response to these is a good measure of patient safety. During 2017/18 we have continued to monitor the amount of harm experienced from patient medication incidents alongside monitoring the total number of incidents across all clinical areas of the organisation.

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

Ward walkabouts were introduced in 2016-17 and have continued in 2017-18 and have maintained the increased reporting of medication incidents whilst the harms have remained low.

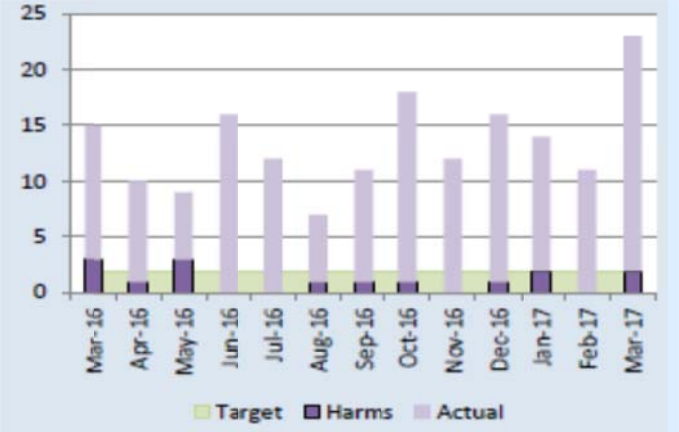
The chart below tracks our progress across the year in relation to the number of incidents and the levels of harm associated with these:

Medication Incidents 2017-18



Source: Integrated Performance Report March 2018

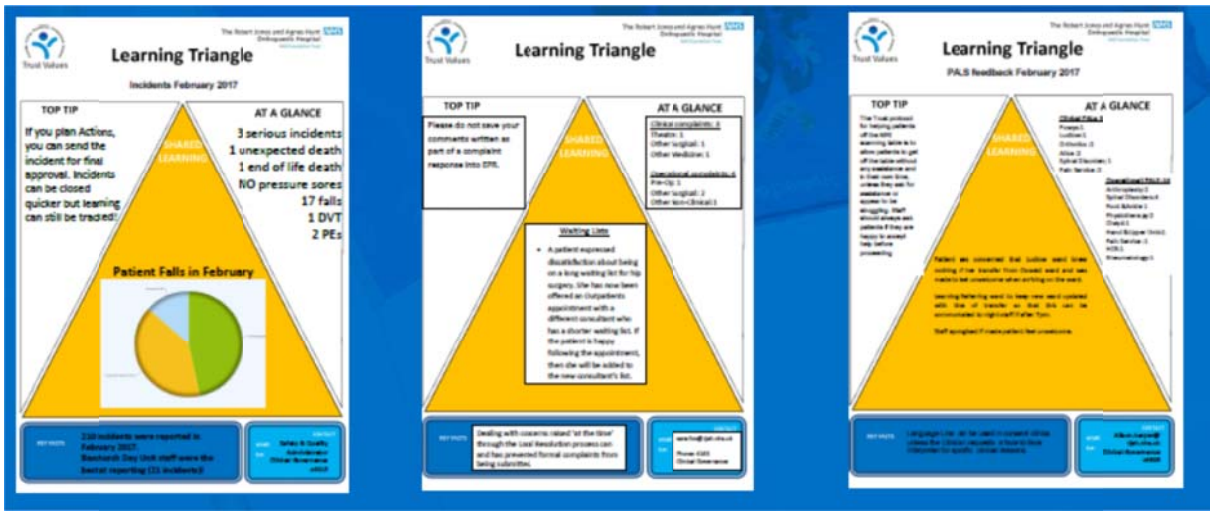
Medication Incidents 2016-17



Source: Integrated Performance Report March 2017

Learning Lessons from incidents

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



Improving Learning from Incidents

- Incidents within the Trust are reported via Datix Web and at the time of reporting, the reporter is asked for their email address. This enables a feedback email to be automated back to the reporter once the incident investigation is completed. During 2018-19 there is going to be a further focus on this to ensure robust feedback.
- The Trust utilises Datix Web to manage its incidents and during 2017-18 has undertaken some significant reconfiguration work to ensure that the data captured is both meaningful and acted on to ensure learning and improvements at every opportunity.

- The Trust also held a poster presentation in May 2017 regarding best practice, learning and innovation from across the organisation. This was led and supported by our library services
- In July 2017 we held a patient safety summit to focus the learning from our Never Events and Serious Incidents. The summit was attended by over 50 clinical staff from across the Trust as well as external regulators and stakeholders. Human factors was a main focus for the event with a main session provided to ensure there was awareness and engagement in the need to look at human factors in our safety incidents. The summit also focused on the learning gained across the trust from our serious incidents and the slide below articulates this.
- Review of the Wound Management and Tissue Viability processes has been undertaken with documentation changes made and training rolled out and continuing
- The reports regarding unexpected deaths triggered further analysis of how a deteriorating patient is managed. VitalPACS (a system used to record vital observations) is in place and had the check and trigger processes for escalation have been reviewed and improved.
- Following the spinal never event, the Trust's policy was re-audited in association with the NOA by the Medical Director with best practice reviews and benchmarking with other centres undertaken. As a result the Trust's process for marking spinal levels has been reviewed and the use of CT in theatres is being considered through the capital programme.

Sign up to Safety

Sign Up to Safety is a national initiative that aims to help the NHS improve the safety of patient care. Organisations are invited to sign up by making pledges under five areas:

1. **Putting safety first.**

Committing to reduce avoidable harm in the NHS by half through taking a systematic approach to safety and making public your locally developed goals, plans and progress. Instil a preoccupation with failure so that systems are designed to prevent error and avoidable harm

2. **Continually learn.**

Reviewing your incident reporting and investigation processes to make sure that you are truly learning from them and using these lessons to make your organisation more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe your services are

3. **Being honest.**

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

4. **Collaborate.**

Stepping up and actively collaborating with other organisations and teams; share your work, your ideas and your learning to create a truly national approach to safety. Work together with

others, join forces and create partnerships that ensure a sustained approach to sharing and learning across the system

5. **Being supportive.**

Be kind to your staff, help them bring joy and pride to their work. Be thoughtful when things go wrong; help staff cope and create a positive just culture that asks why things go wrong in order to put them right. Give staff the time, resources and support to work safely and to work on improvements. Thank your staff, reward and recognise their efforts and celebrate your progress towards safer care.

Effectiveness

The National Institute for Health & Clinical Excellence (NICE) guidance

In 2017-18 NICE published 183 Guidance's to which there were:

- 49 clinical guidelines & National Guidelines
- 26 Interventional procedures
- 89 Technology appraisals
- 6 Medical Technologies guidance's
- 6 Diagnostic Guidance's
- 3 Highly Specialised Technology Guidance's
- 4 Public Health Guidance's

This compares to 149 guidance's in 2016-17.

NICE also produced 71 advice/recommendations to which there were:

- 5 Evidence Summaries
- 40 Medtech innovation briefings
- 26 Quality Standards

This compares to 279 advice/recommendations in 2016-17.

A baseline assessment was carried out for guidance's relevant to the Trust and where appropriate audits were undertaken to measure compliance are put in place. Audits that are being carried out or have been carried out in 2017/18 in relation to NICE guidance include:

- National Rheumatology Audit CG 79 and QS 33
- The effectiveness of track and trigger systems in identifying deteriorating patients/Acutely ill adults in hospital: recognising and responding to deterioration CG 50
- Acute Heart Failure CG 187
- NEWS clinical observation audit/Acutely ill adults in hospital: recognising and responding to deterioration CG 50
- Compliance with VTE Prophylaxis/Venous Thromboembolism: reducing the risk for patients in hospital CG 92
- Reaudit of Delirium among in-patients/Delirium: prevention, diagnosis and management CG 103
- Acute Kidney Injury among in-patients/Acute kidney injury: prevention, detection and management CG 169
- Preventing Pressure Ulcers CG 179
- Compliance with VTE assessment on admission and within 24 hours in non-surgical patients/ Venous Thromboembolism: reducing the risk for patients in hospital QS 29

- Reaudit of Urinary Incontinence/Urinary Incontinence in women: management CG 171
- Patient Group Direction Policy Audit/Medicines Practice Guidelines-Patient Group Directions MPG 1 & 2
- Assessing and document the risk of Venous Thromboembolism/Venous Thromboembolism: reducing the risk for patients in hospital CG 92

Sustaining Quality through Assessment & Review (STAR)

The STAR assessment is a trust wide uniform approach in monitoring quality standards of patient care, and offers managers and their staff a structure of expectations for their wards.

It provides assurance for staff, patients, relatives, visitors and the senior management team, that there is a practical robust system in place which monitors compliance against national standards.

Progress to date

The STAR performance assessment framework has continued to be undertaken on all the adult wards within the trust, and is now being rolled out to other clinical areas. Currently there are:

- Three wards including the paediatric ward have achieved 3 STARS
- Three clinical departments which are Main Outpatients, and Baschurch unit (admit day of surgery and day case unit), and the Pre-Operative assessment unit having achieved 3 STARS.
- Two wards achieved 4 STARS, and the Theatre, Anaesthetics and Recovery achieved a 4 STAR rating in March 2018 for the first time.

The high dependency unit is in the process of developing a bespoke version of the STAR assessment which should be ready to implement in July 2018, and the Midland Centre for Spinal Injuries is in the process of reviewing and developing a bespoke STAR which is multidisciplinary focussed, and will be in a position to implement in January 2019.

The roll out within other areas during 2018 is the Radiology department which is being worked on now which will link in with the national CQC Key Lines of enquiry, and triangulate to the ISAS standards (Imaging Services Accreditation Scheme)

5 STAR Success

During 2017-18 three wards have successfully achieved 5 STAR status which is a fantastic achievement. This compares to two wards in 2016-17.

The 5 STAR criteria and assessment process is for managers to showcase their ward or department through a formal presentation to the senior management team consisting of a panel of observers which includes the lead executive Director of Nursing, an non-Executive Director, a patient panel representative, and an external panellist from another care provider. It gives the ward/department area an opportunity to demonstrate what changes have been implemented to improve quality and safety within their area, and what innovation has been undertaken.

In addition to this, there is also a requirement for the Manager to formulate a portfolio to present to the panel.

Once the ward/department area has been successful in 5 STAR status the area will be required to sustain this, and develop specific objectives for the next 12 months involving the wider team, and members of the multidisciplinary team working collectively together

5 STAR status also incorporates the ward team/department in the safety improvement collaborative relating to reducing specific patient harms. The first two collaborative which has been developed is the Medicine Management collaborative, and the Falls Collaborative. How the ward/department demonstrates the impact of this work is by evidencing this through the ward portfolio and their 5 STAR presentations.

Health and Safety

Health and Safety Incidents are monitored on an ongoing basis through the year and reported to the Health and Safety Committee. Those incidents reported that are of a more serious nature and/or result in more than seven days off work as a result of serious injury such as fractures or dislocations are also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

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

During 2017-18 the Health and Safety Committee oversaw the following

- Development of shared agreement document focusing on expectation of patients for use in MCSI (part of Prevention and Management of Violence and Aggression Policy)
- Luggage issues and the impact this has on the portering staff (increased injuries due to volume of luggage being brought in)
- Bereavement packs for staff and separating this out from Stress when reporting on EPR
- Trend Analysis for MSK across some of the directorates

Experience

Patient Experience Collaborative

On the 19th October 2016. the Trust launched the Patient Experience Collaborative to work in partnership with patients, staff and key partners to ensure that the RJAH is learning from incidents, complaints and patient and staff feedback to ensure a positive patient safety culture is supported across the organisation and embed the process for sharing learning across the Trust.

During 2017-18 the Patient experience strategy for the organisation was concluded. This was developed through a number of collaborative events with our patients, staff and stakeholders. We are now working through the implementation of this strategy, working in partnership with our patients. A key development in order to achieve this was appointing patients as co-chairs to our patient panel to move forward our work relating to co-production

with our patients. We are really trying to focus the delivery about how our patient 'Think' and 'Feel' about their experience with us.

In order to support the strategy implementation further the Trust has invested in electronic patient experience data collection in order for us to be more versatile in collecting this information.

Highlights of the Patient Experience Strategy

The main aims of the Strategy are to:

- Actively engage with patients and carers, encouraging all feedback and demonstrating genuine learning from listening
- Identifying our key ambitions to improve patient and carer experience throughout the Trust
- Providing the best possible experience means getting the basics right, making sure our patients feel safe and well-cared for, that they have trust and confidence in the staff caring for them and that they receive excellent quality care in a clean and pleasant environment.

The Trust, through its Patient Experience Strategy, has introduced 'Always Events'.

Always Event 1

Improving the patient Journey

We have been supported by the Clinical Audit team and patient panel to develop a twice yearly patient experience questionnaire. We have now undertaken 2 of these audits and they are discussed and reviewed by the Patient Experience Group to ensure that action and work plans are aligned to what patients are telling us. To date these have been overwhelmingly positive.

We have continued to work hard to improve our delayed discharge rates, and through the performance report we have seen fantastic improvements in this.

We have been working hard to ensure that our End of Life Care is good and accessible to all areas. We have some exemplary practices that require stream lining across all of our wards and departments and we are doing this with the support of the work being undertaken in the CQUIN delivery programme for End of Life.

Always Event 2

Improving Communication

The Library have supported the publication of many of our information leaflets onto the intranet so that access for patients about our services and procedures is far more accessible. We are also now on track with the implementation of the Accessible information Standard which will ensure we have the right information about our specific patients' needs as they start their care pathway with us.

A carers Café has been developed in collaboration with the carers centre and social care, we will be evaluation the effectiveness of this and holding more carer events during 2018.

The #hellomynameis campaign has been relaunched across the Trust through the Masterclass held in 2017. We now have #hellomynameis on all our name badges across the trust.

Always Event 3

Meeting the Care needs of our Patients

The STAR process has been fully reviewed. We now have three areas who have achieved the 5 STAR status.

We are continuing to collect our examples of providing person centred care and reasonable adjustments to our services for our patients.

One of the objectives for patient pane during 2018 is to support the development of self-management. We will be working in collaboration with Keele Universtiy to do this and drive this agenda forward.

Learning from Patient Feedback/Changes in Practice or Service Improvement

Where appropriate, action plans are produced from complaints and PALS concerns with learning outcomes shared to enable the Trust to learn from all feedback. Good practice examples are shared in the monthly Learning Triangles reports and at the Patient Experience and Communications group to promote shared learning across the Trust. During 2017-18. There have been 60 action plans developed in response to 78 complaints received. This compares to 40 actions plans developed in response to complaints in 2016-17.

Patient Stories

How we use Patient Stories?

The Trust regularly listens to patient stories and shares learning from these with the clinical teams. The monthly Trust Board meetings start with a patient or staff story. This can be told by the patient or carer or staff member attending the meeting in person or by sharing the story in writing or listening to a recording. The Board welcome hearing about both positive and negative experiences and the clinical teams share the learning from the experience and agree actions to be taken.

Patient Stories are also presented at the Senior Nurses and Allied Health Professionals (SNAHP) meeting. Department and Ward Managers are invited to bring their own patient stories to share at SNAHP meetings.

The Trust is also part of a NHS England Carers National Pilot Project in partnership other Shropshire Trusts and Staffordshire University to collect stories and narratives from Carers. Three work streams have been developed to support carers of; parent carers, young and adult carers, dementia carers, and forensic carers

Health watch Shropshire and Shropshire Council Carers support and attend the Trust once a month to collect Patient and Carers stories in the main entrance and to offer help and advice.

Patient stories have also been shared on the Trust's 'Leading with Potential' Course, locally at team meetings such as MCSI Governance meeting and Ward team meetings.

How are patient stories collected?

The Patient Experience Team contact patients following either a PALS contact, complaint or a referral from a department of a suitable patient story. We also ask for patients who have made a complaint if they want to do a patient story.

Patient consent is always obtained so that the patient is aware that their story is being shared across the Trust. They are asked if want a reply and whether to share their story anonymously or not.

Where have we collected and shared patient/staff stories from?

- Midlands Centre for Spinal Injuries Unit
- Research Team
- Hand and Upper limb x2
- Orlau
- Baschurch x2
- Powys ward
- Surgical Registrar
- Clinical Governance
- Volunteer from the League of Friends
- Oswestry Pain Management Programme

Actions from patient stories

All stories are generally complimentarily and where patients make a suggestion or improvement these are followed up. Please find some improvements from stories collected and shared at meetings.

- Following a patients suggestion on MCSI that more recreational activities would be welcome at weekends and evenings; the Ward Manager has arranged more social events such as monthly BBQ's, movie nights, fish and chip suppers, craft sessions, bingo evenings, music night and day trips.
- Following a patient attending the Trust Board, the patient joined the patient panel and met with the Outpatient Manager to give feedback on the waiting area.
- The Trust Secretary wrote to Warwickshire Council and the CCG to pick up on the issues a patient had experienced and shared with the Board on delays due to funding
- Improving signposting to reliable information sources on procedures. The Library Manager now has an input into information and references to support patient leaflets.
- Following the sharing of a patient story by the Theatre Matron, 3 consultants are trialling staggered admissions on Baschurch.
- On Baschurch, a number of improvements have been made by the Manger
  -the admission letter has been updated to advise of potential long waits
  -reception staff to ask every patients if they are ok every half hour or if patients need anything.

-Trying to be proactive, give patients slips on admission to advertise the pagers to patients and for them to inform staff if they have a problem with the wait

- Medicine Management Coordinator raised the wait for TTO's at the Medicine Management meeting following a patient raising this as an issue.

Sit and See Observations of care

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

Since April 2017-March 2018 there have been on average 8 observations per month across wards and departments of which 98% were positive.

There are 23 active Sit & See Observers, of which 7 are Patient volunteers or Trust Governors.

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

- Ensure privacy and dignity is maintained
- Communication to patients, i.e. being updated on waiting times or introduction or welcome to department.
- Facilities issues i.e. temperature of ward, cluttered environment or replenishing hand gels.

Some examples of Positive practice identified from 'Sit and See' during 2017-18:

Recovery: I am clean stickers on patient equipment.

Baschurch: Light, airy, clean and peaceful.

Sheldon: Soap and toiletries are available for patients to use who did not bring any.

Ludlow: It was clear that patients are empowered.

Examples of Passive and Poor themes across the wards:

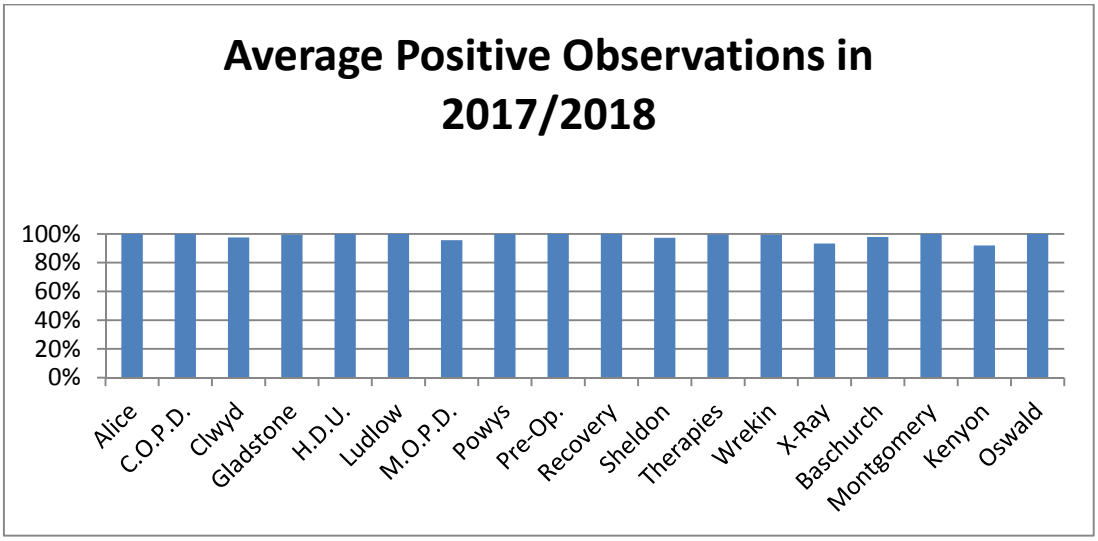
Observation: Baschurch: A patient said she felt alone and isolated as she was waiting for her operation and no one came to check on her.

Observation: Sheldon: Saw 1 doctor not practice good hygiene who wiped her hands to dry on her clothes. This was raised at time.

Observation: Clwyd: Discharge measurements taken in corridor but patient upset and wanted to get away.

Observation: X-Ray: No space for electric wheelchair in changing room even disabled one.

The graph below show the average number of positive observations of care by department



Duty of Candour

The Duty of Candour legislation was introduced by the Care Quality Commission in November 2014. This legislation states that any incident where the patient suffered moderate or severe harm, a process needs to be followed to ensure that there is full communication with the patient, including an apology for the harm suffered and an explanation of any investigations undertaken by the Trust into the incident. The legislation defines moderate harm as any harm that is significant but not permanent, and that leads to a moderate increase in treatment, and severe harm as any harm that is likely to affect the patient permanently.

During 2016-17 the Trust reviewed its existing Being Open policy and incorporated the requirements for Duty of Candour into this policy. In addition, the Datix system was updated

to allow staff to record that the process had been followed. The effectiveness of these measures has been reviewed and work has begun on revising the duty of candour processes to ensure robust and consistent evidence of compliance with the statutory duty. In March 2018 the Board received a report detailing the planned changes and these will be implemented during the course of 2018-19.

Patient Safety Walkabouts

During 2017-18 the Trust introduced Patient Safety Walkabouts. These consist of a member of the Executive Team, a Non Executive Director and a Governor attending a ward or department to observe the quality and safety of the service.

To date a total of18 walkabouts have been undertaken with positive feedback from both those attending and those working within the departments regarding the value of these visits. They provide a clear opportunity for staff to be able to raise any safety concerns they may have and enable senior management to witness first hand the services being provided across the organisation.

Given the value of these felt by all involved, it is planned that these walkabout will continue in 2018-19

Back to the Floor

During 2017-18 the Trust held two back to the floor events whereby senior managers went to work in departments for the day. This interaction, as with the patient safety walkabouts, provided opportunity for staff to provide feedback on their experiences of working in the department. Equally it enables senior managers to speak with patients being cared for in those areas to hear first-hand experiences.

Freedom to Speak Up Guardians

Engagement with staff has continued to be a priority for the organisation and the Trust has undertaken a number of initiatives to encourage staff to speak out about the issues they face within the organisation.

In August 2017 the Trust developed the FTSU App, which is available to download to you phone or selected device. This allows staff to raise concerns in a helpful and accessible way. Notifications can be sent anonymously or they can advise of their name and area of work.

The FTSU processes have been continually evaluated following publications form the National Guardians office to ensure we are up to date with what is required regarding implementation and review.

This has included reviewing the case study recommendations which have been published.

Data has been submitted for each quarter to date to the national guardian's office regarding the numbers of referrals received via this process. Overall we have had good engagement in the FTSU processes. However it must be remembered that this isn't the sole avenue for

raising concerns across the organisation. We continue to promote a number of avenues to enable staff to raise concerns if they need to.

National Quality Indictors

Staff Survey results

Overall the 2017 staff survey results are an improvement on the previous year. 93% of respondents would be happy with the standard of care provided if a friend or relative needed treatment and 75% of respondents would recommend the Trust as a place to work.

Our overall engagement score was comparable with other acute specialist trusts.

The response rate and top and bottom ranked key finding scores are detailed below.

Response Rate	2016		2017		Trust Change
	Trust	National Average	Trust	National Average	
	42%	44%	41.5%	45%	-0.5%

Top 5 ranked key finding scores				
Key Finding	2017	2016	Improvement / Deterioration	National Average
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months*	28%	29%	1%	35%
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month*	21%	22%	1%	27%
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	91%	86%	5%	88%
KF16. Percentage of staff working extra hours*	66%	67%	1%	75%
KF24. Percentage of staff / colleagues reporting most recent experience of violence	80%	82%	-2%	70%

* lower score is better

Bottom 5 ranked key finding scores				
Key Finding	2017	2016	Improvement / Deterioration	Average
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	86%	90%	-4%	92%
KF10. Support from immediate managers	3.73	3.65	.08	3.81
KF13. Quality of non-mandatory training, learning or development	4.00	3.89	.11	4.08
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	48%	52%	-4%	54%
KF5. Recognition and value of staff by managers and the organisation	3.44	3.40	.04	3.53

Our survey results have been shared with our divisional and corporate teams who will develop local initiatives to improve results. Progress will be monitored through divisional performance review meetings and Quality and Safety Committee. The survey is one element of our ongoing work to develop our leadership capacity and capability and support our cultural change programmes.

Single Oversight Framework

The following section outlines the Trust's performance against the relevant indicators and performance thresholds set out in the NHS Improvement Single Oversight Framework where this data does not appear elsewhere in the report.

Referral to Treatment Times (RTT)

Following the Trust being found in breach of its licence conditions in January 2016, the Trust implemented a RTT Recovery Plan and Integrated Governance Action Plan which concluded in March 2017. In June 2017 NHS Improvement confirmed that the Trust was no longer in breach of its licence.

	Info taken from the published annual accounts			
Indicator for Disclosure	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate	**90.89%**	**86.28% (based on Q4 only)**	**88.51%**	**89.49%**
All cancers: 62-day wait for first treatment from: • urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	**78.95%**	**93.75%**	**92.59%**	**75.76%**
C. difficile – meeting the C. difficile objective	**2**	**0**	**0**	**0**
Maximum 6 week wait for diagnostic procedures	**99.33%**	**99.8%**	**99.84%**	**99.57%**
Venous thromboembolism (VTE) risk assessment		**100%**	**100%**	**99.9%**

APPENDICES

Statement of Directors' responsibility in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to March 2018
    - Papers relating to quality reported to the board over the period April 2017 to March 2018
    - Feedback from Shropshire Clinical Commissioning Group dated 21 May 2018
    - Feedback from Telford and Wrekin Clinical Commissioning Group dated 22 May 2018
    - Feedback from the Trust's Lead Governor dated 21 May 2018
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018
    - The latest national patient survey 2016
    - The latest national staff survey 2017
    - the Head of Internal Audit's annual opinion of the trust's control environment dated May 2018
    - CQC inspection report dated March 2016
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

24 May 2018 Date Chairman

24 May 2018 Date Chief Executive

RJAH Quality Account Statement from Shropshire Clinical Commissioning Group 2017/18

NHS
Shropshire
Clinical Commissioning Group
Somerby Suite
Mytton Oak Road
Shrewsbury
SY3 8XL

Tel: 01743 277580

21 May 2018

Ms Bev Tabernacle
Director of Nursing
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust,
Oswestry
Shropshire
SY10 7AG

Dear Bev

Re: Quality Account 1 April 2017-31 March 2018

NHS Shropshire Clinical Commissioning Group (Shropshire CCG) is pleased to have had the opportunity to review the Quality Accounts 2017/18 for the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH).

In a joint vision to maintain and continually improve the quality of services RJAH has worked collaboratively with commissioners to sustain and progress a comprehensive quality framework that includes nationally mandated quality indicators alongside locally agreed quality improvement targets. There are robust arrangements in place with RJAH to agree, monitor and review the quality of services, covering the key domains of safety, effectiveness and experience of care.

In preparing this statement, key intelligence regarding quality, safety and patient experience has been reviewed to test the accuracy of the information reported in the account. It is the CCG's view that the account accurately reflects the achievements made by RJAH in 2017/2018.

RJAH has taken positive steps to ensure that patient safety and experience of care is maintained and the CCG acknowledges the important contribution of all Trust staff in achieving this. Key achievements include the establishment of robust systems to audit compliance with Venous Thromboembolism (VTE) assessments to ensure that deep vein thrombosis and pulmonary embolism are avoided where possible. Focus on preventing infections has been maintained and the trust has had no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) since 2006. It also has low rates of surgical site infections. It has prioritised use of the National Early Warning Score (NEWS) to quickly recognise and appropriately manage clinical deterioration in patients and will continue this work in 2018-2019.

The National NHS Contract and Commissioning for Quality and Innovation (CQUIN) Scheme provides us with additional processes and evidence that quality improvements are made. Of particular note is the progress made delivering the important national CQUIN on screening all patients at risk of severe sepsis and improving the delivery of antibiotics for people with sepsis. Good progress has also been made with improving the Care of Patients through the CQUIN for End of Life Care. We can also confirm that work has been undertaken within RJAH to improve the quality of investigation reports into serious incidents. The CCG continues to participate in the trusts ward based assessment process 'Sustaining quality through assessment and review (STAR) to provide assurances based on national recommendations and is aware of the Executive Team patient safety walkabouts that have been introduced. Each of these improvements will have an important and positive impact on patient care within Shropshire and beyond.

RJAH has shared with the CCG its proposed priorities for 2018/2019 which include further improvement in completion of the WHO Safety Checklist and implementation of the National Early Warning Score (NEWS) for deteriorating patients.
We recognise there are still improvements to be made and therefore support the priorities chosen.

In conclusion, the RJAH has made good progress over the last year with evidence of improvements in key quality and safety measures. The CCG recognises the trusts commitment to working closely with commissioners and the public to ensure the ongoing safe delivery of safe, high quality services and we look forward to continuing this positive collaborative relationship in the forthcoming year.

Yours sincerely

Ms Dawn Clarke
Director of Nursing, Quality and Patient Experience

RJAH Quality Account Statement from Telford and Wrekin Clinical Commissioning Group 2017/18

NHS
Telford and Wrekin
Clinical Commissioning Group
Halesfield 6
Telford
Shropshire
TF7 4BF

Tel: 01952 580300
Fax: 01952 582661

Mrs Bev Tabernacle
Director of Nursing/Deputy Chief Executive
Robert Jones Agnes Hunt (RJAH) Orthopaedic Hospital NHS Trust

(via email)

Date: 22nd May 2018

Dear Bev,

RE: RJAH Quality Account 2017/2018

Firstly, thank you for sharing the draft RJAH Quality Account for 2017/2018 and I would like to take this opportunity to congratulate you on the achievements made during this period.

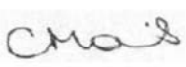
I have reviewed the Quality Account in line with contractual arrangements and minutes from the clinical quality review meetings held during 2017/2018. Overall the findings are positive and demonstrate achievements to deliver high quality patient care. There are two areas that RJAH reported partial delivery during 2017/2018:

- CQUIN Schemes 1c, 2a and 2b (partial delivery)
- Delayed Transfer of Care (DToC)

I appreciate that the CQUIN schemes are contracted to be delivered over a two-year period and this will be monitored formally through the contract. I recognise that the DToC has been challenging in part for RJAH this year and following the full achievement of the Supporting Proactive and Safe Discharge CQUIN I anticipate that much of this work will support DToC in the future.

Finally, we will continue to discuss and monitor the quality at the clinical quality review meeting and we will schedule annual themed reviews for RJAH to share the good practice. Once again, congratulations on the achievements made to deliver high quality patient care.

Yours sincerely



Christine Morris
Executive Nurse/Deputy Chief Officer

Lead Governor's Submission on the Quality Account Report for 2017-18 of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

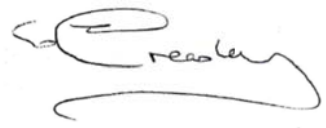
The Quality Account Report 2017-18 demonstrates the significant achievements the Trust has made over the last year with regard to its continued improvement in patient safety, patient experience and clinical effectiveness.

The Patient Safety Walkabouts have been well received and a positive experience for the staff involved. The Governors have particularly enjoyed the opportunity to see first-hand the significant work that goes into providing the highest level of care for the Trust's patients. This is further demonstrated in the excellent inpatient survey results which saw the Trust placed as top in the country. This provides significant assurance to the Council of Governors that the patient needs are consistently being met.

There were pleasing results in the staff survey for 2017 which saw improvements across a number of areas and in particular in the areas of patient safety. It is reassuring that 93% of our staff would recommend the hospital as a place of treatment to friends and family.

Throughout 2017-18 the Council of Governors received regular updates on the progress against the Quality Priorities and in February 2018 considered and agreed the priorities for 2018-19.

On behalf of the Council of Governors, I would like to congratulate the Trust on its quality performance for 2017-18 and we are looking forward to supporting the Trust with its continued quality improvements.



Jan Greasley
Lead Governor

21 May 2018

Independent Auditors Report to the Council of Governors of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

We have been engaged by the council of governors of Robert Jones and Agnes Hunt NHS Foundation Trust to perform an independent assurance engagement in respect of Robert Jones and Agnes Hunt NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Robert Jones and Agnes Hunt NHS Foundation Trust as a body, to assist the council of governors in reporting Robert Jones and Agnes Hunt NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Robert Jones and Agnes Hunt NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Number of patients on incomplete pathways who have been waiting no more than 18 weeks, as a percentage of the total number of patients on incomplete pathways; and
- Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

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

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

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

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below:
    - Board Minutes for the period April 2017 to March 2018;
    - Papers relating to the quality report reported to the board over the period April 2017 to March 2018;
    - Feedback from Commissioners dated 21 May 2018 and 22 May 2018;
    - Feedback from Governors dated 21 May 2018;
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2018;
    - The latest patient survey results 2016;
    - The latest national staff survey 2017;
    - The head of internal audit's annual opinion over the trust's control environment issued May 2018; and
    - The latest Care Quality Commission Inspection Report dated March 2016.

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the 'documents').

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

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

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance to the categories reported in the quality report; and
- Reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially

different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the 'NHS Improvement Detailed requirements for external assurance for quality reports 2017/18' for foundation trusts; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP
Birmingham
United Kingdom
24 May 2018

Glossary

ADOS	Admit on Day of Surgery
AED	Automated External Defibrillator
AKI	Acute Kidney Injury
ALS	Advanced Life Support
BLS	Basic Life Support
CAF	Common Assessment Framework
CARMS	Clinical Audit Registration and Management
CAS	Central Alerting System
CCG	Clinical Commissioning Group
CKD	Chronic Kidney Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CTPA	Computed Tomography Pulmonary Angiography
Datix	Incident reporting system used by the Trust
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguard
EPALS	European Paediatric Advanced Life Support
EPMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Records
FFT	Friends & Family Test
HCR	Healthcare Records
HSE	Health & Safety Executive
IARC	Incident Action Review Committee
IHCR	Integrated Health Care Record
ILS	Immediate Lift Support
INR	International Normalised Ration
IOSH	Institute of Occupational Safety and Health
KAFO	Knee Ankle Foot Orthoses
KIDS	Kids Intensive Care and Decision Support
KPI	Key Performance Indicator
LADO	Local Area Designated Office
MCQ	Multiple Choice Questions
MCSI	Midland Centre for Spinal Injury
MHRA	Medicines Health & Regulatory Agency
MOPD	Main Outpatient Department
MRSA	Methicillin Resistant Staphylococcus Aureus
MSL	Medical Services Limited
MSSA	Methicillin Sensitive Staphylococcus Aureus
MTC	Major Trauma Centre
NEBOSH	National Examination Board in Occupational Safety and Health
NICE	National Institute for Health & Clinical Excellence
NIHR	National Institute of Health Research
NJR	National Joint Registry
NPSA	National Patient Safety Agency

NRLS	National Reporting and Learning System
NSCISB	National Spinal Cord Injury Strategy Board
OSS	Oxford Shoulder Score
PALS	Patient Advice and Liaison Service
PDSA	Plan Do Study Act
PICU	Paediatric Intensive Care Unit
PILS	Paediatric Immediate Life Support
PLACE	Patient Led Assessment of the Care Environment
PONV	Post-Operative Nausea and Vomiting
PROM	Patient Reported Outcome Measures
RCA	Root Cause Analysis
RCN	Royal College of Nursing

INDEPENDENT AUDITOR'S REPORT TO THE 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 subsidiaries (the 'group'):

- **give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2018 and of the group's and foundation trust's income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the group and foundation trust statements of comprehensive income;
- the group and foundation trust statements of financial position;
- the group and foundation trust statements of cash flows;
- the group and foundation trust statements of changes in equity; and
- the related notes 1 to 36.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Summary of our audit approach

Key audit matter	The key audit matter that we identified in the current year was the recognition of NHS revenue. The capital programme and valuations has not been considered a key audit matter in 2017/18 as the Trust's capital programme significantly reduced during the year and there has not been a significant change around the valuation approach.
Materiality	The materiality that we used for the group financial statements was £2.2m which was determined on the basis of 2% of revenue.
Scoping	The focus of audit work was on the Trust, with work performed at the Trust's head offices in Oswestry directly by the group audit engagement team, led by the audit partner.
Significant changes in our approach	There has been no significant change in our approach other than the removal of the capital programme and valuations as a key audit matter for the current year, as explained above.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

NHS revenue and provisions	
Key audit matter description 	There are significant judgements in recognition of revenue from care of NHS service users and in provisioning for disputes with commissioners due to: • the complexity of the Payment by Results regime, in particular in determining the level of overperformance and revenue to recognise; • the judgemental nature of provisions for disputes, including in respect of outstanding overperformance income for quarters 3 and 4; and • the risk of revenue not being recognised at fair value due to adjustments agreed in settling current year disputes and agreement of future year contracts. Details of the Group's income, including £99.3m of Commissioner Requested Services, are shown in notes 3.2 to the financial statements. NHS debtors are shown in note 18 to the financial statements. The group earns revenue from a number of Commissioners, increasing the complexity of agreeing a final year-end position.
How the scope of our audit responded to the key audit matter 	We performed detailed substantive testing on a sample basis of the recoverability of overperformance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise. We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.

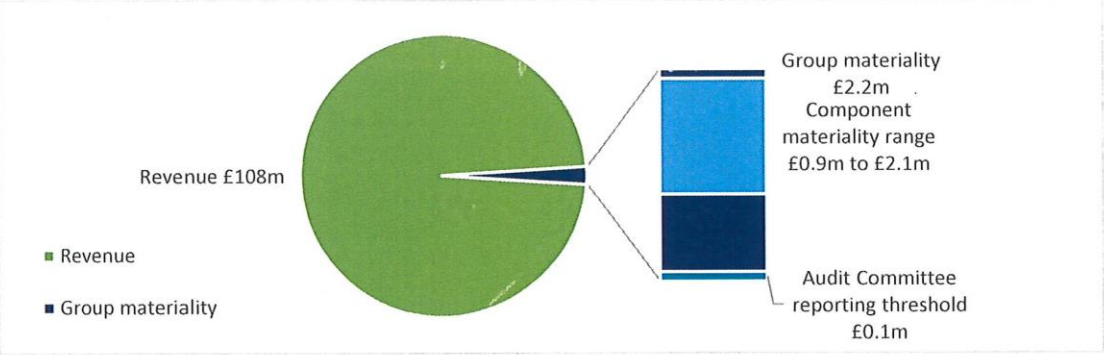
Key observations	Based on the audit evidence obtained, we concluded that NHS revenue is appropriately recognised. We consider management judgements to be within the reasonable range.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation Trust financial statements
Materiality	£2.2m (2016/17: £2.0m)	£2.1m (2016/17: £1.9m)
Basis for determining materiality	2% of revenue (2016/17: 2% of revenue)	2% of revenue (2016/17: 2% of revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £106,000 (2016/17: £101,000), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including group-wide controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed at the Trust's head offices in Oswestry directly by the audit engagement team, led by the audit partner.

Our audit covered all of the entities within the Group, including The Robert Jones and Agnes Hunt Orthopaedic Hospital Charitable Fund, which account for 100% (2016/17: 100%) of the Group's net assets, revenue and surplus.

Our audit work was executed at levels of materiality applicable to each individual entity which were lower than group materiality. The range of materiality used was £0.9m to £2.1m (2016/17: £1.0m to £1.9m).

At the Group level we also tested the consolidation process.

Other information

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

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

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

In our opinion:

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

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

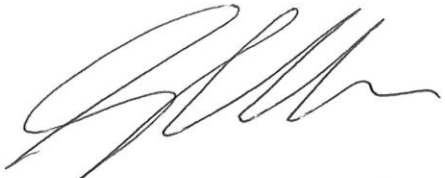
We have nothing to report in respect of these matters.

Certificate

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

Use of our report

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



Gus Miah (Senior statutory auditor)
for and on behalf of Deloitte LLP
Statutory Auditor
Birmingham, United Kingdom
24 May 2018

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Annual Accounts for the Financial Year 2017/18

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Foreword to the Accounts

These accounts, for the year ended 31 March 2018, have been prepared by the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust Group, comprising the Foundation Trust and the related hospital charity. They have been prepared in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Mark Brandreth**

Job title **Chief Executive and Accounting Officer**

Date **24 May 2018**

Consolidated Statement of Comprehensive Income

	Note	Group 2017/18 £000	Group 2016/17 £000	Foundation Trust 2017/18 £000	Foundation Trust 2016/17 £000
Operating income from patient care activities	3	99,324	94,392	99,324	94,392
Other operating income	4	8,424	6,982	8,187	7,564
Operating expenses	6	(104,186)	(97,741)	(103,967)	(97,552)
Operating surplus from continuing operations		**3,562**	**3,633**	**3,544**	**4,404**
Finance income	11	12	14	10	11
Finance expenses	12	(174)	(34)	(174)	(34)
PDC dividends payable		(1,563)	(1,373)	(1,563)	(1,373)
Net finance costs		**(1,725)**	**(1,393)**	**(1,727)**	**(1,396)**
Other net gains	13	4	-	4	-
Surplus for the year from continuing operations		**1,841**	**2,240**	**1,821**	**3,008**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	-	(269)	-	(269)
Revaluations	17	8,061	58	8,061	58
Total other comprehensive income / (expense) for the period		**8,061**	**(211)**	**8,061**	**(211)**
Total comprehensive income for the period		**9,902**	**2,029**	**9,882**	**2,797**

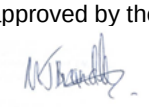
All income and expenditure is derived from continuing operations and there are no minority interests in the Group.

Statement of Financial Position

	Note	Group 31 March 2018 £000	Group 31 March 2017 £000	Foundation Trust 31 March 2018 £000	Foundation Trust 31 March 2017 £000
Non-current assets					
Intangible assets	14	2,298	2,194	2,298	2,194
Property, plant and equipment	15	72,344	64,860	72,344	64,860
Trade and other receivables	20	933	635	933	635
Total non-current assets		**75,575**	**67,689**	**75,575**	**67,689**
Current assets					
Inventories	19	1,003	1,066	1,003	1,066
Trade and other receivables	20	8,442	5,909	8,516	5,907
Cash and cash equivalents	22	5,083	5,384	4,249	4,623
Total current assets		**14,528**	**12,359**	**13,768**	**11,596**
Current liabilities					
Trade and other payables	23	(10,674)	(9,083)	(10,665)	(9,051)
Borrowings	25	(1,176)	(1,201)	(1,176)	(1,201)
Provisions	27	(91)	(67)	(91)	(67)
Other liabilities	24	(139)	(364)	(139)	(364)
Total current liabilities		**(12,080)**	**(10,715)**	**(12,071)**	**(10,683)**
Total assets less current liabilities		**78,023**	**69,333**	**77,272**	**68,602**
Non-current liabilities					
Borrowings	25	(7,060)	(8,236)	(7,060)	(8,236)
Provisions	27	(196)	(232)	(196)	(232)
Total non-current liabilities		**(7,256)**	**(8,468)**	**(7,256)**	**(8,468)**
Total assets employed		**70,767**	**60,865**	**70,016**	**60,134**
Financed by					
Public dividend capital		33,260	33,260	33,260	33,260
Revaluation reserve		24,909	16,848	24,909	16,848
Income and expenditure reserve		11,847	10,026	11,847	10,026
Charitable fund reserves	18	751	731	-	-
Total taxpayers' equity		**70,767**	**60,865**	**70,016**	**60,134**

The notes on pages 164 to 200 form part of these accounts.

The financial statements on pages 159 to 163 were approved by the Board and signed on its behalf by:

Signed: 

Name: Mark Brandreth

Position: Chief Executive and Accounting Officer

Date: **24 May 2018**

Statement of Changes in Equity - Group

For year ended 31 March 2018	Group				
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' & others' equity at 1 April 2017 - brought forward	**33,260**	**16,848**	**10,026**	**731**	**60,865**
Surplus for the year	-	-	1,762	79	**1,841**
Revaluations	-	8,061	-	-	**8,061**
Other reserve movements	-	-	59	(59)	**-**
Taxpayers' & others' equity at 31 March 2018	**33,260**	**24,909**	**11,847**	**751**	**70,767**

For year ended 31 March 2017	Group				
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' & others' equity at 1 April 2016 - brought forward	**33,260**	**17,312**	**6,765**	**1,499**	**58,836**
Surplus for the year	-	-	1,951	289	**2,240**
Other transfers between reserves	-	(253)	253	-	**-**
Impairments	-	(269)	-	-	**(269)**
Revaluations	-	58	-	-	**58**
Other reserve movements	-	-	1,057	(1,057)	**-**
Taxpayers' & others' equity at 31 March 2017	**33,260**	**16,848**	**10,026**	**731**	**60,865**

The charitable fund reserves consist of unrestricted funds which may be spent at the discretion of the trustees in line with the Charity's objectives.

Statement of Changes in Equity - Trust

For year ended 31 March 2018	Foundation Trust			
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' & others' equity at 1 April 2017 - brought forward	**33,260**	**16,848**	**10,026**	**60,134**
Surplus for the year	-	-	1,821	**1,821**
Other transfers between reserves	-	-	-	**-**
Impairments	-	-	-	**-**
Revaluations	-	8,061	-	**8,061**
Taxpayers' & others' equity at 31 March 2018	**33,260**	**24,909**	**11,847**	**70,016**

For year ended 31 March 2017	Foundation Trust			
	Public dividend capital	Revaluation reserve	Income & expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' & others' equity at 1 April 2016 - brought forward	**33,260**	**17,312**	**6,765**	**57,337**
Surplus for the year	-	-	3,008	**3,008**
Other transfers between reserves	-	(253)	253	**-**
Impairments	-	(269)	-	**(269)**
Revaluations	-	58	-	**58**
Taxpayers' & others' equity at 31 March 2017	**33,260**	**16,848**	**10,026**	**60,134**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as unrestricted; a breakdown is provided in Note 18.

Statement of Cash Flows

	Note	Group 2017/18 £000	Group 2016/17 £000	Foundation Trust 2017/18 £000	Foundation Trust 2016/17 £000
Cash flows from operating activities					
Operating surplus		3,562	3,633	3,544	4,404
Non-cash income and expense:					
Depreciation & amortisation	6	2,893	2,486	2,893	2,486
Net impairments	7	-	253	-	253
Income recognised in respect of capital donations	4	(15)	(221)	(22)	(1,225)
Increase in receivables & other assets		(2,831)	(1,778)	(2,907)	(1,209)
Decrease in inventories		63	81	63	81
Increase in payables and other liabilities		995	1,904	1,023	1,895
Decrease in provisions		(12)	(462)	(12)	(462)
Movements in charitable fund working capital		5	1	-	1
Net cash flows from operating activities		**4,660**	**5,897**	**4,582**	**6,224**
Cash flows from investing activities					
Interest received		10	11	10	11
Purchase of intangible assets		(5)	(356)	(5)	(356)
Purchase of PPE & investment property		(2,101)	(5,770)	(2,101)	(5,770)
Sales of PPE & investment property		5	-	5	-
Receipt of cash donations to purchase capital assets		15	221	22	1,225
Net cash flows from charitable fund investing activities		2	3	-	-
Net cash flows used in investing activities		**(2,074)**	**(5,891)**	**(2,069)**	**(4,890)**
Cash flows from financing activities					
Movement on loans from DHSC		(1,201)	(638)	(1,201)	(638)
Other interest paid		(177)	(194)	(177)	(194)
PDC dividend paid		(1,509)	(1,322)	(1,509)	(1,322)
Net cash flows used in financing activities		**(2,887)**	**(2,154)**	**(2,887)**	**(2,154)**
Decrease in cash & cash equivalents		**(301)**	**(2,148)**	**(374)**	**(820)**
Cash and cash equivalents at 1 April - b/f		**5,384**	**7,532**	**4,623**	**5,443**
Cash and cash equivalents at 31 March	22	**5,083**	**5,384**	**4,249**	**4,623**

Notes to the Accounts

Note 1 Accounting policies

1.0 Basis of Preparation

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 and Social Care Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected.

The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

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

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment.

1.3 Consolidation

Subsidiaries

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

Robert Jones and Agnes Hunt Orthopaedic Hospital Charity

The Trust is the corporate Trustee to the Robert Jones and Agnes Hunt Orthopaedic Hospital Charity. The Trust has assessed its relationship to the charity and determined it to be a subsidiary because the Trust is exposed to, or has the rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charity, and has the ability to affect those returns and other benefits through its power over the fund.

The charity's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Trust's accounting policies; and
- Eliminate intra-group transactions, balances, gains and losses.

Note 1 Accounting policies (continued)

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 currently accounts for no other subsidiaries or any associates, joint ventures or joint operations.

1.4 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 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 future periods.

Key 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 17, the Valuation Office Agency provided the Trust with a valuation as at 31 March 2018 of land and building assets (estimated fair value and remaining useful life), based on depreciated replacement value, using the modern equivalent asset alternative site 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 £8m. Future revaluations of the Trust's property may result in further material changes to the carrying values of non-current assets.
2. **Healthcare income** – discussions are held with all commissioners regularly regarding activity levels against their contracts, particularly around the year end. Over and under performance against contracts is calculated and the relevant income adjustments made. £2.2m of income from over-performance against contract activity was offset by £1.1m of under-performance against contracts with other commissioners. In addition, partially completed spells are calculated as at 31 March and the income accrued.

Note 1 Accounting policies (continued)

1.5 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. It is recorded based on the agreed tariff for the completed procedures, although this may be over-ridden by the prior agreement of year-end settlements based on forecast activity for March in order to facilitate a timely closedown of the accounts. At the year end the Trust accrues income relating to activity completed in that year, where a patient care spell is only partially complete.

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

The Trust receives income under the NHS Injury Cost Recovery Scheme (ICR), designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

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

Revenue grants and other contributions to expenditure

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

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.6 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

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

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

Note 1 Accounting policies (continued)

1.7 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.

1.8 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT. 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.

1.9 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.

1.10 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 similar 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, then these components are treated as separate assets and depreciated over their individual useful economic lives.

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 that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts 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, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations of specialised buildings based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust has elected to use an optimised approach for a modern equivalent asset valuation at its current site.

Properties in the course of construction 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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 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 that 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 that 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.

Internally generated intangible assets (development assets) are capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

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

Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same way as for property, plant and equipment.

1.12 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.

1.13 Impairments

At each financial year end, the Trust checks whether there is any indication that any of its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is an indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairments that arise from a clear consumption of economic benefits are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

- the impairment charged to operating expenses; and
- the balance in the revaluation reserve attributable to that asset before the impairment.

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

transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.14 Non-Current Assets Held for Sale

Non-current assets are classified as Held for Sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- The sale is highly probable i.e.
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as Held for Sale; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Assets Held for Sale are measured at the lower of their previous carrying amount and their "fair value less costs to sell". Fair value is open market value including alternative uses. Depreciation ceases to be charged.

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 economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.15 Donated & Government Grant Funded Assets

Donated and government granted non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Assets held under finance leases are initially recognised at the commencement of the lease. The asset is recorded as property, plant and equipment with a corresponding liability for the obligation to the lessor. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. Thereafter, the asset is accounted for as an item of property, plant and equipment.

Lease payments are split between a finance cost and the repayment of the liability, so as to achieve a constant rate of finance over the life of the lease.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the lease term. 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.

1.17 Inventories

Inventories are valued at the lower of cost and net realisable value using the First In First Out (FIFO) method. Valuation is 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 the total value is less than £10k; such transactions are accounted for in revenue.

1.18 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 value.

1.19 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

The Trust has not applied HM Treasury's discount rates because either settlement is expected within one year and/or the impact of discounting is not material.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Note 1 Accounting policies (continued)

1.20 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 27 but is not provided for in the Trust's accounts.

1.21 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 as and when they become due.

1.22 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.

1.23 Financial Assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset transferred.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Impairment

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Receivables are assessed and a provision for impairment made based on the following criteria:

- A provision for impairment for outstanding Injury Cost Recovery (ICR) notifications of 22.84% 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 if 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.

1.24 Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health & Social Care are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health & Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.25 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.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health &Social Care as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less all liabilities, except for:

- donated assets (including lottery funded assets);
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short-term working capital facility);
- any PDC dividend balance receivable or payable.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health & Social Care, the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.26 Foreign Currencies

The Trust's functional and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are 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.

1.27 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts.

1.28 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.29 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)

1.30 Accounting Standards that have been issued by the International Accounting Standards Board (IASB) but have not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 15 Revenue from Contracts with Customers – application required for accounting periods beginning on or after 1 April 2018, but not yet adopted by the FReM; early adoption is not therefore permitted.
- IFRS 16 Leases – application required for accounting periods beginning on or after 1 January 2019 but not yet adopted by the FReM; early adoption is not therefore permitted.
- IFRS 17 Insurance Contract – application required for accounting periods beginning on or after 1 January 2021 but not yet adopted by the FReM; early adoption is not therefore permitted.
- IFRS 22 Foreign Currency Transactions & Advance Consideration – application required for accounting periods beginning on or after 1 January 2018.
- IFRS 23 Uncertainty over Income Tax Treatments – application required for accounting periods beginning on or after 1 January 2019.

Of the above standards, only IFRS 16 is expected to have an effect on the financial statements, with increased leased items being brought onto the balance sheet. The full impact of this has not yet been quantified.

Note 2 : Operating Segments

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust Group consists of the Foundation Trust and the related NHS charity. The segmental analysis based on the Group entities is shown below.

	Group	
	2017/18	**2016/17**
	£000	**£000**
Foundation Trust income attributable to the Group	107,452	100,899
Charity income attributable to the Group	296	475
Total RJAH Group operating income	**107,748**	**101,374**
Foundation Trust surplus attributable to the Group	1,821	3,008
Charity surplus / (deficit) attributable to the Group	20	(768)
Total RJAH Group operating surplus	**1,841**	**2,240**
Foundation Trust net assets attributable to the Group	70,016	60,134
Charity net assets attributable to the Group	751	731
Total RJAH net assets	**70,767**	**60,865**

No material income attributable to the Group was received by the Charity from any single source during 2017/18 or 2016/17.

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

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	
	2017/18 £000	2016/17 £000
Acute services		
Elective income	55,481	52,400
Non elective income	4,367	4,363
First outpatient income	6,418	6,044
Follow up outpatient income	8,580	10,033
High cost drugs income from commissioners (excluding pass-through costs)	5,236	5,214
Other NHS clinical income	13,073	11,036
All services		
Private patient income	5,447	4,311
Other clinical income *(note 1)*	722	991
Total income from activities	**99,324**	**94,392**

Note 1 - other clinical income includes injury costs recovery scheme income.

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

	Group & Foundation Trust	
	2017/18 £000	2016/17 £000
Income from patient care activities received from:		
NHS England	15,639	12,449
Clinical commissioning groups	52,864	52,882
Other NHS providers	64	47
Non-NHS: private patients	5,447	4,311
NHS injury scheme *(note 1)*	655	933
Non-NHS: other *(note 2)*	24,655	23,770
Total income from activities	**99,324**	**94,392**

Note 1 - injury costs recovery scheme income is subject to a provision for impairment of receivables of 22.84% 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 (2017/18: £24,553k and 2016/17: £23,662k).

Note 3 - there was no income from oversea visitors in either 2017/18 or 2016/17.

Note 4 : Other Operating Income

	Group		Foundation Trust	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Research & development	814	816	814	816
Education & training	1,467	1,380	1,467	1,380
Receipt of capital grants & donations	15	220	22	1,224
Charitable & other contributions to expenditure	2	-	54	53
Non-patient care services to other bodies	21	-	21	-
Sustainability & transformation fund (STF) income *(note 1)*	1,807	1,048	1,807	1,048
Rental revenue from operating leases	666	331	666	331
Charitable fund incoming resources	296	475	-	-
Sale of goods & services	1,233	1,251	1,233	1,251
Catering	521	525	521	525
Car parking	361	336	361	336
Other income *(note 2)*	1,221	600	1,221	600
Total other operating income	**8,424**	**6,982**	**8,187**	**7,564**

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

Note 2 - other income includes contributions to services, backdated VAT refunds and sponsorship income.

Note 5 : Fees & Charges

There are no fees or charges where individually the full costs exceed £1m.

Note 6 : Operating Expenses

Note 6.1 : Analysis of operating expenses

	Group	
	2017/18 £000	2016/17 £000
Purchase of healthcare from non-NHS & non-DHSC bodies	36	1,470
Staff & executive directors costs *(note 1)*	59,494	52,536
Remuneration of non-executive directors	109	103
Supplies and services - clinical (excluding drugs costs)	20,411	21,178
Supplies and services - general	1,600	1,155
Drug costs (drugs inventory consumed & purchase of non-inventory drugs)	7,213	7,206
Inventories written down	162	18
Consultancy costs	313	352
Establishment *(note 2)*	922	801
Premises	4,321	3,760
Transport (including patient travel)	708	721
Depreciation on property, plant & equipment	2,816	2,430
Amortisation on intangible assets	77	56
Net impairments	-	253
Increase / (decrease) in provision for impairment of receivables	84	52
Audit fees payable to the external auditor		
audit services- statutory audit	52	56
other auditor remuneration (external auditor only)	22	26
Internal audit costs	121	98
Clinical negligence	2,446	2,224
Legal fees	42	42
Insurance	64	134
Research & development (including staff costs)	680	664
Education & training	392	345
Rentals under operating leases	879	1,293
Car parking & security	67	67
Losses, ex gratia & special payments	137	19
Other support services *(note 3)*	510	425
Other NHS charitable fund resources expended	214	184
Other expenses	294	73
Total	**104,186**	**97,741**

Note 1 - see accounts note 8.1 for breakdown of costs.

Note 2 - establishment costs include printing, stationery, telephones and postage.

Note 3 - other support services includes, payroll, procurement and occupational health.

Note 4 - operating expenses figures relating to the charity are the "Other NHS charitable fund resources expended" line above and £5k (2017/18 and 2016/17) of the "Audit services - statutory audit" line.

Note 6.2 : Other Auditor Remuneration

	Group	
	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	22	18
Other assurance services	-	8
Total	**22**	**26**

The limitation on auditor's liability for external audit work, in accordance with their engagement letter, is £1m (2016/17: £1m).

Note 7 : Impairment of Assets

	Group & Foundation Trust	
	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus resulting from:		
Loss or damage from normal operations *(note 1)*	-	253
Total net impairments charged to operating surplus	**-**	**253**
Impairments charged to the revaluation reserve *(note 2)*	-	269
Total net impairments	**-**	**522**

Note 1 - relates to the removal of Theatre 7 and HDU modules to clear space for the new theatre unit.

Note 2 - relates to revaluation of land & buildings following the theatre unit completion.

Note 8 : Employee Benefits

Note 8.1 : Staff costs

	Group & Foundation Trust	
	2017/18 £000	2016/17 £000
Salaries & wages	46,650	43,278
Social security costs	4,387	4,020
Apprenticeship levy	213	-
Employer's contributions to NHS pensions	5,474	5,180
Pension cost - other	3	-
Termination benefits	24	-
Temporary staff (agency/contract staff)	4,403	1,439
Total gross staff costs	**61,154**	**53,917**
Recoveries in respect of seconded staff	(941)	(701)
Total staff costs	**60,213**	**53,216**
Of which: costs capitalised as part of assets	112	112

Note 8.2 : Retirements due to ill-health

During 2017/18 there were 3 early retirements from the Trust agreed on the grounds of ill-health (1 in 2016/17). The estimated additional pension liabilities of these ill-health retirements is £32k (£33k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 : 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

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 10 : Operating Leases

Note 10.1 : Trust as a lessor

The Trust rents out a small proportion of the hospital buildings to partner organisations which complement the service it provides.

	Group & Foundation Trust	
	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	666	331
Total	**666**	**331**
Future minimum lease receipts due:		
- not later than one year;	580	220
- later than one year and not later than five years;	109	142
- later than five years.	-	-
Total	**689**	**362**

Note 10.2 : Trust as a lessee

The Trust has one significant operating lease for an operating theatre modular building (Menzies Day Case Unit) at a cost of £398k for 2017/18 (£586k in 2016/17). Other smaller leases relate to medical equipment, including an MRI scanner, and lease cars.

	Group & Foundation Trust	
	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	879	1,293
Total	**879**	**1,293**
Future minimum lease payments due:		
- not later than one year;	894	1,081
- later than one year and not later than five years;	2,156	2,875
- later than five years.	1,418	1,759
Total	**4,468**	**5,715**
Future minimum sublease payments to be received	-	-

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 11 : Finance Income

	Group	
	2017/18	2016/17
	£000	£000
Interest on bank accounts	10	11
NHS charitable fund investment income	2	3
Total	**12**	**14**

Note 12 : Finance Expenditure

	Group & Foundation Trust	
	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health & Social Care	173	34
Interest on late payment of commercial debt	1	-
Total finance costs	**174**	**34**
The Late Payment of Commercial Debts (Interest) Act 1998 / Public Contract Regulations 2015:		
Total liability accruing in year under this legislation as a result of late payments	1	-
Amounts included within interest payable from claims made under this legislation	1	-

Note 13 : Other Net Gains

	Group & Foundation Trust	
	2017/18	2016/17
	£000	£000
Gains on disposal of assets	5	-
Losses on disposal of assets	(1)	-
Net gains on disposal of assets	4	-

Note 14 : Intangible Assets

All intangible assets are held by the Foundation Trust.

Note 14.1 : Intangible assets - 2017/18

	Group & Foundation Trust		
	Software licences	Intangible assets under development	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**1,875**	**538**	**2,413**
Additions	93	88	**181**
Reclassifications	(1,112)	1,112	**-**
Disposals / derecognition	(61)	-	**(61)**
Valuation / gross cost at 31 March 2018	**795**	**1,738**	**2,533**
Amortisation at 1 April 2017 - brought forward	**219**	**-**	**219**
Provided during the year	77	-	**77**
Disposals / derecognition	(61)	-	**(61)**
Amortisation at 31 March 2018	**235**	**-**	**235**
Net book value at 31 March 2018	**560**	**1,738**	**2,298**
Net book value at 1 April 2017	**1,656**	**538**	**2,194**

The minimum and maximum useful economic lives of the software licences are 2 years and 7 years respectively. Useful economic lives reflect the total life of an asset, not the remaining life.

Note 14.2 : Intangible assets - 2016/17

	Group & Foundation Trust		
	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - brought forward	**1,596**	**461**	**2,057**
Additions	279	77	**356**
Valuation / gross cost at 31 March 2017	**1,875**	**538**	**2,413**
Amortisation at 1 April 2016 - brought forward	**163**	**-**	**163**
Provided during the year	56	-	**56**
Amortisation at 31 March 2017	**219**	**-**	**219**
Net book value at 31 March 2017	**1,656**	**538**	**2,194**
Net book value at 1 April 2016	**1,433**	**461**	**1,894**

Note 15 : Property, Plant & Equipment

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

Note 15.1 : Property, plant & equipment - 2017/18

	Group & Foundation Trust								
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**1,455**	**58,966**	**135**	**532**	**7,592**	**25**	**2,369**	**272**	**71,346**
Additions	-	862	-	191	1,099	-	38	50	**2,240**
Revaluations *(note 1)*	-	6,046	13	-	-	-	-	-	**6,059**
Reclassifications	-	399	-	(237)	-	-	(162)	-	**-**
Disposals / derecognition *(note 2)*	-	-	-	-	(200)	-	(591)	(3)	**(794)**
Valuation/gross cost at 31 March 2018	**1,455**	**66,273**	**148**	**486**	**8,491**	**25**	**1,654**	**319**	**78,851**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**-**	**-**	**-**	**4,805**	**25**	**1,477**	**179**	**6,486**
Provided during the year	-	2,011	5	-	540	-	230	30	**2,816**
Revaluations *(note 1)*	-	(1,997)	(5)	-	-	-	-	-	**(2,002)**
Disposals / derecognition *(note 2)*	-	-	-	-	(199)	-	(591)	(3)	**(793)**
Accumulated depreciation at 31 March 2018	**-**	**14**	**-**	**-**	**5,146**	**25**	**1,116**	**206**	**6,507**
Net book value at 31 March 2018	**1,455**	**66,259**	**148**	**486**	**3,345**	**-**	**538**	**113**	**72,344**
Net book value at 1 April 2017	**1,455**	**58,966**	**135**	**532**	**2,787**	**-**	**892**	**93**	**64,860**

Note 1 - the revaluation is as a result of the desk-top revaluation of land & buildings by the Valuation Office Agency.

Note 2 - the disposals relate to beds disposed of as part of the bed replacement scheme, and old I/T equipment.

Note 15.2 : Property, plant & equipment - 2016/17

	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 2016 - brought forward	**1,455**	**43,944**	**124**	**14,228**	**6,377**	**25**	**2,117**	**272**	**68,542**
Additions	-	3,068	-	399	1,215	-	252	-	**4,934**
Impairments *(note 1)*	-	(269)	-	-	-	-	-	-	**(269)**
Revaluations	-	(1,872)	11	-	-	-	-	-	**(1,861)**
Reclassifications *(note 2)*	-	14,095	-	(14,095)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**1,455**	**58,966**	**135**	**532**	**7,592**	**25**	**2,369**	**272**	**71,346**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**-**	**-**	**-**	**4,290**	**25**	**1,257**	**150**	**5,722**
Provided during the year	-	1,662	4	-	515	-	220	29	**2,430**
Impairments *(note 1)*	-	253	-	-	-	-	-	-	**253**
Revaluations	-	(1,915)	(4)	-	-	-	-	-	**(1,919)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**4,805**	**25**	**1,477**	**179**	**6,486**
Net book value at 31 March 2017	**1,455**	**58,966**	**135**	**532**	**2,787**	**-**	**892**	**93**	**64,860**
Net book value at 1 April 2016	**1,455**	**43,944**	**124**	**14,228**	**2,087**	**-**	**860**	**122**	**62,820**

Note 1 - the impairments relate to the removal of Theatre 7 and HDU modules to clear space for the new theatre unit, and the revaluation of land & buildings by the Valuation Office Agency following the theatre unit completion.

Note 2 - the reclassifications from assets under construction to buildings mainly relates to the theatre unit.

Note 15.3 : Property, plant & equipment financing - 2017/18

	Group & Foundation Trust								
	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	1,455	51,879	148	486	2,896	-	538	78	**57,480**
Owned - government granted	-	313	-	-	-	-	-	-	**313**
Owned - donated	-	14,067	-	-	449	-	-	35	**14,551**
Net book value total at 31 March 2018	**1,455**	**66,259**	**148**	**486**	**3,345**	**-**	**538**	**113**	**72,344**

Note 15.4 : Property, plant & equipment financing - 2016/17

	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 2017									
Owned - purchased	1,455	45,929	135	532	2,251	-	892	50	**51,244**
Owned - government granted	-	283	-	-	-	-	-	-	**283**
Owned - donated	-	12,754	-	-	536	-	-	43	**13,333**
Net book value total at 31 March 2017	**1,455**	**58,966**	**135**	**532**	**2,787**	**-**	**892**	**93**	**64,860**

Note 15.5 : Economic lives of property, plant & equipment

The minimum and maximum useful economic lives of each class of asset are given in the table below. Useful economic lives refect the total life of an asset, not the remaining life.

	Group & Foundation Trust	
	Min Life Years	Max Life Years
Land	N/A	N/A
Buildings excluding dwellings	18	51
Dwellings	5	46
Plant & machinery	5	20
Transport equipment	7	7
Information technology	3	8
Furniture & fittings	5	15

Note 16 : Donations of Property, Plant & Equipment

The Foundation Trust did not receive any physical donations of property, plant and equipment in 2017/18 (2016/17: nil).

Cash donations were received by the Foundation Trust to purchase property, plant and equipment. All cash received was utliised for this purpose. Donations were received from:

The League of Friends - £15k (2016/17: £220k)

The RJAH charity - £7k (2016/17: £1,004k)

Note 17 : Revaluations of Property, Plant & Equipment

The last full land and buildings revaluation was undertaken by the Valuation Office Agency (VOA) in December 2016, with an effective date of 31st March 2017. This was following the bringing into operational use of the theatres and tumour unit building.

For 2017/18, a desk-top revaluation was undertaken by the VOA with an effective date of 31st March 2018. This resulted in an increase in value of £8,061k.

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 the Modern Equivalent Asset (MEA) alternative site basis, using an optimised approach to land and building constitution.

Note 18 : Analysis of Charitable Fund Reserves

The Robert Jones & 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 only unrestricted income funds held by the charity. Balances are:

	Group	
	31 March 2018 £000	31 March 2017 £000
Unrestricted funds:		
Unrestricted income funds	751	731
	751	**731**

Note 19 : Inventories

All inventories are finished goods and are all held by the Foundation Trust.

	Group & Foundation Trust	
	31 March 2018 £000	31 March 2017 £000
Drugs	148	148
Consumables	855	918
Total inventories	**1,003**	**1,066**

Inventories recognised in expenses for the year were £11,794k (2016/17: £14,841k). Write-down of inventories recognised as expenses for the year were £162k (2016/17: £18k).

Note 20 : Trade & Other Receivables

Note 20.1 : Analysis of trade & other receivables

	Group		Foundation Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade receivables	1,440	357	1,440	357
Accrued income	4,590	2,819	4,590	2,819
Provision for impaired receivables	(425)	(420)	(425)	(420)
Prepayments	1,266	800	1,266	800
VAT receivable	170	456	170	456
Other receivables *(note 1)*	1,401	1,897	1,475	1,895
Total current trade & other receivables	**8,442**	**5,909**	**8,516**	**5,907**
Non-current				
Provision for impaired receivables	(265)	(189)	(265)	(189)
Prepayments	39	-	39	-
Other receivables *(note 1)*	1,159	824	1,159	824
Total non-current trade & other receivables	**933**	**635**	**933**	**635**
Of which receivables from NHS & DHSC group bodies:				
Current	5,004	2,549		
Non-current	-	-		

The majority of trade is with Clinical Commissioning Groups, NHS England and Non-English NHS bodies. As these are funded by central and devolved governments for the commissioning of NHS patient care services, no credit scoring of them is considered necessary.

Note 1 - the majority of other receivables relates to amounts due under the injury costs recovery scheme.

Note 20.2 : Provision for impairment of receivables

	Group & Foundation Trust	
	2017/18 £000	2016/17 £000
At 1 April	**609**	**648**
Increase in provision	88	222
Amounts utilised	(3)	(91)
Unused amounts reversed	(4)	(170)
At 31 March	**690**	**609**

Note 20.3 : Analysis of financial assets past due or impaired

Trade & other receivables	Group & Foundation Trust	
	31 March 2018 £000	31 March 2017 £000
Ageing of impaired financial assets		
0 - 30 days	2	2
30 - 60 Days	-	-
60 - 90 days	26	1
90 - 180 days	3	10
Over 180 days	85	59
Total	**116**	**72**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	793	267
30 - 60 Days	61	59
60 - 90 days	76	12
90 - 180 days	212	21
Over 180 days	60	13
Total	**1,202**	**372**

Note that these values include English NHS receivables for which a provision is not made.

Note 21 : Non-Current Assets Held for Sale

There were no non-current assets held for sale in either 2017/18 or 2016/17.

Note 22 : 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	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
At 1 April	**5,384**	**7,532**	**4,623**	**5,443**
Net change in year	(301)	(2,148)	(374)	(820)
At 31 March	**5,083**	**5,384**	**4,249**	**4,623**
Broken down into:				
Cash at commercial banks & in hand	514	505	10	2
Cash with the Government Banking Service	4,569	4,879	4,239	4,621
Total cash & cash equivalents	**5,083**	**5,384**	**4,249**	**4,623**

Note 23 : Trade & Other Payables

	Group		Foundation Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade payables	2,539	2,923	2,539	2,923
Capital payables	879	564	879	564
Accruals	4,314	4,334	4,314	4,334
Receipts in advance (including payments on account)	2	1	2	1
Social security costs	660	600	660	600
Other taxes payable	599	569	599	569
PDC dividend payable	61	7	61	7
Accrued interest on loans	17	20	17	20
Other payables *(note 1)*	1,593	60	1,594	33
NHS charitable funds: trade & other payables	10	5	-	-
Total current trade and other payables	**10,674**	**9,083**	**10,665**	**9,051**
Of which payables from NHS and DHSC group bodies:				
Current	1,316	1,569		

Note 1 - other payables mainly includes outstanding pension contributions and payments to staff. Both these had previously been included in trade payables and accruals.

Note 24 : Other Liabilities

	Group & Foundation Trust	
	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	128	331
Deferred grants	11	33
Total other current liabilities	**139**	**364**

Note 25 : Borrowings

	Group & Foundation Trust	
	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from DHSC	1,176	1,201
Total current borrowings	**1,176**	**1,201**
Non-current		
Loans from DHSC	7,060	8,236
Total non-current borrowings	**7,060**	**8,236**
Total borrowings	**8,236**	**9,437**

The outstanding loan is a £10m capital investment loan taken out in August 2015, repayable over 10 years at an interest rate of 1.92%. The principal is repaid at 6 monthly intervals until February 2025. The loan was used to finance the building of the Theatre and Tumour Unit.

Note 26 : Finance Leases

There were no finance leases held in either 2017/18 or 2016/17.

Note 27 : Provisions for Liabilities & Charges

2017/18	Group & Foundation Trust			
	Pensions (early departures)	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**152**	**27**	**120**	**299**
Arising during the year	1	14	40	**55**
Utilised during the year	(39)	(27)	-	**(66)**
Reversed unused	-	(1)	-	**(1)**
At 31 March 2018	**114**	**13**	**160**	**287**
Expected timing of cash flows:				
- not later than one year;	38	13	40	**91**
- later than one year and not later than five years;	74	-	-	**74**
- later than five years.	2	-	120	**122**
Total	**114**	**13**	**160**	**287**

2016/17	Group & Foundation Trust			
	Pensions (early departures)	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2016	**190**	**24**	**547**	**761**
Arising during the year	-	10	-	**10**
Utilised during the year	(29)	(7)	(427)	**(463)**
Reversed unused	(9)	-	-	**(9)**
At 31 March 2017	**152**	**27**	**120**	**299**
Expected timing of cash flows:				
- not later than one year;	40	27	-	**67**
- later than one year and not later than five years;	97	-	120	**217**
- later than five years.	15	-	-	**15**
Total	**152**	**27**	**120**	**299**

The pensions relate to NHS pensions payable to staff given early retirement prior to 1995. These are administered and invoiced for by the NHS Business Services Agency Pensions Division with total liability estimated based on life expectancy.

The legal claims relate to employers and public liability claims handled by NHS Resolution. Liability is limited to the scheme excess.

Other relates to the dismantling charges for the day case unit at the end of the lease and a claim from a supplier.

At 31 March 2018, £18,694k was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (31 March 2017: £15,084k).

Note 28 : Contingent Assets & Liabilities

There were no contingent assets in 2017/18 or 2016/17.

	Group & Foundation Trust	
	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(14)	-
Gross value of contingent liabilities	**(14)**	**-**

Note 29 : Contractual Capital Commitments

	Group & Foundation Trust	
	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	756	93
Total	**756**	**93**

Note 30 : 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 2018 £000	31 March 2017 £000
Not later than 1 year	776	579
After 1 year & not later than 5 years	607	772
Total	**1,383**	**1,351**

Note 31 : Financial Instruments

Note 31.1 : Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with commissioners and the way those commissioners are financed, the Group is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Foundation Trust's investment policy limits the investment of surplus funds to institutions with a low risk rating. The charity's investment policy is consistent with that of the Foundation Trust. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Group in undertaking its activities.

The Group's treasury management operations are carried out by the finance department. For the Foundation Trust, this is within parameters defined formally within its Standing Financial Instructions and policies agreed by the board of directors. For the charity, this is within parameters defined formally within the charity's governing document and the Charitable Funds Committee terms of reference. Treasury activity is subject to review by the Group's internal auditors.

Currency risk

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

Interest rate risk

The Foundation Trust holds a DHSC loan, with interest charged at the prevailing National Loans Fund rate when the loan was taken out. The Foundation Trust therefore has low exposure to interest rate fluctuations. The charity has no borrowings.

Credit risk

Because the majority of the Foundation Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other 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 Groups 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 31.2 : Financial assets - loans & receivables

	Group		Foundation Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Trade & other receivables excluding non-financial assets	6,065	5,019	6,065	5,019
Cash & cash equivalents	4,249	4,623	4,249	4,623
Consolidated NHS charitable fund financial assets	834	761	-	-
Total	**11,148**	**10,403**	**10,314**	**9,642**

Carrying value (book value) of these financial assets is assumed to be a reasonable approximation of fair value.

Note 31.3 : Financial liabilities - other financial liabilities

	Group		Foundation Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Borrowings excluding finance lease & PFI liabilities	8,236	9,437	8,236	9,437
Trade & other payables excluding non-financial liabilities	9,344	9,078	9,344	9,078
Consolidated NHS charitable fund financial liabilities	10	5	-	-
Total	**17,590**	**18,520**	**17,580**	**18,515**

Carrying value (book value) of these financial liabilities is assumed to be a reasonable approximation of fair value.

Note 31.4 : Maturity of financial liabilities

	Group		Foundation Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
In one year or less	10,530	10,259	10,520	10,254
In more than one year but not more than two years	1,176	1,176	1,176	1,176
In more than two years but not more than five years	3,528	3,528	3,528	3,528
In more than five years	2,356	3,557	2,356	3,557
Total	**17,590**	**18,520**	**17,580**	**18,515**

Note 32 : Losses & Special Payments

	Group & Foundation Trust			
	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	-	-	-
Bad debts & claims abandoned	70	3	114	9
Stores losses & damage to property	2	162	2	18
Total losses	**73**	**165**	**116**	**27**
Special payments				
Ex-gratia payments *(note 1)*	76	123	45	1
Total special payments	**76**	**123**	**45**	**1**
Total losses and special payments	**149**	**288**	**161**	**28**

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

Note 1 - the ex-gratia payments include an injury benefit for an employee from a past appointment.

Note 33 : Related Parties

During the year none of the Department of Health & Social Care Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Group.

The Department of Health is regarded as a related party. During the year the Group has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. The most significant are:

NHS England
Shropshire CCG
South Cheshire CCG
Telford & Wrekin CCG
West Cheshire CCG

In addition, the Group has had a number of material transactions with UK devolved governments. These transactions have been for the provision of healthcare, mainly with Welsh NHS bodies which are funded by the Welsh Assembly.

Betsi Cadwaladr University LHB
Powys LHB

In addition, the Trust has 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 34 : Third Party Assets Held by the Trust

There were no third party assets held in either 2017/18 or 2016/17.

Note 35 : Events After the Reporting Date

There were no events after the reporting date.

Note 36 : Control Total Reconciliation

The table below shows the Foundation Trust's performance against the control total set by NHS Improvement.

	Foundation Trust	
	2017/18 £000	**2016/17 £000**
Surplus for the year	**1,821**	**3,008**
Add back impairments charged to I&E	-	253
Remove capital donations/grants I&E impact	532	(674)
Adjusted financial performance	**2,353**	**2,587**
Less sustainability & transformation fund (STF)	(1,807)	(1,048)
Adjusted financial performance, excluding STF	**546**	**1,539**
Control total excluding STF	(513)	(1,487)
Performance against the control total, excluding STF	**33**	**52**