ROYAL NATIONAL ORTHOPAEDIC HOSPITAL

NHS TRUST

Annual Report 2017-18

About this document

The **Annual Report** is comprised of two parts, the **Performance Report** which is divided into an **Overview** which is a summary that provides the reader with information with which to understand the organisation, its purpose, the key risks to the achievements of its objectives and how it has performed in the year; and a **Performance Analysis** which reports on the Trust's most important performance measures and longer term trend analysis. The second part is the **Accountability Report** which is divided into the **Corporate Governance Report** which explains the composition and governance structures and how they support the Trust in achieving its objectives. It is made up of the **Directors' Report** containing the Director's details and disclosures for the financial year, the **Statement of Accountable Officer's responsibilities** which explains the Chief Executive Officer's responsibility for preparing the financial statements and the **Governance Statement** which describes and provides information relating to both corporate and quality governance and to risk management and control. The **Remuneration and Staff Report** is the second section of the Accountability Report and sets out the Trust's remuneration policy for Directors and Senior Managers. It reports on how the policy has been implemented and sets out the amounts awarded to Directors and Senior Managers.

Mandatory statements

The Performance Report: Overview forms only part of the RNOH Annual Report and accounts for the year ended March 31, 2018. A copy of the full Annual Report and accounts can be obtained from www.rnoh.nhs.uk or in print form by contacting the Communications Department at the Royal National Orthopaedic Hospital via communications.dept@rnoh.nhs.uk

The auditor's report on the full annual report and accounts was unqualified.

The auditor's report stated that the Performance Report: Overview and Directors' Report were consistent with the accounts and this statement was unqualified.

The Remuneration Report includes the single total figure table in respect of the Directors' remuneration on page 98 of this annual report.

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A. INTRODUCTION & WELCOME

Welcome from Professor Anthony Goldstone, CBE, Chairman and Rob Hurd, Chief Executive

Welcome, to our 2017-18 Royal National Orthopaedic Hospital Annual Report.

It has been another very successful year for the RNOH. We have reflected on our long term strategy this year and agreed that our purpose is best encapsulated by our new vision "**To become a world-leading orthopaedic hospital with the best patient care and staff experience in the NHS**". The goal is far reaching in its ambition and depends on us achieving five strategic aims over the next five years in order to be successful. These are expanded upon later in this Annual Report.

Some of the highlights achieved during the year by our wonderful staff, patients and partners included the following:

- Professor Briggs, Chairman of GIRFT, was made a Commander of the Most Excellent Order of the British Empire (CBE) for services to the surgical profession.
- Professor Flanagan, Professor of Musculoskeletal Pathology at UCL Cancer Institute and Consultant Histopathologist at the Royal National Orthopaedic Hospital, was awarded an Officer of the Most Excellent Order of the British Empire (OBE) for services to cancer research. Professor Flanagan's contribution to developing a better understanding of bone and soft tissue tumours as well as non-neoplastic musculoskeletal disorders is immense. The vital research work that she and her colleagues have undertaken is helping to improve the outcomes for patients every day; both in the UK and globally. Through her role as Cancer Lead for the 100,000 Genome Project, Professor Flanagan will help position the UK as the first country in the world to sequence 100,000 whole human genomes, revolutionising the treatment of inherited diseases and cancers. The RNOH is immensely proud of our association with Professor Flanagan and we are honoured to work with her.
- Andrew Crerar, Organisational Development Manager, won the Speak Up Guardian of the Year Award. Andrew was the driving force and a passionate advocate behind setting up the Speak Up Guardian role at the Trust, embedding it within the Trust's VAL-YOU campaign. The Guardian's role is to work with the Trust's leadership teams to create a culture where staff are able to speak up in order to protect patient safety and to empower workers. Andrew was presented with his award by Dr Henrietta Hughes, the National Guardian for the NHS, and Sir Robert Francis QC, author of the Freedom to Speak Up review, published in February 2015.
- In December 2016, we acknowledged the great work of our various teams at our annual Staff Achievement Awards.
- We are immensely grateful for the support of our associated charities. Their fundraising efforts during 2017/18 have added to the quality of services that we can deliver to our patients and staff. We extend our thanks to our charitable partners and volunteers: the RNOH Friends, Radio Brockley, the Barbara Bus, ASPIRE, SCAT Bone Cancer Trust, the Disability Foundation and, of course, the RNOH Charity for their tireless fundraising.
- The Board is very grateful to Isabel Dolan and to Dr Natalie-Jane Macdonald for their huge contributions and input during 2017/18. During the year, the term of service for Isabel Dolan, Non-Executive Director and Chair of the Audit Committee and of the Finance Committee expired. Isabel Dolan decided to pursue other interests and chose not to renew her term. Dr Natalie-Jane Macdonald, Associate Non-Executive Director also resigned during the year in order to focus on other interests. However, Dr Natalie-Jane Macdonald is still involved working with the Trust on developing its Private Patient services.
- We would also like to extend a warm welcome to Michael Rosehill and to Katherine Murphy who joined the Board during the year. Michael Rosehill was appointed to replace Isabel Dolan on the

Board and Katherine Murphy joined the Board as an Associate Non-Executive Director during the year to replace Dr Natalie-Jane Macdonald. Katherine Murphy's main focus is to promote care provision improvements and the enhancement of patient health outcomes. Robin Whitby who previously served as an Associate Non-Executive Director was appointed as a Non-Executive Director.

We would like to take this opportunity to thank each and every one of our staff for their magnificent contributions to the enduring success that is the Royal National Orthopaedic Hospital.

Professor Anthony Goldstone, CBE

Chairman

Rob Hurd

Chief Executive Officer

B. PERFORMANCE REPORT - OVERVIEW

I. Statement of purpose and activities of the RNOH

This Overview is a summary to provide the reader with information with which to understand the organisation, its purpose, the key risks to the achievements of its objectives and how it has performed in the year.

The Royal National Orthopaedic Hospital (RNOH) is the UK's leading specialist orthopaedic hospital. It is a national tertiary hospital that provides a comprehensive range of neuro-musculoskeletal health care, ranging from acute spinal injury and complex bone tumour to orthopaedic medicine and specialist rehabilitation for chronic back pain sufferers.

Our vision for the RNOH is of continuous improvement in our status as the UK's leading specialist orthopaedic hospital, enhancing our international profile for outstanding patient care, research and education.

To help achieve this vision, we have an established track record of achieving excellent quality of patient experience and outcomes with over 90% of our patients indicating that they would recommend the Trust to friends and family who need similar treatment or care.

During 2017-18 the RNOH provided specialist orthopaedic care to 17,299 in-patients at the Stanmore site. Altogether, there were 132,252 outpatient attendances: 99,432 out-patient attendances at the Stanmore site and 32,820 out-patients attendances at the Bolsover street site.

This has been achieved through the provision of high quality acute medical and surgical services for patients who attend our Trust from as far as Scotland, Northern Ireland and Wales.

Our specialist services are commissioned by NHS England and Commissioners from across London and the UK.

The Trust directly employs 1,491 people with hundreds more employed by partners supporting its work. It provides services on two sites; the Stanmore Hospital site which is set in 112 acres of land in the London Borough of Harrow and is a 220 bed hospital with capacity for 16 intensive care patients and the Bolsover Street site which attends to day case patients only and is located in Central London.

The 21 clinical services provided by the RNOH are:

- Anaesthesia
- Bone Infection
- Clinical Neurophysiology
- Foot and Ankle
- Functional Assessment and Restoration (FARs)
- Histopathology and Pathology
- Integrated Back Unit
- Joint Reconstruction
- London Sarcoma Unit
- London Spinal Cord Injury Centre
- Orthopaedic Medicine
- Orthotics and Prosthetics
- Paediatric and Adolescents
- Pain Management Services
- Peripheral Nerve Injury Unit
- Plastics
- Radiology
- Rehabilitation and Therapy

- Shoulder and Upper Limb
- Spinal Surgery
- Urology

II. Statement from the Chief Executive Officer

The RNOH aims to provide the **best patient care in the NHS**. It will do this by providing sustainable and outstanding patient care at a scale and range of MSK services befitting a world leading reference centre. Delivering the best quality of patient care for all the RNOH patients remains the key focus of the organisation. Whilst striving to become the best, we aim to maintain current levels of care whilst delivering targeted improvements in clinical excellence and high quality care standards. The Friends and Family Test (FFT) is a single question which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. At the RNOH, the FFT question is asked in all inpatient wards, outpatients, and in therapies. For inpatients, the FFT question is part of a longer real-time patient survey in which we ask patients to tell us about their experience of our care, services, and hospital environment. In addition to responding to patient feedback, we have set great a record on listening to staff. We have worked hard to improve the experience that our colleagues have of working at the Trust. These efforts have seen us enhance the way we listen to their feedback and take action to address their concerns and ideas.

Achieving the accolade of providing the **best patient care in the NHS** will require us to recruit, retain and to develop highly skilled and engaged staff who embrace and deliver the Trust's aims and values. This is why our second strategic aim will be to provide the **best staff experience in the NHS** to our employees and other workers. The dedication and professionalism of the staff at the RNOH is fundamental to this focus. We commend the determination and commitment of those staff who work tirelessly to ensure that we make continuous improvements to our services and demonstrate learning from situations when we recognise that things have gone wrong. We know that the highest quality of care is delivered by motivated and happy staff. We are committed to improving the experience of our staff at the RNOH to ensure that they can improve the safety and experience of our patients. In 2017/18 we have continued to make real progress in improving the experience for our staff at the RNOH; our positive staff survey results and resultant quality of care for patients are real evidence of this progress.

However potential risk to quality of service still exists from staff turnover and vacancies. These remain a major challenge for the NHS generally and the RNOH is no exception. On a daily basis, we are managing the quality and cost risks from using temporary staff, with some parts of the Trust experiencing very high vacancy rates. Our workforce action plans are effectively managing this risk, but the pressure this is putting on our workforce is considerable.

Our third strategic aim is to improve the RNOH's **infrastructure**. It is essential that we continue to redevelop our main Stanmore site in order to deliver patient care. This requires that we also have a highly developed supporting infrastructure such as the digital infrastructure, equipment renewal and new redevelopment projects whilst maintaining the current estate in a safe condition for patients and staff. We are thrilled to see the progress that continues to be made with the improvement in our infrastructure. The opening of the new inpatient building is on track for October 2018. This will help to ensure that we are able to deliver high quality care in a setting that our patients and staff deserve.

Research, innovation and education are profoundly important elements of what we do at RNOH. The academic foundation that supports and informs our clinical work is crucial to ensuring we stay at the forefront of musculoskeletal medicine. To that end, the research/education components of the RNOH and our academic-science partnerships are integral to maintaining our national and

international reputation. The RNOH continues to make great strides in patient participation in research, higher than ever before. Research and our partnership projects with our academic partners, particularly University College London, continues to generate innovation and knowledge that translates into both a learning culture and improvements in the quality of patient care. Our fourth strategic aim will be to become a **World leading Research, Education and Innovation** centre that increases the opportunity for RNOH patients to participate in clinical research.

The RNOH, like many other NHS Trusts, continues to face significant financial challenges. The Trust is currently in deficit but actions are in place to control levels of expenditure (for example this year the Trust halved its agency staff premium spend) and to make effective use of existing clinical capacity, and to increase private patient activity that provides a contribution to our NHS activities. Capital expenditure charged against the Capital Resource Limit (CRL) amounted to £31.4m in 2017/18. The Trust has achieved its duty to ensure that capital expenditure does not exceed the CRL.

We are very grateful to the RNOH Charity for its donations to the RNOH. In March 2017 it funded the SCIC expansion costing over £500,000. The table below indicates the charity's immense contribution this financial year:

Project	**Total amount approved**	**Impact / Notes**
New Inpatient Ward Block (including Private Patient Ward)	£1,310,211	This funding will enable the purchase of a range of enhancements for the New Inpatient Ward Block which are not affordable within the limits of NHS funding but which will significantly improve both the comfort of patients and the quality of their care. The creation of the Private Patient Ward will increase the hospital's private patient income by millions of pounds every year. At a time when the Royal National Orthopaedic Hospital is under serious financial pressure, this additional income will sustain the hospital and its services for patients long into the future.
Contributions to the RNOH	£628,789	Areas of funding included: Ward Equipment (£161,406) Volunteer Service (£162,367) Repairs and Maintenance (£106,132) RNOH LSCIC gardening project (39,450) Christmas staff donations (£19,000) Furniture and Fittings (£17,132) Art Curator/Manager (£13,750) Medical Equipment (£5,480) Occupational Therapy Patient Equipment (£5,000)

		Travel scholarship (£2,500) Staff Achievement Awards (£2,000) Baby hip equipment – SonoFix and SonoGuide (£1,074) Aspire membership (£1,000) Christmas fayres for wards (£1,000) Christmas carol service 2017 (£500) Radio Brockley (£300)
Research	£87,000	The RNOH Charity supports ground-breaking research projects at the RNOH including research into musculoskeletal as well as neuro-musculoskeletal conditions, rehabilitation, peripheral nerve injury repair, sarcoma detection and surgical treatments.

The RNOH recognises that although serious incidents are relatively uncommon, from time to time things can and do go wrong. When adverse incidents do occur, the Trust has a responsibility to ensure that there are systematic measures in place for safeguarding people, property, Trust resources and reputation. This includes responsibility to learn from these incidents in order to minimise the risk of these happening again. The combined Incident and Serious Incident policy aims to help the organisation to understand why things have gone wrong, how we can prevent or minimise similar incidents from reoccurring and how we can share any learning across the Trust as well as externally. The policy ensures that serious incidents are investigated by a nominated multidisciplinary team using the root cause analysis process and that action plans are monitored by the Serious Incident and Complaints Review Panel. Monthly reports are submitted to the Clinical Quality Governance Committee to ensure wider governance input.

III. Organisational Vision

The RNOH is a world renowned specialist hospital for the diagnosis and treatment of complex orthopaedic conditions.

Specialised orthopaedics services are those neuro-musculoskeletal services which due to rarity, complexity or the required expertise are focused in certain centres. These services are currently provided in 25-30 hospitals in England, of which 3 are specialist stand-alone hospitals. This includes those that provide the most specialised nationally commissioned services, those that provide a range of complex multidisciplinary team delivered services and those that deliver trauma services where they are designated major trauma centres within a recognised Trauma Network.

We are the largest of the Specialist Orthopaedic Hospitals in the UK providing specialised and complex orthopaedic and related care to patients regionally and nationally. Whilst some local services are also provided, 80% of our workload is defined as tertiary or equivalent.

Our vision is to become to become a world-leading orthopaedic hospital with the best patient care and staff experience in the NHS. The vision is supported by five strategic aims and will be delivered by our 2018-19 objectives which in turn tell us what our strategic risks are.

The Trust Board has agreed the following organisational objectives and strategic risks for 2018/19.

Organisational Objectives	Strategic Risks
a. **Deliver targeted improvements in clinical excellence and high quality care standards (Adults and Children)**	a. **Inability to deliver targeted improvements in clinical excellence and high quality care standards (Adults and Children)**
b. **Deliver prioritised improvement initiatives to increase capacity**	b. **Inability to deliver prioritised improvement initiatives to increase capacity**
c. **Deliver the Organisational Development Programme to improve staff experience**	c. **Inability to deliver the Organisational Development Programme to improve staff experience**
d. **Deliver the RNOH site redevelopment projects and maintain the safe availability of current buildings and equipment**	d. **Inability to deliver the RNOH site redevelopment projects and maintain the safe availability of current buildings and equipment**
e. **Refresh the RNOH digital strategy**	e. **Inability to refresh the RNOH Digital Strategy**
f. **Maintain financial stability**	f. **Inability to maintain financial stability**
g. **Develop relationships and partnerships with academic partners**	g. **Inability to develop relationships and partnerships with academic partners**

IV. Performance Summary

a. Patient safety and quality

The RNOH remains committed to delivering the best quality of care and patient experience. We continue to deliver low infection rates, reduce the number of pressure ulcers excluding those caused by medical devices, improve our medicines management and maintain and support the high standard of care that we deliver. Further information for patients and carers relating to how we deliver and evidence delivery of our commitment to continuous quality improvement is contained in our statutory Quality Account. To access the most recent quality account report please contact our Communications Department on enquiries@rnoh.nhs.uk or visit our website on www.rnoh.nhs.uk

The safety of patients and staff and the level of quality care provided is a central consideration for the Trust. The Infection Prevention and Control Policy Assurance Framework contribute to assurance that the Trust is compliant with the Health and Social Care Act and meets the essential standards for quality and safety outlined by the Care Quality Commission.

Infection Control

The Royal National Orthopaedic Hospital NHS Trust has so much to be proud of in relation to infection control as it continues to make considerable year on year progress with its infection prevention and control agenda, resulting in the following;

- For the 9th consecutive financial year running, there hasn't been MRSA bacteraemia attributed to the RNOH.

- Mandatory C. difficile infection target limits set by NHS England of 2 cases or less were met successively in the last 3 financial years. Whilst the Trust reported 5 cases of C. difficile infection in the last financial year, only 1 of these was deemed as a lapse in care following root cause analysis (RCA) conducted. The target limit is held against the number of incidents that are deemed as resulting due to lapses in care. C. difficile infections were promptly identified resulting to patients having appropriate treatment and recovered aptly. Good practices and areas of patient care needing improvement are generated from the RCAs, are communicated to the multi-disciplinary teams in order to enhance patient experience.

- Continuous regular assessment of clinical care via regular audits, feedback and training to ensure competence and to improve clinical practices gauged against guidelines and standards on areas such as Aseptic Non-Touch Technique, urinary catheter care and wound care among others.

- Robust surgical site infections surveillance to include the Total Shoulder Replacements and Amputations on top of the mandatory orthopaedic procedures: Spinal surgery, Hip and Knee Replacements.

- Steady surge in post discharge questionnaire follow-up as part of Surgical Site Infection Surveillance from 50% in 2015 to 86% in the current year against national target of 70%.

- Infection control mandatory annual update training compliant with 71.3% clinical staff and 89.5% non-clinical staff covered.

- Seasonal flu vaccination uptake amongst RNOH staff was at its highest from 32% (2015) to 74.46% (2017).

- Consistent engagement and teaching on surgical site infection prevention amongst patients scheduled for hip or knee replacements at the Joint Schools arranged by the Joint Reconstruction Unit.

- Successful running of Hand Hygiene and Infection Control weeks in the Trust held in May 2017 and October 2017 respectively, seeing an impact on improved hand hygiene and clinical care audit outcomes.

- Low rate of vascular line related infection with 1 case reported last year. Continual vascular line audits are carried out monthly with the aim of reducing risk of line associated infections.

- Conduct incessant inspections and assessment of environmental safety and cleanliness in collaboration with Estate Service Manager and ISS Domestic Manager to ensure environment conducive for healing and recuperation.

- Initiate through the Surgical Site Infection Prevention Group (SSIPG) means of monitoring and auditing surgical hand scrubbing technique among Theatre staff including medical and nursing staff particularly junior doctors on 6 monthly rotations.

- Working with the Redevelopment Team on making sure that the new ward block building is designed according to infection control and HBN 00 specifications and guidelines.

- Maintained corporate responsibilities for infection prevention and control within the infection control structure; with successful recruitment of the Lead Nurse and Infection Control Nurse into substantive post within the Infection Prevention and Control Department.

Complaints Handling Procedures and Principles of Remedy

During 2017/18, the Complaints and PALS team has worked collaboratively with the rest of the Trust and External Organisations to ensure we manage our patients' complaints effectively. We maintain good relations with our key stakeholders and communicate well with both patients and staff. We have recently updated our complaints policy and procedural flowchart which is advertised across the divisions. This has highlighted the profile of complaints and the importance to adhere to the guidelines to ensure that we meet the 25 working day deadline to respond to patients. Overall we meet this deadline, except in very complex cases which often then converts into an RCA or SI. We continue to work hard to maintain excellent communication and good levels of responsiveness for our patients to ensure we manage their expectations. We have developed a Complaints Starter pack for each division which gives them a guide on how to conduct an investigation, a complaint response template and what quality assurance measures we look for in our responses. This illustrates the care and attention we give every complaint response letter.

We recognise that although patients do value a timely response, they also deserve a high quality response. To help us maintain high quality, all complaint response letters go through an Executive signing procedure. This robust procedure has reduced the number of complaints that go onto the Parliamentary Health Service Ombudsman (PHSO).

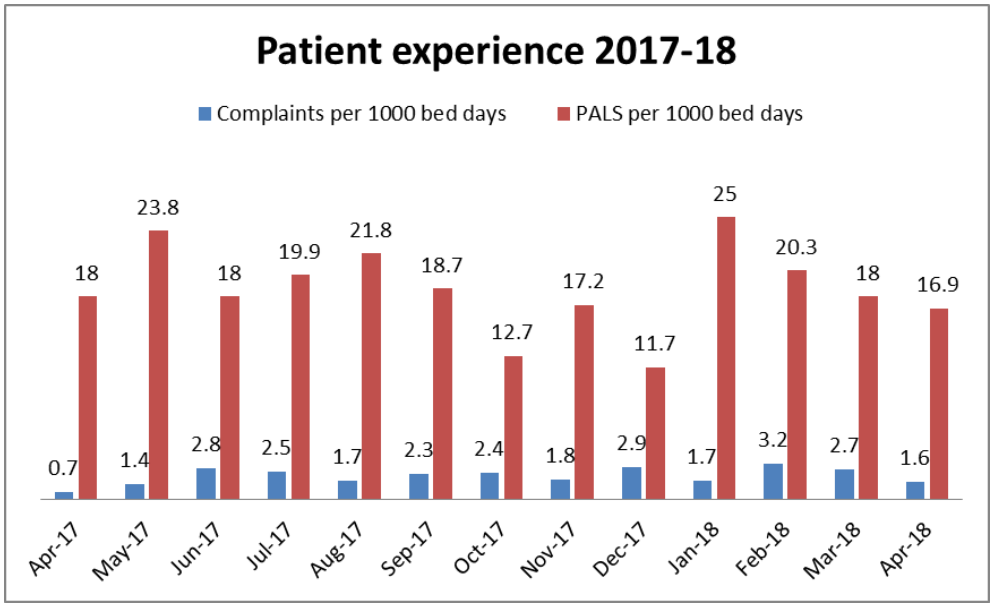
During 2017/18 the Trust received 129 formal complaints. This is a slight increase of 8 complaints compared to last year in which we received 121 formal complaints in 2016/17. High volumes of complaints were seen across the first half of 2017/18 but this has decreased over the latter half of the year.

The top three themes were related to clinical treatment which accounted for 30% and communications which accounted for 21% of the total number of complaints in the year. This was followed by appointments accounting for 13%. We noticed that complaints relating to clinical treatment were declining as the number of complaints relating to communication increased, especially over the previous 6 months. We are developing a customer service training programme for all staff members in an attempt to address this. We are also running Patient Experience workshops in May 2018 for all Trust staff.

To increase awareness of lessons learned from complaints, the Complaints team are capturing learning outcomes for the monthly Quality report and a Clinical Audit on Learning Outcomes, which includes a comprehensive overview of issues and themes arising from complaints and incidents in the Trust. We are currently at an all-time low on open complaints, which is due to having a substantive Complaints team in place, with updated policies and procedures, supporting documentation, triangulating learning outcomes to improve our services for our patients and supporting the divisions in managing complaints overall.

Year	2013/14	2014/15	2015/16	2016/17	2017/18
Total no. of PALS contacts	1,367	1,497	1,881	1,833	1,681

The graph below shows the number of complaints as a rate per 1,000 bed-days, to reflect the number of complaints given the numbers of patients being treated in the organisation. It also compares the formal complaints rate to the number of PALS contacts in the same period.



To increase awareness of lessons learned from complaints, the Trust now provides a Monthly Quality Report which includes a comprehensive overview of issues and themes arising from complaints and incidents in the Trust. Each month, we include the 'patient's voice'; using excerpts from complaints letters to provide feedback to staff. This includes positive and negative feedback.

The Quality report also includes a Trust-wide and divisional metrics which measure how we are performing with respect to delivering high quality care. The report is circulated widely in the hospital and is available on the internal Grapevine site.

Maintaining Patient Safety

A patient safety incident or adverse incident is defined as 'any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care'. This includes all terms such as adverse incidents, adverse events and near misses where an incident was recognised and averted.

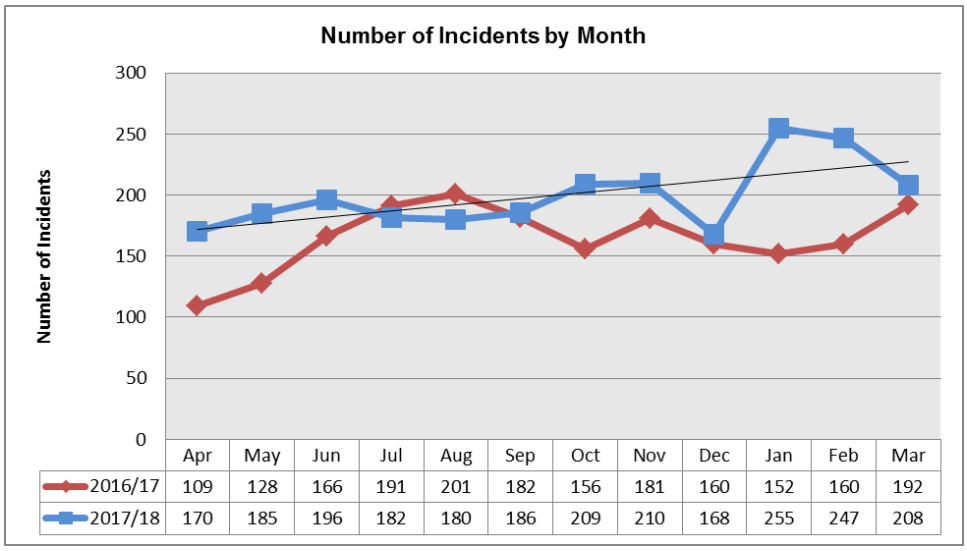
For 2017/18, the Trust reported a total of 2,396 adverse incidents. This was an increase in reporting compared to 1,978 that was reported in 2016/17. All these incidents are reported to the National Reporting and Learning System (NRLS) to enable learning and comparison with similar sized organisations to occur.

For the period 1 April 2017 to 30 September 2017, the Trust report 31.76 incidents per 1,000 bed days. This is based on data that was submitted to the National Reporting and Learning system, (NRLS) and published nationally.

The Trust recognises that its current reporting rate is low compared to its peers and has been working to improve upon this. The 2017 rate shows the Trust is on an upward trajectory of improvement compared to 16.3 per 1000 bed days reported for the same period in the 2016/17 year.

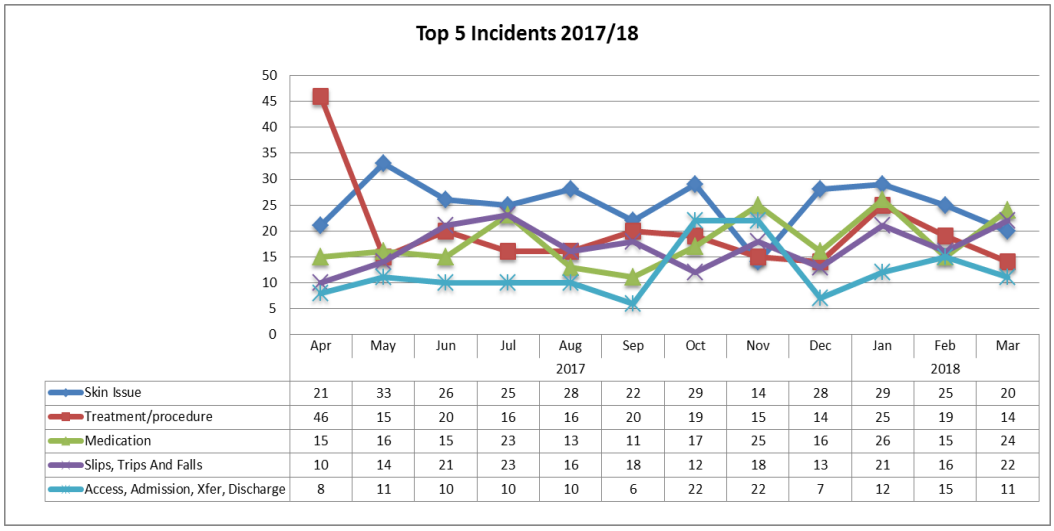
The graph below shows the number of incidents reported monthly for the year 2017/18 compared with 2016/17 data.

Number of incidents reported by month for in 2017/18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	109	128	166	191	201	182	156	181	160	152	160	192
2017/18	170	185	196	182	180	186	209	210	168	255	247	208

Top five themes from incident reporting in 2017/18



	Apr	May	Jun	Jul	Aug 2017	Sep	Oct	Nov	Dec	Jan	Feb 2018	Mar
Skin Issue	21	33	26	25	28	22	29	14	28	29	25	20
Treatment/procedure	46	15	20	16	16	20	19	15	14	25	19	14
Medication	15	16	15	23	13	11	17	25	16	26	15	24
Slips, Trips And Falls	10	14	21	23	16	18	12	18	13	21	16	22
Access, Admission, Xfer, Discharge	8	11	10	10	10	6	22	22	7	12	15	11

The Trust is committed to

- Promoting and supporting the reporting of all adverse incidents, investigations and sharing of lessons learnt.
- Skilling up of staff to conduct and support investigations.
- Supporting staff involved in incidents and
- Continually fostering an open, safe and just culture where the focus is on learning and improvement

Risk Management

Risk Management remains a priority within the organisation. The 2016/17 risk management review and the transfer of risk registers in the last year to an online system were to support the Trust's plan of improving oversight and management of its risks. The divisions are now going through a process of cleansing their registers with further work on risk management planned for 2017/18 year, including exploring the opportunity to work with NHS Improvement on bespoke pieces of work.

Information on environmental, social and community issues

The Trust makes every effort to manage complex cases for admission and safe discharge through assessing the patient's needs, the relationships with support networks and the patient's capacity for independence and emotional support.

Complex cases are referred to the weekly pre-admission complex case multi-disciplinary team meeting. We plan admission through to discharge involving RNOH professionals and external agencies where appropriate**.**

Homeless patients have equal access to the full range of health services available to the rest of the population. A patient who is identified as being homeless is referred to their Social Work Department and to the RNOH Social Work and discharge team. The Trust offers support and advocacy before, during and after their admission.

The Trust follows the best practice of assessing the scope and reliability of the patient's relationship with carers, whose needs must also be recognised and taken into consideration.

Where assistance is deemed necessary, referrals are made to services provided by statutory, voluntary and private agencies.

In carrying out its responsibilities the Trust makes every endeavour to ensure that government legislation is adhered to.

A special needs treatment plan has been adopted for the treatment of patients with learning needs, vulnerable adults and children. These plans are aligned to the job specifications of our Named Nurse for Safeguarding Children, Named Nurse for Safeguarding Adults and the Children's Safeguarding Advisor.

Emergency Planning Resilience and Response (EPRR)

The annual EPRR assurance process is used in order to be assured that NHS organisations in London are prepared to respond to an emergency, and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

The Trust continues to work hard to ensure that it identifies risks which threatens its business continuity and to institute measures to prevent and mitigate such issues as they arise. We also develop and monitor our plans and policies for responding to external major incidents, both for the safety of our patients and staff and for those in neighbouring Trusts.

In November 2017, we underwent an assessment with NHS England. The RNOH was rated fully compliant (green) in all 56 applicable EPRR & HAZMAT standards. The RNOH was commended by NHS England for the substantial progress across all areas.

NHS England recognised that a clear accountable structure exists with the Director of Nursing as the Accountable Emergency Officer (AEO) and the Quality Manager as the Emergency Planning Liaison

Officer. The Emergency Planning Steering Group meets regularly and provides oversight of the Trust's EPRR work, while the EPRR policy sets out the emergency planning framework. The Trust was found to have good "on call" arrangements in place, and performed well in national NHSE communication exercises. The Trust also performed well in cooperating with partners and local agencies, achieving a green compliant rating for all core standards relating to working with them.

b. Referral to Treatment (RTT)

The Trust's performance on elective patients as measured by the Referral to Treatment Target (RTT) NHS standards, improved substantially in 2017/18. We either achieved or exceeded the national standard of 92% treated within 18 weeks during several months of the year and consistently achieved over 90% every month. Our exceptional improvement between June 2016 (87.6%) and June 2017 (93.1%) earned us the accolade of the Trust with the most improved RTT performance in the country and personal congratulations from the Secretary of State for Health, who described this as 'a remarkable achievement…an example to others'.

Comparing specialty performance for Trauma & Orthopaedics nationally in December 2017, the RNOH at 90% outperformed England (85%) and London (83%). These comparisons do not include non–reporting Trusts, so our relative performance was even better than these comparisons inferred. RNOH's specialty performance for Trauma & Orthopaedics also compared well against the other standalone specialist orthopaedic Trusts namely Robert Jones and Agnes Hunt (84%) and Royal Orthopaedic Hospital, Birmingham (78%).

c. Never Events

Never Events are serious, largely preventable, safety incidents that ought not to occur. During the year there was one Never Event reported by the organisation and 24 Serious Incidents.

d. Going Concern

International Financial Reporting Standards (IFRS) require the Trust's Directors to assess and to satisfy themselves that it is appropriate to prepare financial statements on a going concern basis. No material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern have been identified by the Directors.

e. Risks and Uncertainties

The Trust's Board Assurance Framework monitors the primary risks to the Trust achieving its strategic aims.

During the year, the Trust has continued to implement an improved process and governance system for managing risk and patient safety through the development of an enhanced risk management structure. Further detail is available in the Governance Statement on page 62.

The following principal risks were identified and were monitored by the Board and plans were put in place to mitigate their consequences. More detail is provided in the section titled Significant Issues in the Governance Statement on page 62.

1. **Care Quality Commission (CQC) rating – the RNOH received a rating of "Requires Improvement" in 2014**

The CQC Chief Inspector of Hospitals' (CIH) visit of May 2014 and subsequent report of August 2014 indicated that the services at the Trust required improvement in the areas of safety, responsiveness and being well led. In July 2015 the NHS Trust Development Agency (TDA), Commissioners and the CQC agreed that the Quality Improvement Plan would be incorporated into "business as usual" risk

monitoring within the RNOH. Since this date, much progress has been made as a result of the redevelopment of our Stanmore site and the completion of the Organisational Development Strategy.

2. Failure of current estate or infrastructure.

The CQC and NHS Improvement (NHSI formerly NHS Trust Development Agency (TDA)) are aware of significant backlog of maintenance risks at the Trust. The CQC CIH visit of May 2014 and subsequent report of August 2014 stated that the Stanmore location was not fit for purpose. A new ward block is being constructed which will remove the CQC's concerns over the state of the hospital's estate.

3. Finance

The Trust's underlying financial position, before Sustainability & Transformation Funding (STF) and other non-recurrent gains, remained very similar to 2016/17. Increased Private Patient income, overachievement of CQUIN, and reduced premium working costs through tightened control of agency expenditure offset a shortfall against the Cost Improvement Plan (CIP).

The Trust has a strong and stable Executive Team with which to lead the Trust and to build further on its clinical engagement. Our unitary RNOH Trust Board, will continue to ensure that the RNOH is in an excellent position of strength to take on the challenges during 2018/19 and into the future.

C. PERFORMANCE REPORT – PERFORMANCE ANALYSIS

i. How Performance is measured

The Trust Balanced Scorecard encompasses key indicators used by the Trust Board and its Committees to monitor RNOH's performance. During 2017/18, 66 key indicators were monitored covering:

- Clinical Quality
- Access to Services
- Workforce
- Research and Innovation
- Information Management & Technology
- Estates
- Finance

The process of agreeing which key performance indicators and which targets to measure and their methods of measurement, is undertaken prior to the commencement of each new financial year by the Executive Team, and once agreed, they are approved by the Trust Board. Some indicators relate to measures which are national standards and have agreed targets set externally for the Trust to achieve; and in other instances, indicators and their targets are set internally based on historical performance and with some improvement factored in.

The Balanced Scorecard collates information which is used during the month from various reports into a more cohesive and informative format through a single report. It provides the Trust Board with enough information at the right level to ensure that the Trust is able to make informed decisions and to hold the Executive to account for the Trust's in-month performance.

Each month, the indicators are approved by the relevant Executive Director who has ownership of the particular indicator prior to its publication in the Balanced Scorecard. The Executive Directors who are in attendance at both the Trust Board and at various Committee meetings are held accountable for the results.

For 2017-18, the Trust reviewed the indicators and agreed those which measures the Trust's performance most effectively, and is aligned with the CQC Domains and against the Trust's Objectives. In addition all indicators have the following:

- Indicator owner who is responsible for assurance and sign-off
- Target
- Tolerance threshold (if applicable)
- Data Quality Status
- Forecast value or forecast RAG status
- Commentary which should be sufficient to provide the report viewer with all relevant information for the given indicator and highlighting good/improved performance or issues.

ii. Performance during 2017/18

	Target	2016-17	2017-18
Outpatient Attendances	-	134,542	132,252
Inpatient Admissions	-	18,400	17,269
Dementia Screening	>=90.0%	89.2%	81.8%
Mortality Numbers	-	6	6
Number of formal complaints received	-	121	151
Number of PALS Contacts	-	1,853	1,620
Friends and Family Inpatients % of patients responded	>=70%	55.1%	48.3%
Friends and Family Inpatients % unlikely/likely to Recommend Hospital	-	0.8%/96.3%	0.9%/95.1%
Staffing ratios - Number of patients per nurse	<=8	3.71	5.0
Mixed Sex Accommodation Breaches	-	22	49
Diagnostic Waits Compliance	>=99.0%	95.9 %	99.6 %
Referral to Treatment Open Pathways	>=92.0%	87.9%	91.7%
Cancer 2 Week Wait	>=93.0%	98%	95.5%
Cancer 31 day first treatment	>=96.0%	86.6%	97.2%
Cancer 31 day subsequent treat	>=94.0%	93.5%	96.9%
Cancer 62 day standard treatment	>=85.0%	71.8%	75.2%

Operations cancelled not operated within 28 days (Breaches of the standard)	-	10	12
Reportable DoH Last Minute Cancelled Operations	-	0.7%	0.8%
Trust Staff Turnover Rate (%)	<=13%	13.96%	12.82%
Trust Staff Sickness Absence (%)	<=3%	2.91%	2.84%
Staff Engagement (annual figure)	>=3.92	3.97	4.04
Friends & Family Staff would recommend Hospital as a place to receive care	-	88%	88%
Clinical System Availability	>= 99.00%	99.4%	99.5%
Paediatric Referral to Treatment Open Pathways	>= 92.00%	91.9%	94.8%
SUS Data Quality - Data Validity Summary	-	98.6%	97.9%

(The numbers in brackets are updated results reported in last year's Annual Report)

iii. Performance Analysis

PALS contacts

The total number of PALS contact over the year is recorded at 1,115. The top three themes were related to communications and accounts for 34.5% of the total number. This is followed by attitude of staff accounting for 7.5%. We are developing a customer service training programme for all staff members in an attempt to address this. 17.8% of concerns related to outpatient appointments, including delay at appointment, not seeing the consultant in clinic and rescheduled appointments.

Of note, 8.6% of contacts were patients requiring advice or querying their clinical treatment.

There has been a significant decrease in the number of PALS concerns raised in relation to transport, since last year, showing a reduction from 11.8% to 6%.

Of the 1115 PALS contacts recorded, 7% were compliments for the Trust and its staff.

Paediatric Referral to Treatment Open Pathways

The Referral to Treatment pathway in paediatrics was compliant with the national access target.

Adult Referral to Treatment and Cancer Performance

The Trust's performance on elective waiting times as measured by the Referral to Treatment Target (RTT) NHS standard improved substantially in 2017/18. We achieved or exceeded the national standard of 92% of patients treated within 18 weeks during several months of the year and consistently achieved over 90% every month. Our exceptional improvement between June 2016 (87.6%) and June 2017 (93.1%) earned us the accolade of the trust with the most improved RTT performance in the country and personal congratulations from the Secretary of State for Health, who described this as 'a remarkable achievement…an example to others'.

Comparing specialty performance for Trauma & Orthopaedics nationally in December 2017, the RNOH at 90% outperformed England (85%) and London (83%). These comparisons do not include non–reporting trusts, so our relative performance was even better than these comparisons infer. RNOH's specialty performance for Trauma & Orthopaedics at 90% also compared well against the other standalone specialist orthopaedic trusts: Robert Jones and Agnes Hunt (84%) and Royal Orthopaedic Hospital, Birmingham (78%).

The Trust's cancer waiting time performance continued to improve during 2017/18 despite continuing growth in demand. The Trust achieved the **two week wait** target for first consultation following urgent GP referral throughout the year, with the exception of one month. The Trust achieved compliance with the **31 day standard from diagnosis to first treatment** in nine of twelve months, a material improvement on the previous year. In a further improvement, the Trust also achieved the **31 day standard for subsequent treatment** throughout the year. The standard for a maximum **62 day wait** from referral to treatment was achieved with increasing frequency as the year progressed; performance was over 80% for more than half the year. The proportion of confirmed sarcomas remains static but the total referrals have been increasing by approximately 10% year on year. We analyse every waiting time breach to understand bottlenecks and review internal processes to improve patient care and access.

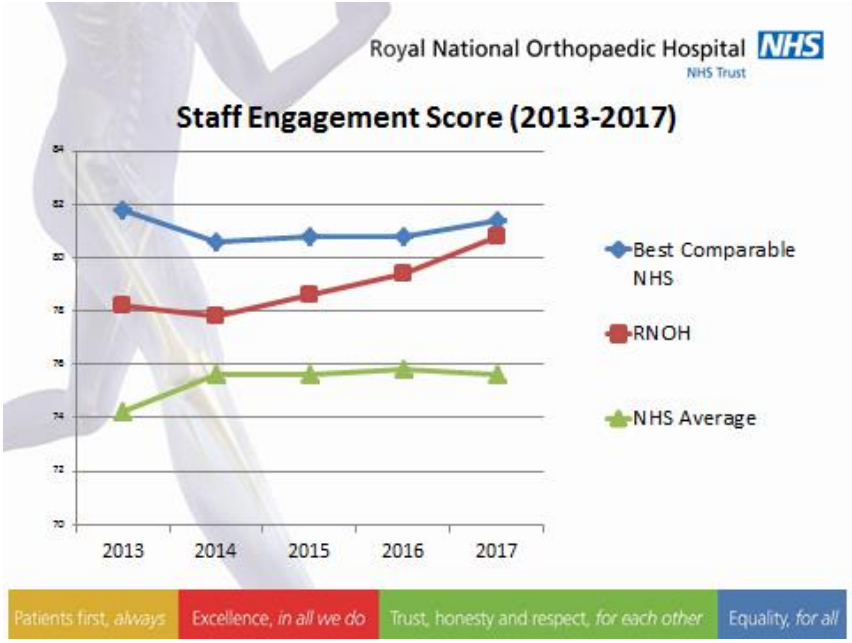
Staff Engagement

The Trust delivered the second phase of its Workforce & Organisational Development Strategy over the last 12 – 18 months. Amongst the highlights were; the introduction of a leadership development offering including bespoke RNOH leadership programmes; a refresh of the Trust appraisal process aligning it with the Trust's Values and Behaviours; the establishment of an Equality Achievement Network and Listening into Action Group, providing staff with opportunities to work collaboratively to improve staff and patient experience and; the development of an extensive range of tools and products to provide managers with 'just in time' support and to also help them to take a proactive role in setting an effective and compassionate workplace culture.

The Trust is particularly proud of the launch of the Freedom to Speak Up Guardians. We currently have three Guardians located in frontline services; their roles are to provide encouragement and support to staff wishing to speak up about concerns and to provide the organisation with feedback to help us improve our systems and processes and to identify development needs. We are already seeing an increase in staff utilising internal processes rather than them escalating them outside of the organisation and have made adjustments to our leadership offering to reflect the findings of the Guardians.

The evidence of the direct causal link between staff experience and patient experience and outcomes continues to grow as does evidence about the financial benefits of a highly motivated and engaged workforce. We have also seen internal evidence of the return of investment into our Organisational Development programme through significant gains in our Staff Survey findings for 2017/18. For the third year, we have improved our engagement score and have seen increases in 23 of 32 Key Findings (against an NHS backdrop of declining staff experience). We achieved a national best score in staff believing their role makes a difference and had a further 11 Key Findings in the top 10 scores nationally against comparable NHS Trusts.

The chart below shows the Trust's staff engagement score (measured through the annual Staff Survey) over the last four years, against the NHS average and best score year on year amongst NHS Trusts. The RNOH has seen a consistent improvement since 2014, and is close to achieving the best score in the NHS.



Our focus in 2017/18 will be on continuing to embed the Values Charter and the tools and products that have been developed and continue to develop the Trust culture through a well-supported and developed Leadership cohort. We will also focus on delivering an improved experience for staff from minority groups and/or who have a protected characteristic, as this is one area we did not see improvement in the staff survey scores. Some key activities to help us achieve this will be the strengthening of the Equality Achievement Network, the roll out of unconscious bias training across the Trust and the piloting of a reverse mentoring programme.

Our key objectives will be;

- **Do the right thing** – support our staff to live excellent, values based behaviour everyday
- **Develop inclusive, inspirational and effective leaders** – setting high standards while providing the support and development required to help leaders meet the needs of their teams
- **Share the important stuff** – share a clear vision and goals for the Trust and support staff to make this meaningful in their roles
- **Value our People** – listen to, communicate with and care about our people by giving them opportunities to make their experience, and that of their patients better

Sickness absence

The Trust sickness absence rate for 2017/2018 was 2.67 %, which remained below the Trust target of 3% for another year.

Proactive management of sickness absence is actively undertaken by the Trust and managers are supported by HR colleagues with the management of sickness absence. Sickness absence data is available on the Workforce Dashboard accessible to all line managers.

Turnover

The Trust staff voluntary turnover rate for 2017/2018 was 12.42 %, which was slightly above the Trust target of 12% and down from the previous year's voluntary turnover rate of 13.76%. This is a gradual but welcomed reduction in voluntary turnover. This rate excludes retirements; fixed term contracts that end and employee transfers i.e. TUPE.

A certain amount of staff turnover is normal and healthy, but the Trust believes it is important to practically look at the reasons why people leave, to ensure a sustainable workforce with the skills, motivation and values to deliver excellence in patient care.

Staff turnover figures are reported and monitored on a monthly basis as well as receiving greater scrutiny at Workforce and Organisational Development Committee, through specific papers reviewing turnover analysis and trends.

The staff group with the highest turnover in 2017/2018 was registered nursing. The biggest reason recorded by leavers is work-life balance relocation, which was 18.3 % of the overall number of leavers. However 18.9 % of all leavers have not specified their reason for leaving.

The exit interview and data collection process has been reviewed and refreshed to ensure that the process is less timely and user friendly in order to encourage and increase the extent and quality of the feedback provided by leavers to the Trust.

Reasons for leaving and exit data are monitored and analysed by senior managers, in conjunction with Trade Union colleagues to ensure the Organisational Development strategy is addressing feedback from staff.

iv. Financial Performance

Annual report Statement

The 2017/18 Annual Accounts have been provided in full as an annex to this Annual Report. The Trust's Annual Governance Statement explains the Trust's system of internal control and governance, has been signed by the Chief Executive and is included in the Annual Accounts.

2017/18 Financial Performance

This section looks at the Trust's financial performance indicators, capital investment and financial risks.

Overall financial performance

The Trust reported an adjusted deficit of £11.807m for the financial year ended 31st March 2018, after adjusting for donated asset transactions (comprising of £1.482m charitable donations less £232k depreciation on donated assets). Prior to these adjustments, a headline deficit of £10.557m was recorded for the financial year.

In summary, the Trust's financial position for the year is shown below:-

Financial Summary (£'000)	2017/18 Plan	2017/18 Actual	Actual Variance
Total Income	136,008	143,653	7,645
Total Expenditure	(144,358)	(147,284)	(2,926)
EBITDA	**(8,350)**	**(3,631)**	**4,719**
Retained Deficit	(21,653)	(10,557)	11,096
Adjusted Retained Deficit	**(16,207)**	**(11,807)**	**4,400**
Cash at end of period	3,479	8,732	5,253
Capital Expenditure	43,687	32,841	(10,846)
I&E Cost Improvement Plan (CIP)	4,828	3,367	(1,461)

£3.170m over-achievement against planned income, and over-spend against planned expenditure, is associated with increased income and expenditure for the Get It Right First Time (GIRFT) programme hosted by the Trust. It should be noted GIRFT expenditure is a pass-through cost for the Trust, and therefore does not impact upon the Trust's bottomline financial position. Without GIRFT expenditure was £244k below plan.

In addition, the Trust received £2.830m additional Sustainability and Transformation Funding (STF) as incentive and bonus STF for improving upon our Control Total for the year. Excluding GIRFT and STF income over-achieved by £1.305m against plan, primarily due to increased Insourcing income.

The planned retained deficit of £21.653m included £6.232m planned impairment, this did not materialise in 2017/18 due to slippage on the scheme to vacate the Western Development Zone (WDZ)

Capital expenditure amounted to £32.8m in 2017/18. Capital expenditure was mainly on estate infrastructure, with significant investment commencing on the New In Patient Ward Block. In addition a number of IT schemes were undertaken. The Trust's backlog maintenance programme continued, along with equipment replacement. Capital expenditure on each of these categories is shown in the 'Capital Investment' section below.

Achievement of cost improvement plans for the year was adverse to plan – with savings of £3.367m recorded against a plan of £4.828m. It should be noted delivery of cost improvement plans increased by £615k compared to 2016/17, an increase of 22.3%

Achievement of the Trust's External Financing Limit, which is the centrally set cash target for the organisation, and the Capital Resource Limit, which sets out the quantum of capital expenditure, is also noted.

Financial performance indicators

Risk ratings

Finance and Use of Resources ratings (as determined by NHS Improvement for assessing Trusts) are allocated using a scorecard which compares key financial information. A rating of 1 reflects the lowest level of financial risk and a rating of 4 the greatest. The Trust achieved an overall financial risk rating score of 3. The score was introduced in October 2016.

Metric Description	2017/18 Full Year Plan	2017/18 Full Year Actual
Liquidity Ratio	3	1
Capital Service Capacity	4	4
I&E Margin	4	4
Distance from Financial Plan *		1
Agency Spend - Distance from Cap	3	1
Finance and Use of Resources Rating		**3**

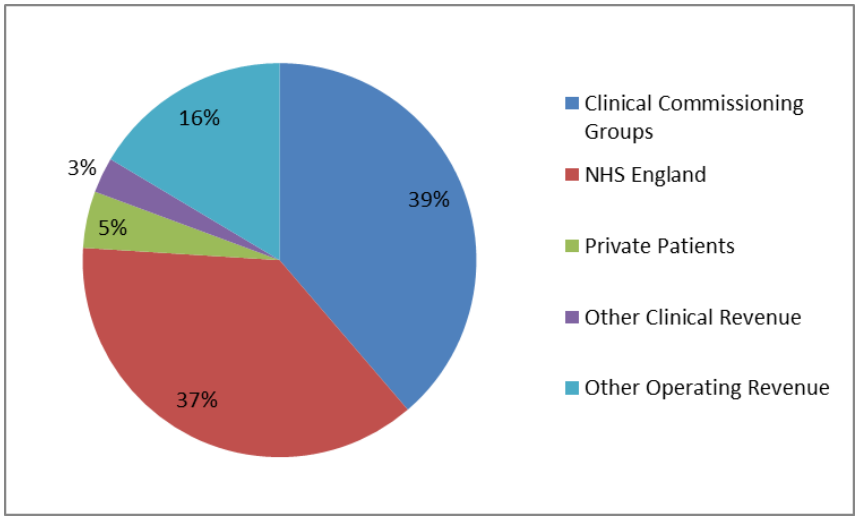
* A plan score was not issued in relation to 'Distance from Financial Plan'

Income and Expenditure analysis

1. **Income**

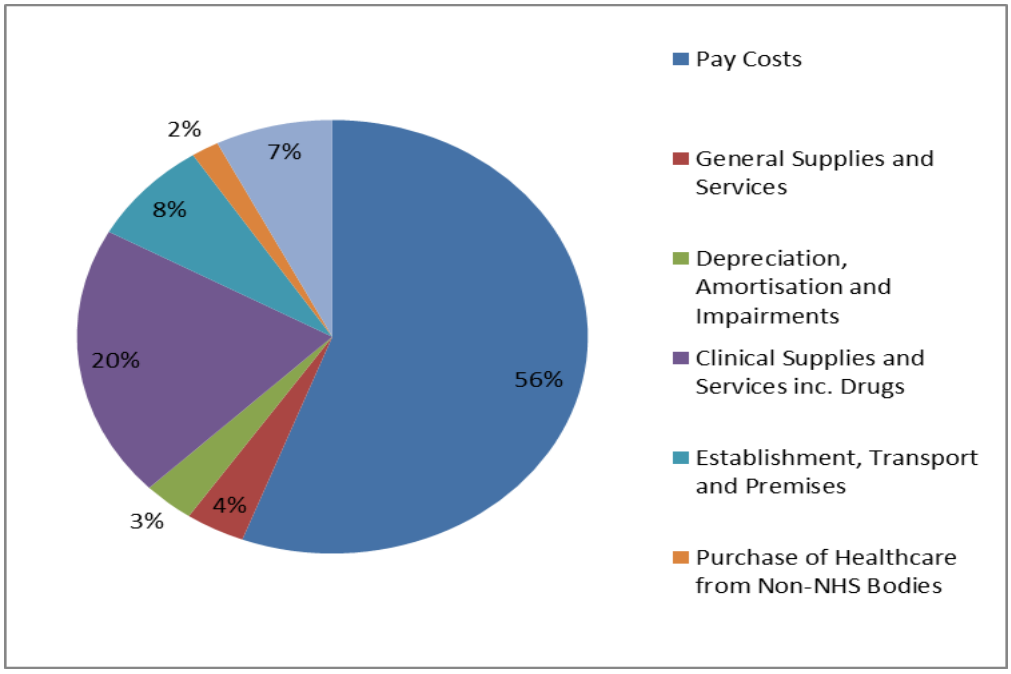
Income of £143.7 million was recorded by the Trust in 2017/18. Clinical income from Clinical Commissioning Groups was the highest proportion, accounting for £55.6 million or 38.7% of the total income of the Trust, with the purchase of specialist healthcare services by NHS England also being a highly significant item (£53.6 million or 37.3%). The remaining material items were comprised of Private Patient income (£6.7 million or 4.7% of income). Other operating revenue (£23.6m or 16.4% of income) includes patient transport services (£3.9m), education, training and research (£3.2m), sustainability and transformation funding (£3.9m), charitable and other contributions to expenditure (£1.5m) and host arrangements including Getting It Right First Time (£8.2m).

The major sources of income for the Trust are set out in the chart below.



2. Operating Expenses

Total operating expenses for 2017/18 were £152.2 million, and are set out in the chart below:



Expenditure on pay costs

The Trust spent £84.6 million on staff pay costs during 2017/18, and within this amount £8.7 million was spent on bank (£5.3m) and agency staff (£3.4m), 10.3% of the total pay cost. £4.9m of the £84.8m related to GIRFT and other external funded departments host by the Trust.

Expenditure on other costs

The Trust's non-pay operating expenses of £67.4 million were due to the costs of clinical supplies (£30.9 million – 45.9% of non-pay expenditure), utilisation of healthcare capacity outside of the Trust (£2.7 million – 4% of non-pay expenditure), and general supplies and services (£5.7 million – 8.5% of non-pay expenditure) required to maintain the operational services of the Trust. The residual costs were incurred on establishment, transport and premises costs (£11.8 million – 17.5% of non-pay expenditure), depreciation and amortisation (£4.9 million – 7.3% of non-pay expenditure), and other expenditure (£11.3 million – 16.8% of non-pay expenditure).

Capital Investment

Capital expenditure during 2017/18 was £32.8 million. An analysis by category is provided below.

	£'000
Major Developments	29,542
Estates Backlog and Business as Usual	1,223
Medical Equipment	900
Information Technology inc. Telephony Upgrade	1,176
	32,841

The Trust achieved its capital allocation or Capital Resource Limit by £1.6 million in 2017/18.

Estate valuation

During 2017/18, the Trust engaged Gerald Eve LLP, an independent firm of chartered surveyors, to undertake a desktop valuation of its land and buildings as at 31 March 2018. In accordance with International Accounting Standard 16, assets are required to be carried at Fair Value. Specialised buildings i.e. those used for the provision of services have been valued at depreciated replacement cost, and non-specialised buildings such as residential properties have been valued at market value. The valuation of hospital land assumes a continuation of existing use.

Future financial plans

NHS Improvement requires each Trust to develop an annual plan that identifies the Trust's objectives and financial plans for the coming year alongside the risks associated with delivering those plans.

The Trust's key strategic aims over 2018/19 centre on patient care, staff experience, infrastructure (buildings, equipment and digital systems), financial stability and research, innovation and education. Our long term goal is to be a world-leading orthopaedic hospital with the best patient care and staff experience in the NHS.

Future Financial Plan

The 2018/19 business plan aims to deliver the priorities set out above, and financial performance will be monitored through the Trust's performance management framework and overseen by the Finance Committee on behalf of the Trust Board.

The Trust's future financial plans can be summarised as follows:

Financial Summary (£'000)	**2018/19 Plan**
Total Income	154,800
Total Expenditure	(162,812)
EBITDA	**(8,012)**
Retained Deficit	(17,938)
Adjusted Retained Deficit *	**(7,012)**
Cash at end of period	8,732
Capital Expenditure	23,744
I&E Cost Improvement Plan (CIP)	4,880

* Adjustments relate to impairments and transactions associated with donated assets.

It should be noted £19.8m of income and expenditure have been included in the plan associated with GIRFT and other externally funded departments on a pass through cost basis.

The Trust has agreed a control total of (£7.012m) adjusted deficit with NHSI, including £1.232m Provider Sustainability Funding (PSF).

Risks Identified within the plan

- Due to delays relating to WDZ Land Sale Enabling during 2017/18, there is a risk the WDZ land sale, with associated planned profit (£9.8m), will not be completed during 2018/19 as assumed within the financial plan.
- Though the Trust delivered higher CIPs in 2017/18 than any previous financial year, and has development of schemes for 2018/19 to the value of £4.85m, there remains a risk of under-delivery against the £4,880k CIP target as £0.6m of schemes are classed as High Risk and £1.1m as Medium Risk.
- Insourcing Income is material for the Trust, but is variable and has greater risk than other clinical income streams.
- Contracts with all significant commissioners have been signed for 2018/19, income assumed within the plan is consistent with those agreements.
- Working capital – achievement of the financial plan assumes access to adequate Interim Revenue Support Loan funding.

Better payments practice code (BPPC)

The Department of Health requires Trusts to pay their non-NHS trade creditors and NHS creditors in accordance with the CBI prompt payment code and Government Accounting rules, which the Trust is signed up to. The target set for the Trust was to pay 95% of non-NHS trade and NHS creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

Details of compliance with the code are given in note 29 to the Accounts, with a summary provided below:

	2017/18 Number	**2017/18 £000**	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	25606	112961	29945	99387
Total non-NHS trade invoices paid within target	20669	94582	5063	48089
Percentage of non-NHS trade invoices paid within target	**80.72%**	**83.73%**	16.91%	48.39%
NHS Payables				
Total NHS trade invoices paid in the year	850	11123	860	10227
Total NHS trade invoices paid within target	578	8721	146	4675
Percentage of NHS trade invoices paid within target	**68.00%**	**78.41%**	16.98%	45.71%

Improved liquidity has led to a significant improvement in performance against BPPC

Treatment of pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. This is described in Note 7 in the Annual Accounts and further details on pension entitlements of Directors are given in the Remuneration Report.

In 2017/18 there were no retirements on ill health grounds (prior year, no retirements).

Policies on fraud and dishonesty

The Trust has an anti-fraud and anti-bribery policy which sets out how the Trust works to have an anti-fraud culture through pro-active work such as fraud awareness lectures and positive reinforcement through Trust communications structures, such as senior staff briefing meetings and articles in the Trust newsletter, Articulate.

The Trust has contracted an external firm, RSM Tenon, to provide its local counter fraud service and they also investigate any cases of alleged fraud brought to their attention. Through other policies, Standing Orders, Standing Financial Instructions and various operational procedures, the Trust endeavours to minimise the risk of fraud and, through its internal control mechanisms, ensures that these are implemented. The Audit Committee regularly reviews the work of the local counter fraud services and the Trust's response to any issues raised.

External Audit

The Trust's external auditor, Grant Thornton, is appointed by the Trust and is required to comply with the Commission's Code of Audit Practice and Standing Guidance for Auditors. Auditors are also required to comply with auditing standards and ethical standards issued by the Auditing Practices Board. The findings on all the work undertaken by the external auditor are reported to the Audit Committee.

The auditor is required to audit the Trust's financial statements and to give an opinion as to:

- whether they give a true and fair view of the financial position of the Trust and its income and expenditure for the year
- whether they have been prepared properly in accordance with relevant legislation, applicable accounting standards and other reporting requirements
- whether the Annual Governance Statement has been presented in accordance with relevant requirements and to report if it does not meet these requirements, or if the statement is misleading or inconsistent with their knowledge

The auditor is also required to issue a conclusion on whether the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the Value for Money (VfM) conclusion. The VfM conclusion is based on two reporting criteria specified by the Audit Commission:

- that the Trust has proper arrangements in place for securing financial resilience
- that the Trust has proper arrangements for challenging how it secures economy, efficiency and effectiveness

All providers of NHS healthcare services are required to produce a Quality Account, an annual report to the public about the quality of services delivered. The external auditor is mandated by the Audit Commission to carry out work on the Quality Account in accordance with published guidance and to report on the results of this work to the Trust.

Grant Thornton (UK) LLP was appointed by the Audit Commission on a five-year term, beginning in April 2007. The Commission extended Grant Thornton's appointment for a further five years from April 2012. The Trust re-appointed Grant Thornton for a 2 year term commencing April 2017.

The cost of the statutory audit services work performed by Grant Thornton in 2017/18 was £48,000 including VAT.

The Trust has an Audit Committee whose purpose is to conclude upon the adequacy and effective operation of the integrated governance, non-clinical risk management and internal control systems which support the achievement of the Trust's objectives. In order to ensure the Committee's independence and objectivity, its members are drawn exclusively from the Trust's Non-Executive Directors. Mr Michael Rosehill chairs this Committee. The other members who have served during the year are Councillor Joe Carlebach and Mr Bertie Leigh. The Committee meets a minimum of four times a year.

v. Information Management and Technology

The focus of the directorate for this year has been to continue the implementation of the IM&T Strategy covering the period 2014 to 2018. It continued to facilitate the delivery of excellent patient care by moving the Trust from being passive users of information and associated technology to being active users. A new strategy is being developed as a Digital Strategy to drive forward change that delivers efficiencies, excellent patient care and achieve our ambition to be paper-light by 2020.

The key achievements and areas of developments include:

- Maintained protection for the Trust against cyber attacks through further investment, excellent governance and running high quality IT Services demonstrated by ISO/IEC 20000-1 international IT service delivery accreditation. This is despite a background of an increasing level of cyber attacks.

- Maintaining a modern, robust and resilient IT Infrastructure and ICT network to deliver a high quality service with 99% availability of systems and networks.

- The IT infrastructure has been strengthened with a programme of replacement of older technology and upgrades to desktop software which provides incremental improvements for clinical users and increased security for the overall infrastructure.

- Implemented the National NHS mail service to maintain secure delivery of emails meeting the NHS requirements for the protection of confidentiality.

- A number of system upgrades providing bug fixes and enhancements have been performed during the year to maintain a high quality service for clinical users.

- The Coding department maintained high quality coded data standards to continue consistently achieving the highest possible Information Governance toolkit score. Continuation of the programme of coding validation to ensure that correct payment for specialist activity has been achieved.

- We have continued to deliver high quality information via our Business Intelligence portal for management decision making, planning and performance monitoring.

- Our telephony system with advanced digital telephony and unified communications system has been implemented across the Trust with further development of unified communications still being progressed.

vi. Sustainability Report

Our Estate

Stanmore redevelopment

The landscape of the RNOH has dramatically changed with the construction of the new inpatient ward block. The countdown has begun and we are on target to open the new Inpatient Ward Block in late October 2018. A regular schedule of visits are in place to the site meaning staff are already getting the opportunity to see the building develop and familiarise themselves with the new layout.

The Trust will take handover of the building at the end of August 2018, there will then be a two month commissioning period. A significant amount of work is underway to ensure a safe, smooth transfer of patients, services and staff. This includes a comprehensive training programme to ensure staff and volunteers are familiar with every element of working in the new building before it opens to patients. The service transition has been planned so that there is minimal disruption to the overall operational running of the hospital.

The New Inpatient Ward Block will accommodate NHS and Private inpatient beds across four floors, each of which will have space for therapy services delivered to patients within the ward environment in addition to recreation spaces. The Children and Young People's Unit will contain internal and external play areas and a school.

Sustainability

As a NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term, even in the context of the rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements are met. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint. The RNOH is committed to reducing the impact on the environment from its daily activities wherever possible whilst at the same time improving the quality of care to its patients and services. The environmental impact ranges from energy use on site and carbon emissions, to waste and transport issues.

Our Buildings

Our designs for new capital developments maximise opportunities to reduce our environmental impact, improve our natural environment and make ready for a change to our climate; helping us create environmentally sustainable care. We recognise the importance of delivering on this agenda through the design and build process with projects undergoing an environmental, risk and quality assessment.

Waste

The Trust has continued to engage with its waste contractors and facilities service providers to ensure that all wastes are stored safely, and collected frequently from the hospital site for final disposal. The Trust complies with waste regulations and obtains assurance to ensure segregating and consigning waste is undertaken with a full commitment to sustainability. Systems are in place to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

The hospital produces a wide range of waste materials such as clinical and offensive waste, sharps, medicines and domestic waste, as well as batteries, cardboard, dry mixed recycling and waste electrical and electronic equipment (WEEE). Each of these waste types are segregated before being sent to waste disposal or recycling facilities. The waste materials that are recycled are then able to be re-used to make other products. Auditing and monitoring of the different waste streams is carried out routinely, which helps to ensure that each waste type is properly packaged and labelled correctly. Waste training is provided to help staff understand what to do with their waste to ensure it goes to the correct type of disposal site.

With the opening of the new ward block at Stanmore later this year, plans to manage waste are already being developed and new ideas carefully considered. These are aimed at further improving the patient environment, reduce the environmental impact caused by waste and to save money where possible. A more sustainable, re-usable sharps container system is being trialled that avoids re-purchasing plastic containers which are incinerated and a bag to bed method of taking waste away from the patient bedside areas, which will reduce odours from waste and the number of bins needed, enhancing the environment and patient areas.

Transport

The Trust has in place a travel plan approved by the London Borough of Harrow Council which sets out our ambition to reduce single car journeys to the site and to encourage staff to consider healthy travel as part their commute to work. During last year the Trust has started a share ride arrangement where staff who are looking for a ride to work can contact a colleague living in the same area who is willing to car share. We hope this will help reduce the congestion in the hospital car parks and provide staff an opportunity to meet and socialise with their colleagues from across the Trust.

Sustainable Food procurement

The Trust's catering provider, ISS, continues to strive to move from existing working practices to more sustainable, streamlined and efficient ways of working

Biodiversity

The RNOH understands that sustainable health requires not only effective medical treatments but also healthy environments. The value of green space and nature is reflected in the Government's Biodiversity Strategy reflecting that people intuitively feel nature is good for them, and the RNOH believes good environments make us feel better. Therefore our capital projects are designed to provide, wherever possible, accessible green space to help maintain ecosystems and to provide areas for exercise, relaxation and to promote wellbeing. It is our strategy to provide sustainable development which maximises green space to give a feel good factor to as many people as possible.

We are committed to continually improve on minimising the impact of the Trust's activities on the environment. Our Director of Estates & Facilities is the Trust Board Lead for Environmental Sustainability.

Procurement

The Trust continues to work within current terms and conditions from the NHS and is still an active member of the NHS London Procurement Programme and the North Central London Sustainability

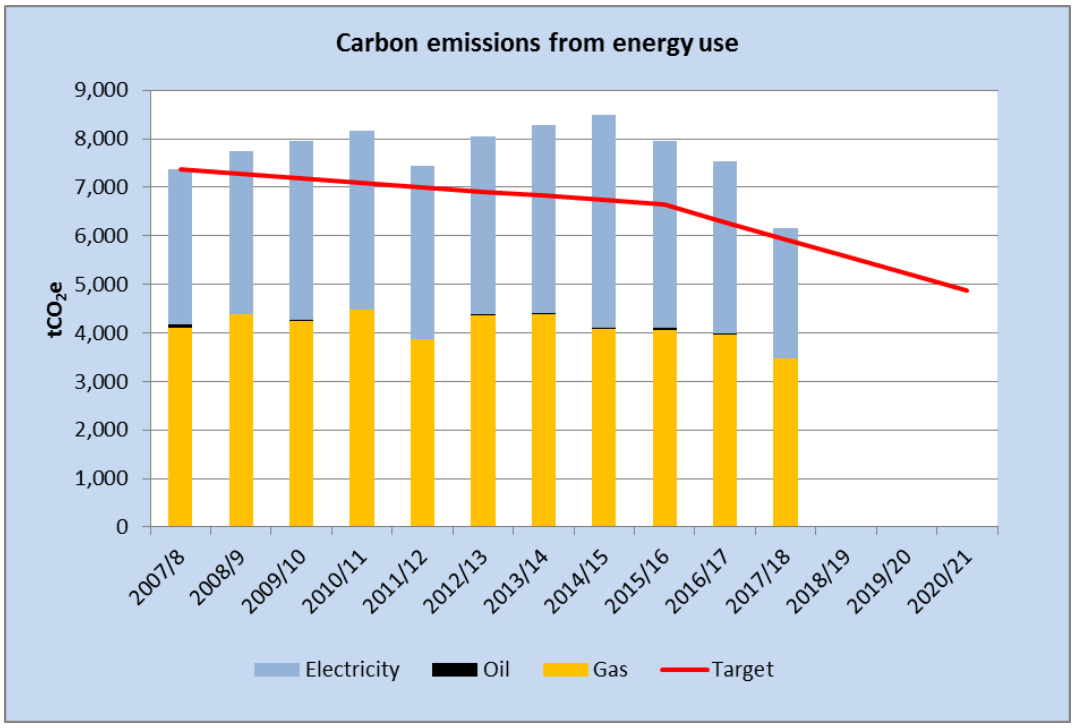
and Transformation Plan (NCL STP). The Procurement department arranges recycling ink cartridges and carbon boxes.

Carbon Emissions

The Trust has set new carbon dioxide equivalent emission targets to match those of the NHS i.e. a 34% reduction in carbon emissions by 2020 using 2007/8 as a baseline (on the basis that the 2007/8 baseline is similar to the 1990 baseline, the baseline chosen by NHS). The basis for these targets is an expected improvement in energy efficiency in the building and facilities currently being constructed and closure of energy inefficient older buildings. However, in the transition period there may be a slight increase in emissions due to consumption of energy by the building contractors.

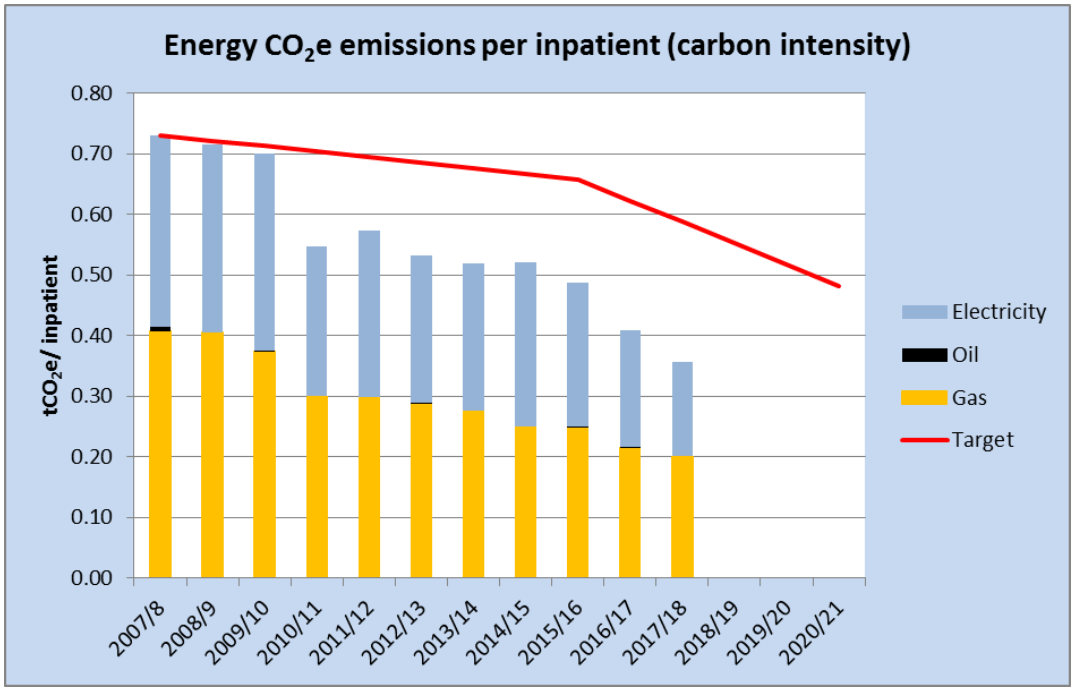
Energy

RNOH spent £1,283,923 on energy in 2017/18, an increase of 3.5% in energy spend compared with last year. Electricity consumption has increased by about 1% whilst gas consumption decreased by 0.6% compared with last year and hence the increased cost is likely to be due to increased energy costs. The Trust has set a new carbon reduction target of a 34% reduction in carbon emissions by 2020 compared with the 2007/8 baseline. This represents an ambitious target as the Trust is planning to move from an 8% increase in carbon emissions to a 34% reduction target in a period of 5 years (2015/16 to 2020/21). Energy is a significant contributor to the Trust's carbon footprint (carbon dioxide equivalent emissions – CO_2e) and the change in energy carbon emissions since 2007/8 is shown in the following chart against the 2015/16 (10% reduction) and 2020/21 (34% reduction) targets (note the carbon emissions include scope 3 emissions for energy transport and transmission).



In absolute terms, the Trust has not met its carbon emissions target but the trend over the last three years is downward, partly explained by the reduction in carbon emission factors for electricity, caused by the national decline in coal generation. The reduction in energy carbon emissions in 2017/18 is largely due to the reduction in carbon emission factor for electricity by 15% compared with 2016 as coal generation has decreased significantly and gas and renewables electricity generation increased. Furthermore, over this period the Trust has provided a service to a steadily increasing number of inpatients and out-patients which has resulted in an increase in both gas and electricity consumption, despite measures to improve energy efficiency.

The graph below compares the energy related carbon emissions for each inpatient (annual carbon intensity) against the target emissions per inpatient (target carbon intensity) for the period 2007/8 to 2017/18 and shows that annual carbon intensity is decreasing and well below the target. Inpatient numbers have been chosen, rather than out-patient or staff numbers, as they have the greatest impact on energy use through the consumption of electricity and heating for an overnight stay and for food preparation.

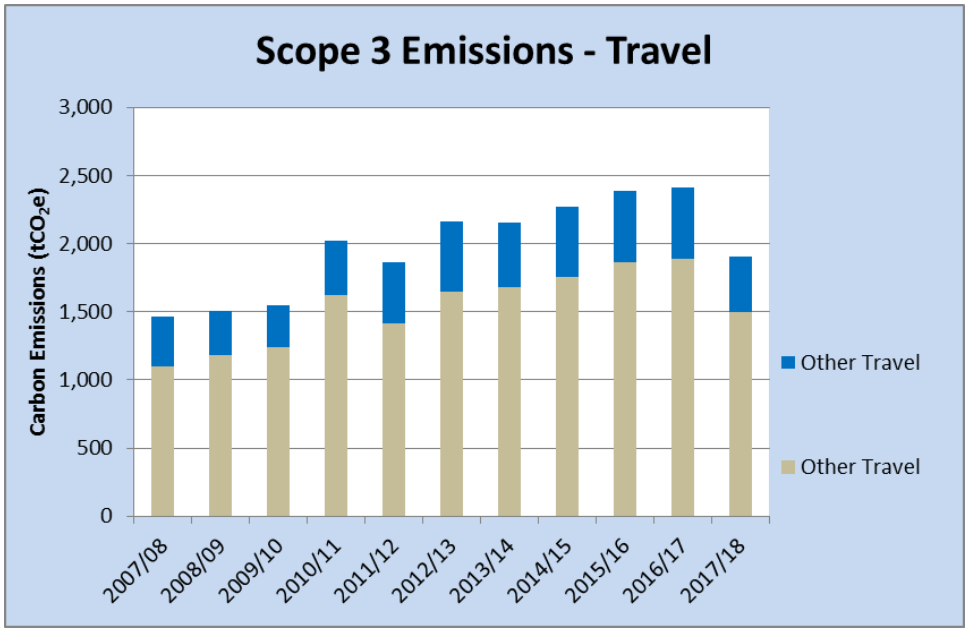


Scope 3 emissions

Scope 3 emissions are indirect emissions caused by activities not under the control of the RNOH. The scope 3 carbon dioxide equivalent emissions given in this report cover commuting travel, waste collection and disposal, water provision, sewage production and calculated emissions associated with energy production (well to tank, transmission and distribution) emissions. These elements of the footprint are shown in the graphs below.

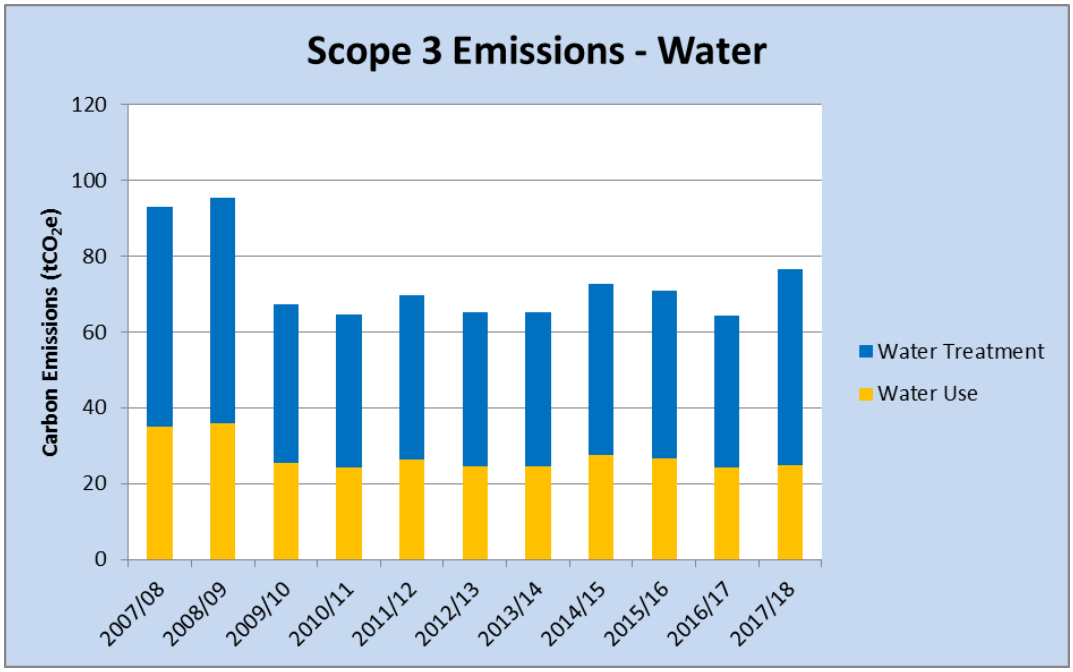
Patient and visitor travel and staff commuting

The travel emission calculations for patients and visitors are determined from an average travel distance of 15km and assuming 3.7 patient and visitor journeys per patient contact (inpatients and out-patients), as advised by the NHS Sustainable Development Unit. However, for the last four years we have also taken account of the National Travel Survey data which shows a fluctuation in average travel distance year on year and we have adjusted the figures accordingly. Travel emission calculations for staff commuting is based on the average annual commuting distance by road from the National Travel Survey NTS 2016 updated in 2017, and number of staff. Emissions are presented below.



Use of natural resources

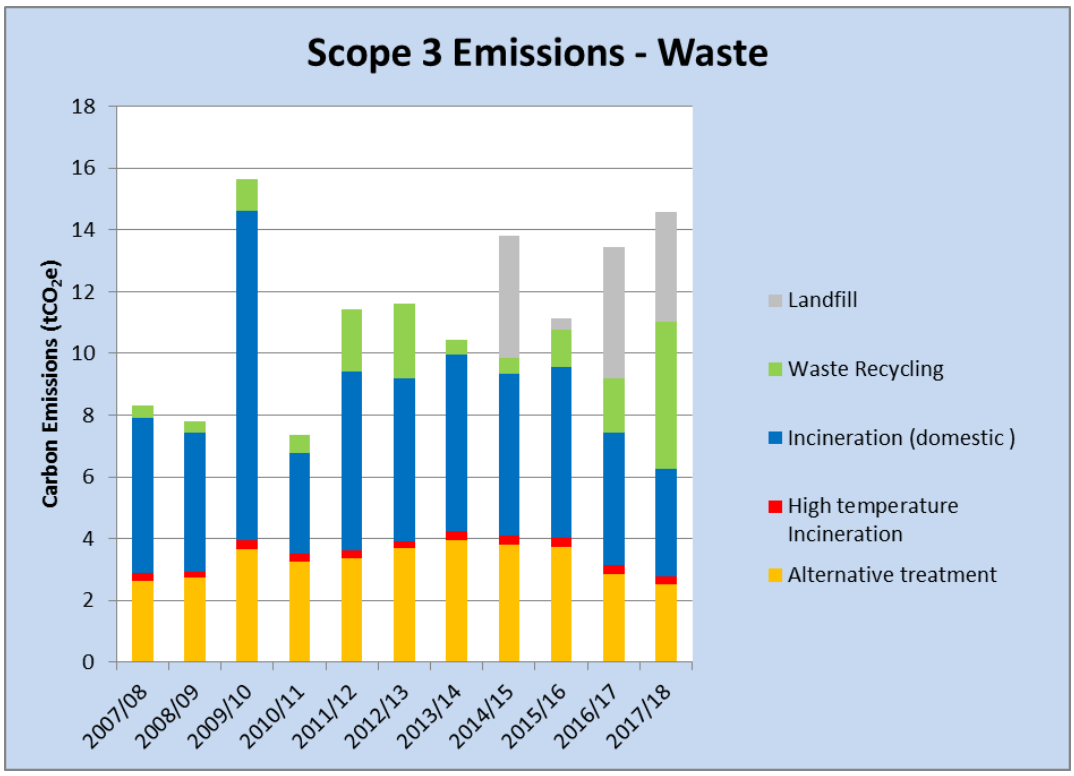
The cost of water and sewage was £140,012 in 2017/18, an increase of 17.2% on the previous year due to an increase in water consumption of 2.6% and sewage volumes of 29% this year compared with 2016/17. Water consumption may have increased due the building activities on site. Sewage data now uses invoices from the sewage services provider rather than a fixed proportion of water volume consumed. The graph below shows the contribution to scope 3 carbon emissions from water consumption.



Waste generation

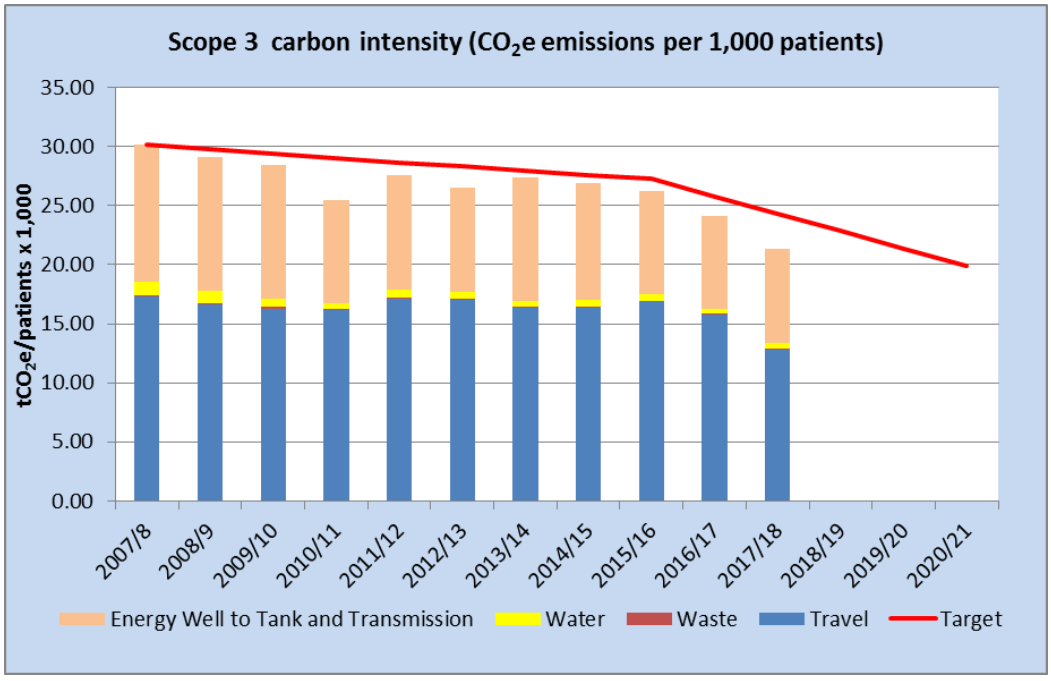
The Trust spent £111,387 on waste recovery, recycling and disposal in 2017/18, a 2.1% increase from 2016/17 due to an increase in the weight of waste generated.

Most waste is sent for incineration as domestic waste. About 10% of clinical waste is sent for high temperature incineration and the remainder is sent for alternative treatment. The total amount of waste generated has increased by 18% this year compared with 2016/17 whilst the proportion of waste recycled has increased significantly from 16.9% (2016/17) to 38.9% (2017/18). The graph below shows the contribution to scope 3 carbon emissions from waste and shows the dominance of domestic waste incineration although this is now being replaced by greater proportion of waste recycled.



Carbon intensity

The scope 3 carbon emissions produced by the Trust will increase with the number of patient contacts. The graph below therefore shows the scope 3 carbon emissions for every 1,000 patients and the contribution from travel, water and waste. The carbon intensity has been determined from the actual attendance numbers for out-patients rather than appointments booked. This is shown against the target of 10% reduction in emissions by 2015/16 and then a 34% reduction in emissions by 2020/21 with 2007/8 as the baseline year.


Scope 3 carbon intensity (CO_2e emissions per 1,000 patients)
tCO_2e/patients x 1,000
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
2007/8
2008/9
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20
2020/21
Energy Well to Tank and Transmission
Water
Waste
Travel
Target

D. ACCOUNTABILITY REPORT - CORPORATE GOVERNANCE REPORT

i. DIRECTORS' REPORT

a. DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE PREPARATION OF THE ANNUAL REPORT AND ACCOUNTS

The Directors are responsible for preparing the Annual Report including the financial statements in accordance with applicable law and regulations. By law the Directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs at this Trust.

The Directors are responsible for keeping adequate accounting records that are sufficient to show and explain the financial position of the RNOH and to enable them to ensure that the financial statements comply with the Treasury guidance. The Directors are also responsible for safeguarding the assets of the RNOH and hence must take reasonable steps for the prevention and detection of fraud and other irregularities.

Each of the Directors, whose names and functions are set out in this document, confirms that, to the best of their knowledge:

- the financial statements give a true and fair view of the assets, liabilities, financial position and profit of RNOH; and
- the Performance Report includes a fair review of the development and performance of the RNOH, together with a description of the principal risks and uncertainties that it faces.

Furthermore, so far as each of the Directors is aware, there is no relevant audit information of which the auditors are unaware, and each of the Directors has taken all the steps that ought to have been taken in order to become aware of any relevant audit information and to establish that the auditors are aware of that information.

The Directors consider that the Annual Report including the financial statements, taken as a whole, is fair, balanced and understandable and provides the necessary information.

b. RNOH TRUST BOARD MEMBERS

Professor Anthony Goldstone

Chairman

Voting member

In post since:

February 2011

Trust Roles:

Chair: Trust Board, Remuneration Committee, Quality Committee and Strategy & Sustainability Committee

Attendance at the following Trust Board Sub-Committees: Redevelopment Programme Board

Other Roles: Improvement Lead, Quality Lead, New Hospital

	Design Champion and Private Patients Development Lead **Experience:** Joined the NHS in 1969. Consultant Haematologist at University College London Hospital (UCLH) from1976 to 2011. Worked for UCLH in a clinical, academic and managerial capacity initially developing the leukaemia and transplant unit at UCLH, which is internationally recognised. Medical Director of UCLH from 1992 to 2000. Central figure in the planning, redevelopment and rebuild of the new UCLH hospital in Euston Road. Directed the North London Cancer Network from 2000 to 2009 taking considerable responsibility for developing and rationalising super specialist activity and making many contacts across the North Central London region. Published more than 330 papers. Appointed as a personal Chair in Haematology at University College London in 1999. Awarded a CBE for academic, clinical and managerial contributions to healthcare in June 2008.
	## Rob Hurd **Chief Executive** Voting member **In post since:** August 2008 **Trust Roles:** Chair: Executive Committee, Redevelopment Programme Board, Private Patient Development Sub-Committee, Fundraising Sub-Committee, Improvement Programme Board and Royal Free Partnership Programme Board Member: Trust Board, Strategy and Sustainability Committee, Quality Committee, Finance Committee, Joint Academic Committee and Information Management and Technology Committee Attendance at the following Trust Board Committee: Audit Committee

	Member of the following Trust Board Sub-Committee: Clinical Quality and Governance Sub-Committee **Experience:** 1992: Joined NHS on the NHS Graduate Financial Management Training Scheme and worked at Southampton University Hospitals. Rob has 26 years NHS Senior Management experience, including 13 years at Board level and ten years as Chief Executive of the Royal National Orthopaedic Hospital NHS Trust. Rob played a leadership role in the successful UCLH Foundation Trust application in 2004. He also played a leadership role in the implementation of the full business case for the £422m UCLH FT New Hospital PFI (opened in April 2005) and was the lead for numerous associated business cases. September 2005 until August 2008: Director of Finance at the RNOH. As Chief Executive, Rob has led the turnaround of the RNOH from a `double weak' rated Trust (2008) to nine outstanding ratings from the CQC (2014). The internal culture and external engagement of the organisation has also been transformed. In partnership with Professor Briggs he established the "Getting it Right First Time" (GIRFT) Programme, linked to the Vanguard Programme and the National Orthopaedic Vanguard. The GIRFT also has academic validation as a formal NIHR CLAHRC evaluation project and publication in BMC Health Services Research (and highly commended HSJ Award). Chair: Specialist Orthopaedic Alliance, a collaboration of major specialist orthopaedic centres, which has a membership of 12 specialist orthopaedic units from across the UK. He is developing the RNOH's contribution to the International Society of Orthopaedic Centres. Qualifications include: BSc (Social Science) Economics, CPFA Qualified (Chartered Institute of Public Finance and Accountancy).
	## Councillor Joe Carlebach **Vice Chairman** Voting member **In post since:** January 2014

	Trust Roles: Chair: Workforce and Organisational Development Committee and Information Management and Technology Committee Member: Trust Board, Strategy and Sustainability Committee, Audit Committee and Remuneration Committee Attendance at the following Trust Board Sub-Committee: Fundraising Sub-Committee Other Roles: Fundraising Lead RNOH, RNOH Charity Link, Workforce and Organisational Development Lead, Trustee of Royal National Orthopaedic Hospital Charitable Trust **Experience:** A graduate of Newcastle University currently serving on the University Court. Past Chairman of the University's Faculty of Biomedical Sciences Development Committee. Previous Executive and general management experience: Nortel Networks - responsible for Nortel's business in half of Western Europe, Panduit Corporation - Managing Director for Europe, Middle East and Africa, Wideyes AB - Chief Executive Officer. Served as Non-Executive Director on a number of Boards and as Chairman of the leading Savile Row tailor Henry Huntsman and Sons, Chairman of Myacom; a telecoms manufacturing business. Cabinet Member for Adult Social Care and Health in Hammersmith and Fulham. Present roles include: Councillor in the London Borough of Hammersmith and Fulham. Member of the Adult Social Care and Health a scrutiny committee. A member of the Corporate Parenting Board. Trustee of Arthritis Research UK, and the Hammersmith and Fulham Citizens Advice, Vice Chair of the Wormwood Scrubs Common Charitable Trust, a Trustee of the Royal National Orthopaedic Charitable Trust and an Ambassador for Hammersmith and Fulham Mencap.
	## Bertie Leigh **Non-Executive Director** Voting member **In post since:** November 2015

	Trust Roles: Senior Independent Director Member: Trust Board, Audit Committee, Finance Committee, Strategy and Sustainability Committee, Remuneration Committee and Quality Committee **Experience:** Bertie is a qualified solicitor who joined Hempsons in 1973 as a trainee. He qualified in 1976 and was made Partner a year later. He became a Senior Partner in 1995 and Solicitor Advocate in 2005. He stepped down as Partner at the end of June 2015, but will continue to act for Hempsons in a consultancy capacity. Bertie has specialised in medical law throughout his career, handling over 2,500 cases. Outside of medicine he has also acted for the NSPCC, the Law Society. In addition he has lectured extensively on many aspects of law, medical ethics and risk management. Outside of his full time role as a solicitor, Bertie is currently President of the Society for Ethics in Law and Medicine (SELM) and Chair of the following bodies: Clinical Disputes Forum, National Confidential Enquiry in Patient Outcome and Death (NCEPOD), SELM and St Christopher School Governors. He is also a Trustee of Charm UK. He is a past Governor of City Lit Adult Education College, a former President of the Medico-Legal Society and a former Trustee of Core (Gastroenterology).
	## Mr Michael Rosehill **Non-Executive Director** Voting member **In post since:** October 2017 **Trust Roles:** Chair: Audit Committee and Finance Committee Member: Trust Board, Strategy and Sustainability Committee, Remuneration Committee **Experience:** Graduate of University College Cork and a qualified Chartered Accountant and Corporate Treasurer

	Experienced Chief Financial Officer and Investment Director of a large private conglomerate in the UK, LFH International Board member of LFH International and serves on its key strategic committees Operated and engaged at the most senior levels often in complex stakeholder landscapes Non-Executive director of Everyman Cinemas, an AIM listed company
	## Professor David Isenberg **Non-Executive Director** Voting member **In post since:** June 2011 **Trust Roles:** Chair: Joint Academic Committee Member: Trust Board, Remuneration Committee, Strategy and Sustainability Committee, and Quality Committee Other Roles: Academic Link Lead **Experience:** Since 1991: Academic Director of Rheumatology at UCL. He has co-authored approximately 700 scientific manuscripts and 17 books. Since 1996: Arthritis Research UK Diamond Jubilee Professor of Rheumatology at University College London Medical School. Since 2008: Chair of the Autoimmune Rheumatic Disease clinical trials sub-committee for Arthritis Research UK. 2004 to 2006: President of the British Society for Rheumatology. 2006 to 2011: Chair of the British Society for Rheumatology's Biologics Register Committee. 1998 to 2004: Chair of the Systemic Lupus International Collaborating Clinics Group . Chair: British Isles Lupus Group. Member: Centre of North London Clinical Trials Network Board.

Robin Whitby

Non-Executive Director

Voting member

In post since:

September 2013

Trust Roles:

Member: Trust Board, Strategy and Sustainability Committee, and Remuneration Committee

Attendance at the following Trust Board Sub-Committee: Redevelopment Programme Board

Other Roles: Redevelopment Lead

Experience:

Robin is a Chartered Builder previously employed as a Bid Director and SPC Director with one of the UK's largest construction and engineering contractors. He is currently providing consultancy services to both public and private sector clients and maintains an active interest in the development of healthcare facilities.

Robin's experience, in excess of 30 years in property development and construction, spans most elements of public and private sector property development with particular emphasis on preconstruction project development and project procurement. During the last 10 years, Robin's experience includes leadership on many successful awards winning major hospital developments/redevelopments for the private sector on behalf of the NHS, as well as being a Director of Special Purpose Company Boards providing ongoing services to the NHS.

Mr Aresh Hashemi-Nejad

Medical Director

Voting member

In post since:

January 2017

Trust Roles:

Co-Chair: Clinical and Quality Governance Sub-Committee and Information Quality & Governance Steering Sub-Committee

	Member: Trust Board, Strategy and Sustainability Committee, Finance Committee, Quality Committee, Joint Academic Committee, Information Management and Technology Committee and Executive Committee Member of the following Trust Board Sub-Committees: Redevelopment Programme Board and Private Patient Development Sub-Committee **Experience:** Aresh has worked at the RNOH as a Consultant Orthopaedic Surgeon since 1997 and has played a significant role in the developments that have taken place at the Trust in recent years. He has taken on a number of leadership posts during this time, including Clinical Lead of the Paediatric Surgical Unit (2003-7), Clinical Director for the Division of Surgery (2007-12) and President of the British Society of Children's Orthopaedic Surgery (2014-16).
	## Hannah Witty **Director of Finance** Voting member **In post since:** September 2016 **Trust Roles:** Member: Trust Board, Strategy and Sustainability Committee, Finance Committee and Executive Committee Attendance at the following Trust Board Committee: Audit committee Member of the following Trust Board Sub-Committees: Redevelopment Programme Board, Improvement Programme Board and Private Patient Development Sub-Committee **Experience:** February 2016 until August 2016; Acting Director of Finance and Estates at the Home Office. Hannah's previous roles were Head of Financial Planning (Home Office), Head of Corporate Services (Committee on Climate Change), and Head of Governance and Assurance (Her Majesty's Courts and Tribunals Service). She also has worked in the private sector, and qualified as a Chartered Accountant with the National

	Audit Office. Qualifications: BA (Hons) English Language and Literature, FCA (Fellow Institute of Chartered Accountants England and Wales).
	## Professor Paul Fish **Director of Nursing, Quality & Patient Experience** Voting member **In post since:** February 2015 **Trust Roles:** Co-Chair: Clinical and Quality Governance Sub-Committee Member: Trust Board, Strategy and Sustainability Committee, Quality Committee, Information Management and Technology Committee, Workforce and Organisational Development Committee and Executive Committee Member of the following Trust Board Sub-Committees: Improvement Programme Board and Redevelopment Programme Board Other Roles: Director of Quality, Director of Infection Prevention and Control (DIPC), Accountable Officer for Controlled Drugs, Accountable Emergency Officer / Director for Emergency Planning, Executive Lead for Safeguarding, Chief Clinical Information Officer, Human Tissue Authority Executive Lead **Experience:** Paul has worked in a variety of nursing roles in both the North of England and London. His clinical background is in critical care and emergency nursing in addition to working as a Nurse Consultant with a focus on improving practice. Paul's senior leadership roles have included being an Associate Director of Nursing at a large integrated foundation trust, where he took a particular lead on clinical standards and practice development issues before moving to London to be Deputy Chief Nurse at University College London Hospitals. Paul has experience of providing operational leadership in large specialist hospitals and has an interest in/expertise in nursing workforce issues, research, education, leadership and practice improvement. Paul is a Virginia Mason Certified Leader and has first and higher

	degree's in nursing practice. He is a visiting professor in nursing leadership at London Southbank University.
	## Lucy Davies **Chief Operating Officer** Voting member **In post since:** May 2015 **Trust Roles:** Executive Director for Operational Performance Member: Trust Board, Strategy and Sustainability Committee, Quality Committee, Workforce & Organisational Development Committee and Executive Committee Member of the following Trust Board Sub-Committees: Improvement Programme Board, Workforce & Organisational Development Committee, Cancer Strategy Sub-Committee, and Clinical Quality and Governance Sub-Committee Other Roles: Trust lead for Decontamination **Experience:** Lucy joined the NHS as a General Management Trainee, and then worked at Morriston Hospital NHS Trust in Swansea before moving to Milton Keynes General NHS Trust as a Services Manager. In 1997 Lucy joined the Royal Brompton Hospital NHS Trust, where she has been ever since, firstly as a Directorate Manager of the Surgery Division, and as General Manager of the Division. Six years later, she became Head of Performance, and subsequently Head of Modernisation, delivering the 18 week target two months early. In 2010, she took on the Divisional General Manager role of the Heart and Critical Care division, reporting directly to the Chief Operating Officer and managing a budget of £92 million. She was also the senior operational manager for the Harefield site, one of the two specialist hospitals within the Trust. Lucy holds a first class BA honours degree in French and an MBA with distinction.

Dr Gabrielle Silver

Associate Non-Executive Director

Non-voting member

In post since:

November 2015

Trust Roles:

Member: Trust Board, Strategy and Sustainability Committee, and Workforce and Organisational Development Committee

Attendance at the following Trust Board Sub-Committees: Improvement Programme Board

Experience:

Gabrielle is a qualified doctor. In that capacity, she spent her early career from 1998 to 2001 as House Physician at the Royal Free Hospital in London, House Surgeon at the Lister Hospital in Hertfordshire, Senior House Officer at Northwick Park Hospital and the Royal Free and UCL School of Anaesthesia.

In 2001 she moved into the commercial sector as Senior Euopean Medical Advisor Eisai Europe.

From 2005 to 2006 she worked for pharmaceutical company, Bristol Myers Squibb as Therapeutic Area Director, Neuroscience. She then returned to Eisai as Director of CNS Franchise. She joined GE Healthcare in 2010.

Within GE she also holds a voluntary appointment as EMEA Women's Network Commercial Leader and she is a supporter of the Sickle Cell and Young Stroke Survivors Charity.

Katherine Murphy

Associate Non-Executive Director

Non-voting member

In post since:

September 2017

Trust Roles:

Member: Trust Board, Strategy and Sustainability Committee and Quality Committee.

Experience:

	30 years' experience in highly influential roles, across complex and demanding healthcare and NHS environments. A passionate campaigner and advocate, promoting care provision improvements and enhancement of patient health outcomes, within the UK. Former CEO of The Patients Association 2007 to 2017. Director of The Patients Association 2000 to 2007. Former nurse by profession. An innovative strategist, leading successful projects and change initiatives, aimed at driving significant improvements in service delivery. Active Member of Norman Lamb's Panel of Independent Specialists 2016/17; studying funding models to support the future of health and social care. Part of Sir Bruce Keogh, Medical Director, NHS England Review Team; reviewed high mortality rates and failing hospitals within the NHS, 2013 to 2014. Instrumental and extensive involvement in reforming the NHS Complaints Systems; highlighting failures of the Parliamentary Health Service Ombudsman. Promoted and championed the first media contact of the PA; conducted a vast number of interviews with TV, radio and broadsheets, concerning various health and social care stories. Set up the new APPG for Patient Safety; launched with Andrea Jenkyns MP as Chair, focusing on ensuring that patient safety remains at the heart of the Governments agenda, bringing together interested Parliamentarians, members of the public and healthcare experts to address all issues affecting patients in the care sector. Positively represented on the Prime Minister's Nursing Care Quality Forum; the Chief Nursing Officers for England Vision for Nursing.
	## Professor John Skinner **Director of Research and Innovation Centre** Non-voting member **In post since:** January 2017

	Trust Roles: Member: Trust Board, Joint Academic Committee, Strategy & Sustainability Committee and Executive Committee Other Roles: Professor of Orthopaedic Surgery, UCL and Royal National Orthopaedic Hospital Specialist interest: revision hip surgery **Experience:** Professor John Skinner has now been a Consultant at Stanmore since 1999, initially as Senior Lecturer in Orthopaedics at the UCL Institute of Musculoskeletal Science, with an Honorary Consultant Orthopaedic Surgeon contract at the RNOH since 2003. He has collaborated and published with more than 200 co-authors worldwide and mentored and supervised several MD theses and supervised research projects for trainees, medical students and other researchers. John has also contributed to work at the RNOH by taking various leadership roles, such as chairing the Infection Control Committee for 11 years and the Medical Staff Committee for five years. Nationally, he chairs the Joint BOA –MHRA Expert Advisory Group on Metal Bearing Hips and has been President of the British Hip Society. He is on the council of the British Orthopaedic Association and the Editorial Board of the Bone and Joint Journal.
	## Dr Zilla Huma **Director of Children's Services** Non-voting member **In post since:** September 2015 **Trust Roles:** Chair: Children's Services Operational Sub-Committee Member: Trust Board, Quality Committee, Strategy & Sustainability Committee and Executive Committee **Experience:** Zilla graduated from Medicine at Glasgow University and very quickly concentrated her efforts on working with children at the Royal Hospital for Sick Children in Glasgow, then at Manchester,

	followed by the Westminster Children's Hospital in London. After gaining her MRCP, in 1990, she moved to Cornell University / the New York Hospital to undertake a post-doctoral fellowship in Paediatric Endocrinology with the then President of the Endocrine Society. After two years as a fellow she became an Assistant Professor and focused her research on genetic conditions leading to disorders of sexual differentiation. In 1996, she returned to the NHS and became a Consultant Paediatrician at Wexham Park and the John Radcliffe Hospitals in Oxford. Over the next 18 years she became Regional Advisor for Oxford Deanery, Undergraduate Tutor, Clinical Director and continued her work as a Paediatric Endocrinologist. In September 2015, Zilla moved to become the Director of Children's Services at the RNOH and hopes to develop an Endocrine service around metabolic bone disease and disorders of growth, as well as promoting excellence in the care of children throughout the Trust. Zilla is on the Board of the Cure2Children charity which performs hundreds of bone marrow transplants in children all over the developing world every year.
	## Dr Saroj Patel **Director of IM&T and Innovation** Non-voting member **In post since:** March 2005 **Trust Roles:** Member: Trust Board, Strategy and Sustainability Committee, Information Management and Technology Committee, and Executive Committee Member of the following Trust Board Sub-Committees: Improvement Programme Board **Experience:** 2003: Joined the NHS. More than 20 years IT industry experience in both private and public sectors including development of ICT strategies, programme management, process transformation and solutions delivery. Since 2005: Director of IM&T.

	2009: Appointed the Trust's Senior Information Risk Officer (SIRO). October 2011: Appointed a Trustee of Aspire (Spinal Injury Charity) based at Stanmore, Middlesex. 2011: Role extended to include Workforce and Corporate Affairs and as a subsequence became a voting member of the Trust Board. Qualifications include: BSc Statistics and MSc Computer Science (University of London), MBA, Diploma in Marketing, PhD (Cranfield School of Management) and MSP Practitioner.
	## Mark Masters **Director of Estates and Facilities** Non-voting member **In post since:** November 2003 **Trust Roles:** Chair: Estate & Facilities Sub-Committee and Medical Gas Sub-Committee Member: Trust Board, Quality Committee, Strategy & Sustainability Committee, and Executive Committee Member of the following Trust Board Sub-Committees: Redevelopment Programme Board and Decontamination Sub-Committee **Experience:** 25 years management experience in estates and facilities having worked both for the NHS and the Private Sector. MSc in Planning Buildings for Healthcare. B.Eng (Honours) Degree in Building Services Engineering. PRINCE2 Registered Practitioner. Chartered Engineer. Fellow of the Institute of Healthcare Engineering and Estate Management.

Tom Nettel

Director of Workforce and Improvement

Non-voting member

In post since:

April 2015

Trust Roles:

Member: Trust Board, Strategy & Sustainability Committee, Executive Committee, Joint Academic Committee, Workforce and Organisational Development Committee

Member of the following Trust Board Sub-Committees: Redevelopment Programme Board, Private Patient Development Sub-Committee and Improvement Programme Board

Experience:

Tom joined the NHS as a Management Trainee across East Kent. He then worked at Ealing Hospital NHS Trust before moving to North West London Hospitals NHS Trust in 2009.

Tom became Assistant Director of Human Resources at North West London and was responsible for the effective running of all operational HR services in the Trust. He was also responsible for delivering a significant element of the Trust's cost saving and transformation plans.

In February 2013, he joined the RNOH as the Deputy Director of Workforce and Organisational Development. In March 2016 he became Director of Workforce and Organisational Development.

Tom holds a BA honours degree in English Literature from Durham University, an MA in Human Resources Management and is a qualified member of the CIPD (Chartered Institute of Personnel and Development).

Frank Hennessy

Director of Redevelopment Programme

Non-voting member

In post since:

July 2015

Trust Roles:

Member: Trust Board, Strategy & Sustainability Committee, and

	Executive Committee Member of the following Trust Board Sub-Committees: Redevelopment Programme Board and Private Patient Development Sub-Committee **Experience:** Frank, a Chartered Building Surveyor (FRICS), brings 35 years Healthcare Property and Facilities Management experience to RNOH's Redevelopment Programme objectives for a redeveloped Hospital and Academic Campus in Stanmore. His experience spans the management of Healthcare buildings facilities and engineering services for the ongoing safe and efficient delivery of healthcare services to wholesale redevelopment of hospital estates. Frank worked in the Public and Private Healthcare Sectors across the UK and for a three year period in Australia.
	## Daryl Lutchmaya **Trust Secretary / Head of Corporate Affairs** Non-voting member **In post since:** November 2015 **Trust Roles:** Attendance at the following: Trust Board, Quality Committee, Strategy & Sustainability Committee, Audit Committee, Remuneration Committee, and Executive Committee Co-Chair: Information Quality & Governance Steering Sub-Committee Senior Information Risk Owner **Experience:** Daryl's career experience been gained from working in a wide variety of sectors including having worked for Government Executive Agencies, International Organisations, private sector businesses and a Professional Membership Body. Daryl graduated from the Royal Holloway College, University of London with a degree in Economics and Public Administration, and also studied at the University of Geneva in Switzerland where he gained his MBA focusing on the management and governance of International Organisations.

	Daryl is a Fellow of the Association of Chartered Certified Accountants (FCCA) and member of the Institute of Risk Management (MIRM).

c. BOARD MEMBERS WHO SERVED DURING THE YEAR

	**Isabel Dolan** **Non-Executive Director** Voting member **In post since:** October 2015 **Trust Roles:** Chair: Audit Committee, Finance Committee and Access Improvement Programme Board Member: Trust Board, Strategic and Sustainability Committee and Remuneration Committee
	**Dr Natalie-Jane Macdonald** **Associate Non-Executive Director** Non-voting member **In post since:** September 2013 **Trust Roles:** Member: Trust Board and Strategy and Sustainability Committee and Information Management and Technology Committee Member of the following Trust Board Sub-Committee: Private Patient Development Sub-Committee Other Roles: Private Patients Development Lead and Safeguarding Lead

d. RNOH TRUST BOARD MEMBERS' DECLARATIONS OF INTERESTS

Date	Title	First Name	Last Name	Position Title	Declaration	Organisation Name	Nature of interest
29/03/2018	Professor	Anthony	Goldstone	Chairman	Yes	HCA Hospitals	Chief Medical Adviser, Cancer Services
29/03/2018	Councillor	Joe	Carlebach	Vice-Chairman & Non-Executive Director	Yes	Avonmore & Brook Green ward in Hammersmith & Fulham	Local Councillor
29/03/2018	Councillor	Joe	Carlebach	Vice-Chairman & Non-Executive Director	Yes	RNOH Charity	Trustee
29/03/2018	Mr.	Mark	Leigh	Non-Executive Director	Yes	Nil	Nil
29/03/2018	Professor	David	Isenberg	Non-Executive Director	Yes	Nil	Nil
29/03/2018	Mr.	Michael	Rosehill	Non-Executive Director	Yes	Nil	Nil
29/03/2018	Mr.	Robin	Whitby	Non-Executive Director	Yes	Nil	Nil
29/03/2018	Dr	Gabrielle	Silver	Associate Non-Executive Director	Yes	General Manager at Lloyds Pharmacy Clinical Homecare, a member of the Celesio UK group of companies	Lloyds Pharmacy Clinical Homecare supplies medications to the RNOH
29/03/2018	Ms.	Katherine	Murphy	Associate Non-Executive Director	Yes	Nil	Nil
29/03/2018	Mr.	Robert	Hurd	Chief Executive	Yes	Nil	Nil
29/03/2018	Ms	Lucy	Davies	Chief Operating	Yes	Grant	Ex-Husband

				Officer		Thornton (External Auditor to the RNOH)	currently works at Grant Thornton as Director, Financial Services Advisory
29/03/2018	Professor	Paul	Fish	Director of Nursing, Quality & Patient Experience	Yes	London South Bank University	Visiting academic appointment with the RNOH's link university
29/03/2018	Mr	Aresh	Hashemi-Nejad	Medical Director	Yes	Nil	Nil
29/03/2018	Mrs.	Hannah	Witty	Director of Finance	Yes	Nil	Nil
29/03/2018	Mr.	Thomas	Nettel	Director of Workforce and Improvement	Yes	Nil	Nil
29/03/2018	Dr	Sarojini	Patel	Director of IM&T and Innovation	Yes	Aspire	Chair of the Trustee Board
29/03/2018	Dr	Zilla	Huma	Director of Children's Services	Yes	Nil	Nil
29/03/2018	Mr.	Thomas	Hennessy	Director of Redevelopment	Yes	Nil	Nil
29/03/2018	Mr.	Mark	Masters	Director of Estates and Facilities	Yes	Nil	Nil
29/03/2018	Mr.	Daryl	Lutchmaya	Head of Corporate Affairs/Trust Secretary	Yes	Nil	Design consultant
29/03/2018	Professor	John	Skinner	Director of Research and Innovation Centre	Yes	Medacta	Consultant advising on TKR, teaching surgical Techniques &

							lectures. Use MEDACTA knee prosthesis
29/03/2018	Professor	Timothy	Briggs	Director of Strategy & External Affairs	Yes	The Thalidomide Trust	Trustee
29/03/2018	Professor	Timothy	Briggs	Director of Strategy & External Affairs	Yes	The Skeletal Cancer Action Trust	Trustee

e. Personal Data incidents reported to the Information Commissioners Office

During 2017/18, the Trust reported one Level 2 incident using the Information Governance Incident Reporting Tool, as a result of personal identifiable information having been sent to an external email account. The incident was reported to the Information Commissioner's Office (ICO) for the Data Protection security breach.

f. Modern Slavery Act 2015

The Modern Slavery Act 2015 establishes a duty for commercial organisations with an annual turnover in excess of £36 million to prepare an annual slavery and human trafficking statement. This is a statement of the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its own business. The RNOH does not receive turnover in excess of £36 million from commercial or Non-Government sources and is not required to prepare an annual slavery and human trafficking statement.

g. Director's disclosure to the Trust Auditors

The law requires that all Directors take active steps to ensure that the Trust's Auditors are made aware of all information that is, or might be, relevant to their work in reviewing the Annual Report and Accounts.

Each individual who is a Director of the Trust at the date of the approval of this Annual Report formally confirms that:

a. As a Director, they have taken all of the steps that they ought to take, in order to make themselves aware of any relevant audit information; and to establish that the auditor is also aware of that relevant audit information;

b. So far as they are aware, there is no relevant audit information which has not been brought to the attention of the auditor.

ii. STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and believe that they have complied with the above requirements in preparing the accounts.

By order of the Board

25/05/18 

..... Date..... Chief Executive Officer

25/05/18 

..... Date..... .Director of Finance

iii. STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed ..... Chief Executive Officer

25/05/18

Date.....

iv. GOVERNANCE STATEMENT 2017 – 18

a. INTRODUCTION

This Governance Statement describes the Royal National Orthopaedic Hospital NHS Trust's corporate and quality governance and risk management and control systems. Through a range of reporting mechanisms and evidence, assurance is provided to the Trust Board and to NHS Improvement about the effectiveness of the Royal National Orthopaedic Hospital NHS Trust's stewardship and provides details about any significant internal control issues that have arisen during the year.

b. SCOPE OF RESPONSIBILITY

As Accountable Officer, I have the responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable Officer Memorandum.

As the Chief Executive Officer I am accountable to the Trust Board, Chairman, and to NHS Improvement. My accountability to them can be demonstrated through my management and regular performance reporting of the Trust's activities which are undertaken in a transparent manner. The Trust Board and its Committees receive a range of reports to provide assurance, including the timely reporting of Key Performance Indicators covering the safety, effectiveness, responsiveness, productivity and efficiency of services, including assurance that the RNOH's services are caring.

The Board also receives monthly financial reporting including actual performance and the forecasting of future performance based on the latest available information. An annual planning process refreshes the long term financial plan for the Trust and is reviewed by the Board. A Chief Executive's Report is provided to the Board each month providing updates about RNOH's strategic priorities, risks and progress on these issues to date.

I have also ensured that Trust decisions have been taken in consultation with stakeholders and that the Trust has worked effectively in partnership across the wider health community. Examples include the following:

- Monthly Integrated Delivery Meetings with NHS Improvement (NHS I);
- Monthly meetings between the RNOH and NHS England (NHS E) with the NHS I in attendance, known as the Clinical Quality Review Meeting;
- Regular meetings with the RNOH Patient Group, Healthwatch, Clinical Commissioning Groups and the Local Authority Health and Social Care Scrutiny Committee;

- RNOH and the Royal Free London NHS Foundation Trust continue to work in line with the Memorandum of Understanding (MOU) which sees both organisations working closer together in three areas;
    - a joint venture for routine orthopaedics,
    - consolidation of RNOH outsourced services and
    - shared back office functions;
- During the year, a Memorandum of Understanding was approved to support the development of stronger working relationships and productive partnership between The Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust (RJAH), Royal National Orthopaedic Hospital NHS Trust (RNOH) and Royal Orthopaedic Hospital NHS Foundation Trust (ROH) with a particular focus on Specialised paediatric orthopaedics, Orthopaedic cancer services, other small scale specialised services, Orthopaedic coding, Commissioning and Specialised prosthesis procurement;
- RNOH is a member of the University College London Partners (UCLP) Academic Health Science Network and its Executive Group includes the RNOH Chief Executive and meets monthly;
- The GIRFT Programme is jointly hosted by NHS Improvement and the RNOH. This is a national programme supported by NHS Improvement which engages clinicians working in acute care with their own data to accelerate the adoption of evidence based practice through peer to peer discussion and review;
- The RNOH is a mandated member of the National Joint Registry. This was set up by the Department of Health and the Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, with a view to improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. I am appointed as the Management member representing providers on the National Joint Registry Executive Committee;
- The Trust has agreed a deed of understanding and a 'Ways of Working' document with the RNOH Charity which is an independent charity. A Non-Executive Director of the RNOH NHS Trust is also a trustee of the Charity. The Charity works closely with the Trust on fundraising activities and the RNOH NHS Trust Fundraising Committee is run in partnership with the Charity;
- Princess Eugenie House (PEH) is an intended donated asset which is in development and which will operate under a Memorandum of Understanding amongst RNOH, the RNOH Charity, the Sick Children's Trust and the Child Based Partnership Nurseries; and
- RNOH is a leader of the Specialist Orthopaedic Alliance (SOA), which has been successful in achieving national vanguard status under the NHS England national New Models of Care programme – known as the National Orthopaedic Alliance (NOA). The SOA and NOA work consistently with the national GIRFT Programme with the stated aim of enhancing quality and reducing complications. This is a vital project for securing sustainability of orthopaedics as a whole within the NHS.

c. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal National Orthopaedic Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

d. GOVERNANCE FRAMEWORK

The Trust Board

The Royal National Orthopaedic Hospital NHS Trust is a statutory body that was formed on 1st April 1991 under The Royal National Orthopaedic Hospital NHS Trust (Establishment) Order 1991. The Trust Board membership consists of 5 Executive Directors, 5 Non-Executive Directors and 1 Non-Executive Chair of the Board of Directors.

The voting Executive Directors serving on the Trust Board are the:

Chief Executive Officer
Medical Director
Director of Finance
Director of Nursing, Quality and Patient Experience
Chief Operating Officer

During the year, the term of service for Isabel Dolan, Non-Executive Director and Chair of the Audit Committee and of the Finance Committee expired. Isabel Dolan decided to pursue other interests and chose not to renew her term. Dr Natalie-Jane Macdonald, Associate Non-Executive Director also resigned during the year in order to focus on other interests. However, Dr Natalie-Jane Macdonald is still involved working with the Trust on developing its Private Patient services. The Board is very grateful to both of them for their huge contributions and input during 2017/18. The Chairman's term of service was also extended during the year by NHSI for one further year.

Michael Rosehill was appointed to replace Isabel Dolan on the Board and Katherine Murphy joined the Board as an Associate Non-Executive Director during the year to replace Dr Natalie-Jane Macdonald. Katherine Murphy's main focus is to promote care provision improvements and the enhancement of patient health outcomes. Robin Whitby who previously served as an Associate Non-Executive Director was appointed as a Non-Executive Director.

The Trust Board is considered to be well-balanced and to be of sufficient size, skill and experience to fulfil its responsibilities. The Board as a whole continued to develop its balance of skills and diversity. The Trust Board met 11 times during the year.

The legal framework underpinning the Trust is set out in the Trust's governing documents and includes;

- the Establishment Order;
- Standing Orders;
- Standing Financial Instructions; and
- the Board of Directors Reservation of Powers and Scheme of Delegation.

The Trust Board complies with the HM Treasury/Cabinet Office Corporate Governance code where applicable. The Chief Executive Officer, who is responsible for the governance and assurance processes across the Trust, is supported by the Trust Secretary.

The Trust Board convenes on a monthly basis, both in public sessions where its agenda is managed according to the annual cycle of the RNOH's business, and in closed sessions, which take place in private where the matters considered are both sensitive and not intended for public disclosure.

At each of its public meetings, the Trust Board considers the following matters as standing items;

- An update from the Chief Executive;
- the Balanced Scorecard of Key Performance Indicators which covers all aspects of the work of the Trust;
- Quality;
- Safe staffing;
- Safeguarding;
- Finance;
- Research and Development;
- a report from the Patient Group and
- the Board Assurance Framework (informed by the Trust Risk Register).

During this financial year, the Trust Board confirmed that its strategic aim continues to be to provide the best patient care in the NHS in orthopaedics through aiming to provide sustainable, outstanding patient care at a scale and range of MSK services befitting a world leading reference centre. One important, but not exclusive, measure of this is to aim for an overall "Outstanding" rating from the Care Quality Commission.

The Trust also aims to continue to recruit, retain and to develop highly skilled and engaged staff who embrace and deliver the Trust's aims and values. The 2017 NHS annual staff survey provided an important, but not exclusive, barometer of the Trust's achievement of this aim. The RNOH was above average when compared to other Acute Specialist Trusts on 17 of the 32 key findings.

The Trust aims to improve its infrastructure which requires modernising and requires the development of high quality buildings and equipment and digital technology infrastructure befitting the delivery of high quality patient care.

Financial stability is the fourth aim and in line with many NHS organisations, the RNOH is now experiencing, and projecting in the future, significant financial challenges. This strategic aim seeks to enhance the Trust's financial sustainability through optimising its productivity, increasing non-NHS income as a proportion of total income, meeting NHS growth targets agreed with Commissioners, and seeking fair recognition of the cost of providing specialised complex MSK services through the tariffs which provide funding for the patients that are treated. This aim will be measured by setting, agreeing and delivering a challenging but achievable long term plan that indicates a sustainable financial outlook for the services provided by the RNOH and that is agreed with Commissioners and Regulators.

The final strategic aim is to deliver world leading research, education and innovation. This means that the RNOH aims to promote a culture of learning and education that benefits our staff, our patients at the RNOH and patients elsewhere, and that RNOH patients participate more and more in clinical research. All of these activities will raise the profile of the role of the RNOH and our aim will be to ensure we achieve appropriate value out of these activities; a vibrant culture that learns and educates has been shown to contribute to higher quality patient care. This culture will enhance all of our behaviours in line with our values and assist in the recruitment and retention of high quality staff. We will also aim to achieve direct financial value from these activities. This aim will be measured by the progress we make on agreeing our Research and Education Strategies and delivery of the development that these strategies lay out over future years.

The RNOH agreed a two year deficit control total for 2017/18 and 2018/19 but this is reliant on realising significant land sales in 2018/19 which remains a material risk. The RNOH is currently projecting to be in deficit for the duration of our five year plan and the solutions to growth in non-NHS funding have not been clearly identified nor implemented to mitigate the long term financial risks. Agreement of this control total allows the Trust access to Sustainability and Transformation Funding and also facilitates the ability of the Trust to draw down cash funding to ensure that it can more effectively manage its cash flow.

Referral to Treatment for planned care for June 2017 performance, represented the best improvement in RTT performance nationally over the previous twelve months and earned the RNOH a personal letter of congratulation from the Secretary of State for Health.

The attendance of Board members and permanent invitees during the financial year is shown in the Board attendance register below.

		26-Apr	24-May	28-Jun	26-Jul	30-Aug	27-Sep	25-Oct	29-Nov	13-Dec	24-Jan	28-Feb	28-Mar	Attendance Record
Professor Anthony Goldstone	**Chairman**	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	**11/11**
Mr Rob Hurd	**Chief Executive Officer**	✓	✓	✓	A		✓	✓	✓	✓	✓	✓	✓	**10/11**
Councillor Joe Carlebach	**Vice Chair (Non-Executive Director)**	✓	✓	✓	✓		✓	✓	✓	✓	A	✓	✓	**10/11**
Professor David Isenberg	**Non-Executive Director**	A	✓	✓	✓		A	✓	✓	A	✓	A	✓	**7/11**
Mr Bertie Leigh	**Senior Independent Director (Non-Executive Director)**	✓	✓	A	✓		✓	✓	✓	✓	✓	✓	✓	**10/11**
Mr Michael Rosehill	**Non-Executive Director (From October 2017)**							✓	✓	✓	✓	✓	✓	**6/6**
Mr Robin Whitby	**Non-Executive Director**	✓	✓	A	✓		✓	✓	✓	A	✓	A	A	**7/11**
Ms Katherine Murphy	**Associate Non- Executive Director (From September 2017)**						✓	✓	✓	✓	✓	✓	✓	**7/7**
Dr Gabrielle Silver	**Associate Non-Executive Director**	✓	✓	✓	✓		✓	A	✓	✓	✓	A	✓	**9/11**
Mr Aresh Hashemi-Nejad	**Medical Director**	✓	✓	✓	✓		✓	A	✓	✓	✓	✓	A	**9/11**
Ms Lucy Davies	**Chief Operating Officer**	✓	A	A	✓		✓	✓	✓	✓	✓	✓	✓	**9/11**
Professor Paul Fish	**Director of Nursing, Quality and Patient Experience**	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	**11/11**
Mrs Hannah Witty	**Director of Finance**	✓	✓	✓	✓		✓	✓	✓	A	✓	✓	✓	**10/11**
Dr Saroj Patel	**Director IM&T and Innovation**	✓	✓	✓	✓		✓	A	✓	✓	✓	A	✓	**9/11**
Mr Mark Masters	**Director of Estates and Facilities**	✓	✓	✓	A		✓	✓	✓	✓	✓	✓	A	**9/11**
Mr Tom Nettel	**Director of Workforce and OD**	✓	✓	✓	✓		✓	✓	✓	✓	✓	A	✓	**10/11**

Mr Frank Hennessy	**Director of Redevelopment Programme**	✓	A	A	✓		A	✓	A	✓	A	A	✓	**5/11**
Professor Tim Briggs	**Director of Strategy & External Affairs**	✓	A	A	A		A	A	A	A	A	A	A	**1/11**
Mr John Skinner	**Director of Research & Innovation Centre**	A	✓	A	✓		A	A	✓	A	A	✓	A	**4/11**
Dr. Zilla Huma	**Director of Children's Services**	A	✓	✓	✓		✓	✓	✓	✓	✓	A	✓	**9/11**
Mr Daryl Lutchmaya	**Trust Secretary / Head of Corporate Affairs and Governance**	✓	✓	✓	✓		A	✓	✓	✓	A	✓	✓	**9/11**
Ms Isabel Dolan	**Former Non-Executive Director**	✓	✓	✓	✓		✓							**5/5**
Dr Natalie-Jane Macdonald	**Former Associate Non- Executive Director**	✓	A	A	A		✓	A						**2/6**

Board Committees

The Trust Board is supported by nine Board Committees and an Auditor Panel:

- Audit Committee
- Auditor Panel
- Remuneration Committee
- Quality Committee
- Strategy and Sustainability Committee
- Executive Committee
- Finance Committee
- IM&T Committee
- Workforce and Organisational Development Committee
- Joint Academic Committee

The Trust Board Committees report to the Board through Committee Updates. The Trust Board is invited to discuss and to deliberate the Board Committees' work, actions arising and any recommendations and decisions made by them. Other than the Executive Committee, which is chaired by the Chief Executive, all Board Committees are chaired and attended by Non-Executive Directors.

Similarly, Sub-Committees and other Programme Boards which report to Board Committees and which are chaired by Executive Directors, escalate issues to their respective Board Committees through Sub-Committee Updates and minutes.

During the year, the Access Improvement Programme Board which was a 'task and finish' Committee of the Trust Board was retired. Its purpose was to ensure that RNOH delivered sustainable compliance with the national referral to treatment (RTT) standard.

The following Trust Board Committees and Auditor Panel have convened during this financial year:

Audit Committee 4 meetings

Remuneration Committee 1 meeting

Quality Committee 5 meetings

Strategy and Sustainability Committee 6 meetings

Executive Committee 51 meetings

Finance Committee 12 meetings

IM&T Committee 3 meetings

Workforce and Organisational Development 6 meetings

Joint Academic Committee 4 meetings

All the meetings of these Board Committees during the financial year have been quorate.

The Trust Board Committees have received delegated authority to scrutinise, monitor, and review and to make decisions within their terms of reference on behalf of the Trust Board. These Committees have been established on the basis of the following principles:

- the need for them to strengthen the Trust's overall governance arrangements and to support the Trust Board in the achievement of the Trust's strategic aims and objectives,
- the requirement for a governance structure that strengthens the Trust Board's role in strategic decision-making and supports the Non-Executive Directors to scrutinise and to challenge Executive Management actions,
- maximising the value of the input from Non-Executive Directors , and
- to support the Trust Board to fulfil its role, given the nature and magnitude of the Trust's wider agenda, to support background development work and to perform scrutiny in more detail than is possible at Trust Board meetings alone.

Board Review

During the year, a Board Review was performed. Board Reviews are used to provide the Board with feedback about the way it conducts its business and to seek ways of continuously improving. Other

than being good corporate governance practice, Board Reviews are a strong indication that an organisation is well-led. During 2017, the Board Review focused on the internal administration of the Board. The 2018 Board Review focused on the CQC's Well Led domain: "the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture". The questions were based on the CQC's eight Key Lines of Enquiry (KLOE) within the Well-Led domain and included the following questions:

1. Does the Board have the leadership capacity and capability to deliver high quality, sustainable care?

2. Does the Board have a clear vision and credible strategy to deliver high quality sustainable care to people, and robust plans to deliver it?

3. Is there a culture of high quality, sustainable care provided by staff to people using the services?

4. Is the Board satisfied that there are clear responsibilities, roles and systems of accountability to support good governance and management, delivery of the strategy and sustainable services?

5. Is the Board satisfied that there are clear and effective processes for managing risks, issues and performance?

6. Is appropriate and accurate information being effectively processed, challenged and acted on?

7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

8. Are there robust systems and processes for learning, continuous improvement and innovation?

The results of the review were extremely positive and indicated that the Board is satisfied with progress to date. Some follow up actions have been agreed by the Board and the Executive Team will be implementing them during 2018/19.

Audit Committee

- The Committee is chaired by a Non-Executive Director who is a finance professional and it includes two further Non-Executive Directors as members. External and internal auditors and the Local Counter Fraud professional are invited to attend all meetings. Executive members of the Trust are also invited to attend the Audit Committee meetings.
- During the year, the Audit Committee discharged its responsibilities including;
    - Reviewing the Annual Financial Statements and Annual Governance Statement, including meetings with, and a review of the planning and work of the External Auditor, Grant Thornton.
    - Reviewing the clinical and non-clinical internal controls of the Trust and scrutiny of reports from the Trust's Internal Auditor, RSM.
    - Reviewing the work and reports of the Trust's Local Counter Fraud resource, which is provided by RSM.

- Receiving and reviewing the Trust Board Assurance Framework documents and the underlying risk processes and requesting further work to ensure that the Trust's risk reporting systems were fit for purpose.
- Reviewing tender waivers, losses and special payments.
- Reviewing the effectiveness of the Audit Committee.
- Monitoring the process of implementation of management actions arising from Internal Audit Reports.
- Reviewing the Terms of Reference for the Audit Committee and of the Auditor Panel.

Remuneration Committee

- The Remuneration Committee is chaired by the Chair of the Trust Board and comprises the other Non-Executive Directors. It assures appropriate remuneration and terms of service for the Chief Executive, other members of the Corporate Executive Team and other senior employees (those who are not subject to the Agenda for Change agreement) to ensure that they are fairly rewarded for their individual contributions to the Trust; having proper regard to the Trust's circumstances and performance and in accordance with any national arrangements for such.
- The Remuneration Committee also oversees provisions for other benefits, including pensions and cars, season ticket loans; arrangements for termination of employment and other contractual terms.

Quality Committee

- The Committee is chaired by the Chair of the Trust Board and includes two further Non-Executive Directors. All Chairs of the Sub-Committees are required to attend the Quality Committee which meets bi-monthly.
- The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of quality including its delivery and governance, clinical risk management, information governance and the regulatory standards of quality and safety. It provides assurance to the Trust Board that the RNOH is a safe, effective, caring, well-led, and responsive hospital service.
- Two key responsibilities of the Quality Committee are to oversee an effective system for delivering a high quality experience for all its patients and service users, including carers, with particular focus on involvement and engagement for the purposes of learning and making improvements; and to oversee an effective system for monitoring clinical outcomes and clinical effectiveness. There is strong focus on ensuring that patients receive the best possible outcomes of care across the full range of the Trust's activities.

During the year the Quality Committee focussed on the following important areas:

- external Review into the Safeguarding function at the RNOH and Safeguarding Review Action Plan;

- steps to avoid breaching the 62 day pathway cancer target;
- review of the Spinal Cord Injury Tissue Viability pathway;
- work to ensure that junior doctors conducted more rapid reviews of patients and is now a part of their induction;

- The Committee recommended the Trust's Quality Account to the Board for publication in accordance with statutory requirements.
- The following Sub-Committees report to the Quality Committee:
  - Clinical Quality and Governance Sub-Committee;
  - Information Quality and Governance Steering Sub-Committee;
  - Children's Services Operational Group; and
  - Safeguarding Sub-Committee
  - There is a dotted reporting line to the Quality Committee relating to quality issues from the following Sub-Committees and Programme Boards:
    - Redevelopment Programme Board;
    - Improvement Programme Board;
    - Children's Services Development Strategy Sub-Committee;
    - Cancer Strategy Sub-Committee; and
    - Private Patient Development Sub-Committee.

The reporting Sub-Committees and Programme Boards provide regular accounts of the operational performance of the Trust to the Quality Committee. Performance Balanced Scorecards are presented to it for scrutiny and discussion and patient stories are presented to assure Board to Ward oversight.

Strategy and Sustainability Committee

- The Strategy and Sustainability Committee is a 'whole of Board' Committee responsible for the oversight and review of the Trust's medium to long term strategies, Representatives from NHS E and NHS I are invited to attend. The Committee is chaired by the Chair of the Trust Board.
- The Committee has oversight of the delivery of the Trust's strategies and major strategic projects, and has responsibility for reviewing the development of future organisational sustainability strategies, programmes and plans.
- During the year, the Strategy and Sustainability Committee has considered the following;
- Reports relating to change initiatives from the Improvement Programme Board;

- Sustainability and Transformation Plans (STPs) and partnership working;
- national tariffs and the challenges relating to a specialist hospital;
- GIRFT; and
- the Stanmore redevelopment;

Executive Committee

The Executive Committee, which is chaired by the Chief Executive has delegated powers from the Trust Board to oversee the day to day management of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical). It is responsible for reviewing, approving and monitoring the Trust's performance against strategic risks, key targets, business plans, CQC Outcomes and other corporate objectives. It also supports the achievement of the organisation's objectives and monitoring of strategic risks within the Board Assurance Framework.

The Executive Committee also ensures that governance and assurance systems are operating effectively, thereby underpinning clinical care. In order to achieve this, the Committee agrees strategies, policies and plans to ensure that the Trust has a proper system of controls in place to deliver this.

During the year, the Executive Committee agreed business cases within the business plan in line with the delegated authority of the Chief Executive Officer and that of the Director of Finance and as per the Scheme of Delegation. The Committee has continued to work extensively on developing the RNOH's 5 Year Strategy and the associated workstreams that will deliver on its strategic aims and organisational objectives.

Finance Committee

The Finance Committee is chaired by a Non-Executive Director who has a finance background and its membership includes a further Non-Executive Director, the Chief Executive Officer and the Director of Finance.

The Committee provides assurance that the Trust has a robust understanding of key financial issues to enable sound decision-making. The Committee conducts detailed consideration and oversight of the Trust's financial position, including activity and productivity.

During the year the Finance Committee has considered the following matters;

- monthly actual and forecast financial performance;
- the cashflow consequences of operating with a deficit as a result of tariff pressures;
- the financial risk and delivery of Cost Improvement Plans;
- the Board Assurance Framework and the Performance Balanced Scorecard relating to financial matters;

- undertaken a review of the effectiveness of the Committee;
- reviewed its Terms of Reference;
- a review of the 2018/19 business plan.

IM&T Committee

The IM&T Committee is chaired by the Vice-Chair of the Trust Board. An Associate Non-Executive Director is also a member of the Committee. The purpose of the IM&T Committee is to provide oversight on behalf of the Trust Board for the implementation of the Trust's Digital Strategy and the governance and management of the Trust's Information Technology infrastructure and to deliver on relevant projects.

During the year, the Committee has:

- reviewed the progress of IM&T Projects and matters affecting the overall Directorate;
- considered risks to the Trust IM&T Infrastructure including Cyber Security weaknesses and approved action plans where appropriate;
- ratified various policies that expired during the year; and
- Considered the IM&T Business Plans.

Workforce and Organisational Development Committee

The Workforce and Organisational Development Committee is chaired by the Vice-Chair of the Trust Board. It is responsible for ensuring that effective workforce enablers are implemented to facilitate the delivery of the Trust's strategic goals, drive high performance and quality improvement and to deliver the Organisational Development Strategy.

During the year, the Committee has considered the following;

- Workforce key performance indicators with a particular focus on appraisals, staff turnover and vacancies;
- WRES Action Plan;
- Staff Survey results for 2017; and
- Staff experience and the delivery of the Trust's Staff Experience Strategy.

Joint Academic Committee

The Joint Academic Committee is chaired by a Non-Executive Director.

The purpose of the Joint Academic Committee (JAC) is to oversee on behalf of the Trust Board, the implementation of the Trust's vision for Academic activities and the delivery of joint vision of research and education within the Stanmore Campus. During the year the Committee considered the following:

- continued increase of National Institute of Health Research (NIHR) Portfolio studies which are both RNOH led and RNOH hosted;
- delivering Research and Innovation Centre Strategy, and
- review of standard operating procedures (SOPs) and Working Practice Documents (WPDs) to support safe delivery of studies.

Quality Governance

The Trust has robust arrangements in place to seek and to provide assurance on the clinical quality and safety of care provided at RNOH and this is described above in the Quality Committee and its Sub-Committees' structures.

The Clinical Quality Review Meeting provides assurance to external stakeholders including Commissioners, NHS I and NHS E. The Director of Nursing, Quality and Patient Experience and the Medical Director and the Deputy Director of Quality are members of the Group.

Other mechanisms to ensure quality within the Trust include;

- Having a Director of Nursing, Quality and Patient Experience in post who is the Executive lead for quality governance and oversees the work relating to clinical governance, quality assurance and compliance.
- Risk management structures for the identification, reporting and management of risks which may impact quality of care.
- A dedicated Quality Team which works with the Clinical, Operational and Corporate teams to manage Patient & Staff Safety; Patient Experience & Involvement; Clinical Effectiveness; Regulatory Compliance and Emergency Planning, Resilience and Response.
- Development of a monthly Quality Report and scorecard system covering Trust wide and divisional performance in relation to Quality.

The Clinical Audit function within the Trust ensures participation in national clinical audits as well as ensuring that local audits are completed on key priority areas. Key areas of focus for clinical audit during 2017/18 have included WHO surgical safety checklist compliance, Consent Audit, End of Life Care, National Surgical Site Infection Audit (GIRFT), Gastrostomy Care Audit, Combined Nursing Audit, Hand hygiene, Vascular access, Environmental spot checks and safety thermometer.

e. RISK ASSESSMENT

The Trust Risk Register is a composite of risk information across all of its activities. It includes clinical, quality, organisational and operational risks. An overview of this process is included in the Risk and Control Framework section in this Annual Governance Statement.

The RNOH Trust Board is committed to leading the organisation to deliver quality services and excellent patient outcomes and recognises that embedded risk management is an essential feature

to achieve this. The Audit Committee and Quality Committee assist the Board in identifying whether risk processes are adequate, and in overseeing the required improvements.

The Trust Risk Register is used to inform the Board Assurance Framework which identifies and quantifies all risks that might compromise the organisation's ability to meet its strategic objectives. At the strategic level, the organisation's risk profile is monitored by the Trust Board at each meeting through the Board Assurance Framework (BAF). The BAF assesses the major internal and external risks which could impact on the Trust's ability to deliver its strategic objectives. Each risk is owned by an Executive Director who is responsible for the controls and mitigating actions to manage the risk. Implementation of the mitigating actions is reviewed on a monthly basis with summary updates provided to the Board. Although the BAF is populated by the Executive Directors' knowledge of their own directorate risks and those from the Trust Risk Register, work is still underway to record all of the risks in one place and to systemise the risk management process into the Trust Risk Register.

A summary of the Trust's strategic risks as contained in the BAF as at March 2018 are as follows:

Board Assurance Framework	Residual Risk	Overview
SR(a) Inability to maintain excellent quality standards for patients (Adult Nursing)	**12**	▪ Recruitment of key clinical staff continues to be challenging. The national workforce issues suggest that this is likely to be a long term risk for the Trust. Data suggests that planned versus actual staffing levels for nursing are at an acceptable level, although this is often supported via use of temporary staff. ▪ Learnings from two recent Serious Incidents has translated into a number of actions including the introduction of a medical emergency team, training, enhanced audit, improvement in sepsis management and an enhancement of IT systems. ▪ The transition to the SWLP pathology service is being managed through stricter contract management procedures to manage key issues and risks.
SR(a) Inability to maintain excellent quality standards for patients **(Children's Services)**	**12**	▪ Estates issues continue to be a problem for the inpatient ward as still awaiting the new build. ▪ A Business Case for medical cover has been ratified and we are now recruiting to substantive consultant posts to improve onsite cover and to develop sub-speciality paediatric work which will fund these posts. ▪ Closer working with the Sarcoma team is addressing the gaps which were identified by last year's two Serious Untoward Incidents.
SR(b) Inability to deliver service activity levels	**12**	Risks to the sustained delivery of the RTT standard include:

		▪ Clinical staff leave patterns which is being addressed through a Leave Policy which is being implemented by the Divisions, ▪ Barriers to improved chronological booking, including case mix complexity and experience levels of new consultant surgeons. Mitigation includes a focus on chronological booking. ▪ Absence of key surgeons as a result of either health problems or resignations who are difficult to replace.
SR(c) Inability to deliver programmes and to increase capacity	**12**	▪ "Perfect Theatre Week" in September delivered improved utilisation due to earlier starts. A Theatre Action Group was set up in October to drive further improvements to intra-session utilisation and the take-up of vacated sessions. ▪ The Length of Stay Steering Group is driving steady progress against its objectives and several pilots of improved practice are underway.
SR(c) Inability to deliver programmes and to increase capacity	**12**	▪ Safer Staffing formal project is in place as part of the Improvement Programme with governance and monitoring in place. Progress is measured by the achievement of agreed project milestones which are on track. ▪ Job plans are being uploaded on to the IT software – Allocate. ▪ A Local Negotiating Committee has agreed the job planning and consultant leave guidance which is being implemented via the Medical Staff Committee and Divisional Leadership Teams.
SR(d) Inability to realise benefits from organisational development programme	**12**	▪ OD Strategy KPIs performing well and on track. ▪ Workforce KPIs have seen ongoing improvement (month on month) which suggests the impact of OD programme is beginning to deliver measurable improvements. This was supported by significantly improved staff survey results in 2016. However these are offset by no improvement in scores related to bullying and harassment, and equality and diversity. These remain areas for concern and represent significant focus of projects in 17/18. ▪ Governance and grip over workforce spend remains work in progress with a significant focus on additional sessions in medical staffing supported by job planning guidance and leave policy implementation.
SR (e) Milestones for enabling projects	**8**	▪ The NHS Phase 1 New Inpatient Ward Block

aimed at realising benefits of the redevelopment programme are not delivered on time		(NIWB) is due to be completed and be ready for occupation in October 2018. There are 11 further phases to complete with the next of which will focus on the vacation of the Western Development Zone (WDZ) for disposal in March 2021. Failure to achieve the vacant possession by this date will result in a delay in disposing of the land and a delay in re-paying the short term loan to part fund the first phase building. ▪ The Operational Planning and Commissioning for the NIWB is critical for the opening of the NIWB and the transfer of 91 NHS and the Private Services Inpatient beds to the new facility. Initial meetings have taken place with the Double Triumvirate to agree the planning structure for this work. The Transitional budget has been set for this work which will see resource allocated to complete the plan and the production of Operational Policies for use in the new building. The Plan will also confirm transfer arrangements and operational commissioning of the building as a whole involving all RNOH functions. The Operational Planning and Commissioning work stream is underway and the Trust has appointed a Clinical Commissioning Manager to lead the clinical aspects of the plan. Draft Operational Policies and Plans are in place and under consultation and regular review. Task groups have been established for each function and regular meetings are now progressing the operational commissioning planning processes.
SR (e) Milestones for enabling projects aimed at realising benefits of the redevelopment programme are not delivered on time	**12**	▪ The postponement of the development of the Biomedical Engineering Hub (BEH) has presented the Trust with a challenge as two major occupiers of the WDZ were to be re-accommodated as a result of the BEH development. In addition, 350 car parking spaces, staff residential blocks and a number of minor occupiers have to be relocated off the WDZ. The Redevelopment and Estates and Facilities Teams are planning all necessary projects to deliver a vacant WDZ in line with financial control totals agreed with NHSI. ▪ The BEH project is being re-evaluated in the light of a reduced budget and the Trust awaits the outcome of this evaluation. The site Masterplan has been reviewed in the light of the postponement of the BEH delayed development. Interdependent projects comprise the relocation of 450 car parking spaces, two staff residential

		blocks, Prosthetics and Orthotics functions, vacation of UCL space used for Biomedical Engineering and some minor occupiers of the WDZ to the retained estate. ▪ Failure to deliver the series of projects listed above will delay the disposal of the WDZ land and the capital receipt resulting from disposal to part fund the NIWB project and the repayment of a short term loan.
SR(f) Failure to develop a Digital Strategy to achieve the expected benefits from technology	**16**	▪ CareCert (NHS Cyber security service) and NCSC (National Cyber Security Centre) have informed Trust CEOs and Boards of the increased threat of Cyber attacks affecting the UK infrastructure. ▪ The Trust's Cyber Security Action plan includes recommended actions that the Trust can take to protect itself.
SR(g) Failure to maintain financial control and achieve agreed activity levels	**12**	▪ For 2017/18 the Trust is £9,680k better than the revised financial plan, and £2,986k ahead of the control target year-to-date. The most significant movements are the deferred impairment associated with WDZ £6,232k, and £1,493k received as incentive STF as a pound for pound benefit from doing better than the control total. ▪ Year to-date-capital expenditure to the end of March is £32.8m of which £29.5m relates to the New In-patient Ward Block (NIWB) and Western Development Zone decant works. Capital expenditure year-to-date is £10.8m less than plan. ▪ The CIP Target for 2017/18 is 4,828K. The total Identified CIP in March is £3,367K; this leaves an unidentified gap of £1,461K. The unidentified CIP value is an accumulation of the divisions that have not identified enough CIP schemes to meet their CIP target.
SR(g) Failure to maintain financial control and achieve agreed activity levels	**12**	▪ The Audit Committee has approved the 2017/18 year-end External Audit plan, the 2018/19 Internal Audit plan, and the 2018/19 Local Counter Fraud Service plan. ▪ The draft internal audit opinion for 2017/18 is amber/green, with reports on the Board Assurance Framework and Temporary Staffing to be received. ▪ On behalf of NHSI, E&Y have recently issued a Costing Transformation Programme Post Submission Assurance Report 2016/17 which was rated Substantial Assurance (green). This supersedes the previous amber/red report.

SR(h) Failure to increase income from non-NHS sources	**16**	▪ This is measured by achievement of Private Patient income growth targets and overall proportion of NHS: Non NHS income. ▪ 2017/18 private patient continues to grow relative to previous years. ▪ 2017/18 overall increase of 2% in proportion Non-NHS Income year on year as a proportion of total income. ▪ 2017/18 year to date private income is behind plan with significant risk that the forecast growth target for 2017/18 is not met, primarily due to individual consultant absences and lack of ring fenced theatre capacity expansion. ▪ A Private Patient Business Plan has been agreed for 2017/18. An independent review of Private Patients income capture and pricing controls to maximise income was completed by Monmouth March 2017. Implementation of enhanced controls is being monitored by the Private Patient Development Steering Group
SR(h) Failure to increase income from non-NHS sources	**16**	▪ Measured by achievement of R&D income growth targets, elimination of financial subsidy from NHS income for R&D expenditure and overall proportion of NHS: Non NHS income. ▪ Recruitment into NIHR research trials, commercial trials, and 100k genomes project are at an all-time high. ▪ Key next step component of the R&D strategy is a stepped increase in post market devices surveillance for commercial trials to meet the 2017/18 increased income target. Additional BRC funding of £180k has been notified to RNOH and ongoing dialogue with multiple academic partners on non-commercial and commercial trials continues. Year to date delivery and forecast income delivery is in line with plan.
SR(i) Failure to develop relationships and partnerships to help achieve Trust vision	**12**	▪ Key external stakeholders from which this measurement assurance is available are NHS I, NHS E, CCGs, CQC, Department of Health, etc. ▪ This range of stakeholder perspectives currently available will be formalised into a formal external stakeholder map and alignment with RNOH strategy will be monitored by the Strategy and Sustainability Committee from 2018/19. ▪ The RNOH Sustainability plan which has been drafted continues to be developed in parallel with local and national orthopaedic Sustainability and Transformation Plans being led locally by North Central London STP and Nationally by NHS England.

SR(j) Failure to develop financially viable integrated clinical research activities and academic track record	**16**	▪ The recent developments in the BEH building, potentially represents a serious risk to developing and embedding education and research capabilities at the RNOH.
SR(j) Failure to develop financially viable integrated education, training and development, track record	**12**	▪ The Senior education leadership is in place and has enabled the draft education strategy to begin again. This includes review of income generating courses.

Risk registers are dynamic documents which are populated through the organisation's risk assessment and evaluation processes. In order to support the overall Trust-wide risk management process, work continues to ensure that local Clinical and Operational teams are supported to locally identify, assess, and manage and to escalate risks using the Trust's Risk Register process.

There are currently 30 risks on the risk register on Safeguard across all divisions with a residual risk score of 15 and above.

Some of these risks are around

- Achievement of the RTT 18 week target
- Concerns around Nursing and junior doctors vacancies
- Risks around achievement of the General Data Protection Regulation (GDPR)
- Risks around the Accessible Information Standards
- Risk around Emergency Preparedness Standards

The Trust reviews the actions and mitigation arrangement for each of these risks as described in our risk management policy and risk management approach.

Incident Reporting

When an incident is reported and it meets the Serious Incidents (SIs) criteria, the incident is highlighted by the patient safety team to the Director of Nursing, Quality and Patient Experience, Medical Director and Chief Operating Officer for confirmation. The Trust process in reporting incidents is through the Safeguard reporting system which is monitored by the Patient Safety team. Learning themes are shared at the Quality Improvement and Lessons Learned meeting (QUILL) and the Patient Safety team works with the services to support with investigating the root cause analysis report and to ensure local ownership of actions are implemented from investigations.

During the last financial year (1st April 2017- 31st March 2018) one Never Event and 24 Serious Incidents occurred and were reported.

There is a dedicated PALS and Complaints team who are based in the Outpatients departments at the Stanmore Hill Site. Lessons learned from complaints are routinely included in the monthly Quality Report to promote wider learning.

During 2017/18, the Trust reported one Information Governance Level 2 SIRI (serious incidents requiring investigation) to the Department of Health and the Information Commissioner's Office.

Date of Incident	ID	IG SIRI Level	Status	Date of Closure	Breach Type	Volume	Format	Summary of Incident
26/06/2017	IGI/8038	2	Closed	20/12/2017	Unauthorised Access/Disclosure	Information about 501-1,000 individuals	Digital	Information about individuals and sensitve commerical information relating to the RNOH was sent to an employee's personal Hotmail email account. The transfer was organised into folders and emailed using remote access whilst outside of business hours. The employee has since left the Trust.

The incident highlighted concern around the ease with which staff can send confidential material to their personal email accounts. As a result, the Trust tightened up the Mailmarshall software to limit the size of files that can be emailed from the Trust's servers. Information Governance training that will be offered to RNOH staff during 2018/19 will have particular focus on the General Data Protection Regulations (GDPR) and the confidentially and security of digital information.

The Trust is pleased to announce that it achieved a level 2 in its Information Governance Toolkit for 2017/18. The intention is for the Trust to develop a stronger Information Governance framework during 2018/19.

f. THE RISK AND CONTROL FRAMEWORK

- The Quality team (Nursing, Quality & Patient Experience Directorate) is the custodian of the Trust's clinical and operational risk management process, ensuring that the process is effectively managed and monitored and that Trust staff are trained, supported and have editorial control over the Trust Risk Register.

This is an overview of how the risk and control process works:

- Identification of risk(s) by an individual or a team in the department where hazards or concerns are identified as threatening the delivery of its operation or objective(s). This may include incident reports, complaints, claims, external reviews, external recommendations and guidance, financial challenges, underperformance against internal and external metrics etc.
- Analysis and documentation of the risk is undertaken by a local manager in consultation with the Quality Team.
- Each risk has an allocated owner who is responsible for ensuring that appropriate action is taken to mitigate the risk.
- The local risk register (a document comprising all relevant operational risks) is reviewed by the relevant departments and risk scores are assigned for clinical and operational risks. The progress of actions towards mitigation of these risks is reviewed and updated in a frequency which is determined by their severity (as per the Risk Management Policy).
- In the event that a risk highlights a strategic risk i.e. one which threatens the organisations ability to achieve its stated aims or objectives or is graded as 15+ ('red'), this is then escalated as per the Risk Management Policy. Consideration will be given to changing the 'risk owner' to reflect the severity of the risk.
- Risks which are placed on the risk register are reviewed at regular intervals depending on the severity of the risk.
- Risk register and action plan progress reviews take place at a series of local and Trust wide meetings, including Divisional, Operational and Executive Leadership Team meetings, Clinical Quality and Governance Sub-Committee, Board committees including the Quality Committee and at the Executive Committee meetings.

Work is still being undertaken to ensure that the Trust Risk Register is fully populated for clinical and operational risks to better inform the Board Assurance Framework by ensuring that any dependencies are mapped between them and that there is a clear line of sight between Trust Risk Register and strategic risks on the BAF.

The Trust Board is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to NHS organisations. This includes the development of systems and processes for financial control, organisational control, governance and risk management.

Board members are responsible for ensuring that the systems, policies and people that are in place to manage risk, are operating effectively, focused on key risks and driving the delivery of objectives.

Executive Directors are accountable and responsible for ensuring that their Directorates and corporate functions are implementing the Risk Management Strategy and related policies. Each Executive Director is accountable for the delivery of their particular service.

The Chief Executive Officer is the Accountable Officer of the Trust and as such has overall accountability and responsibility for ensuring that the Trust meets its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of Governance. This responsibility also encompasses risk management, health and safety, financial and organisational controls. The Chief Executive Officer, supported by the Trust Secretary, is the lead for maintaining the Board Assurance Framework and its supporting processes.

Executive Directors are responsible for ensuring that the Board Assurance Framework and the risk management reporting timetable are delivered to the Board. Regular reporting and oversight of the key strategic risks to the organisational objectives is achieved through the compilation and submission of the Board Assurance Framework at each Board meeting.

The Director of Nursing, Quality and Patient Experience has delegated authority for the clinical and operational risk management framework including its training.

The Risk Management Policy also defines how risks are linked to one or more of the Trust's objectives. Once a risk has been identified, it is described and assigned an owner. At this stage, key mitigation controls that are to be taken to reduce the likelihood of the risk happening, or reducing its impact, are stated.

The Risk Management Policy provides detail about the levels of authority that staff have to manage risk. The authority which individuals have is appropriate to their grade; and training is provided by them covering risk assessment and investigation techniques relating to adverse events.

Corporate induction is compulsory for all new starters and includes sessions on risk management and information on aspects of internal control such as clinical and non-clinical risk, corporate governance, health and safety. A summary of the policy is provided to staff during their induction and the entire document has been distributed to all wards/departments and is also available on the Trust's website.

The mitigation of risk and its associated training has been identified across the organisation through the development of a schedule of statutory and mandatory training for staff. Staff are required to receive training and refresher training as set out in the Trust's Training Needs Assessment. This is a fundamental and critical step to implementing risk mitigation.

Training is provided to all staff by formal in-house workplace training sessions, and also through arrangement with the Quality Team. Other arrangements to facilitate the mitigation of risk also include the Local Risk Management Handbook, which is available within all wards and departments.

g. REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

As Accountable Officer, I have the 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 trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in 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 Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have also relied on the Head of Internal Audit's opinion when reviewing the effectiveness of internal control. In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on

the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the following:

- External Auditor's value for money assessments
- Achievement of new and existing performance targets
- Financial performance and achievement of financial targets
- NHS London risk ratings
- Internal and External audit reports
- Counter fraud reports
- Reviews of tender waivers
- Declarations on the register of interests and hospitality register
- Audit Committee
- Serious untoward incident progress reports to the Quality Committee
- Infection control reports to the Board
- Compliance with NICE guidance
- The Trust's participation in national clinical audits
- The Trust's performance against NHS peers through the Strategic Orthopaedic Alliance
- Reviews of clinical negligence claims
- Analysis of complaints and Trust response times
- An effective whistle blowing policy and process

In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement.

During the year, Internal Audit undertook a number of reviews. Positive assurance opinions rated as "Substantial Assurance" were issued with respect to Accounts Receivable and Fixed Assets and "Reasonable Assurance" with respect to Freedom to Speak Up, Board Assurance Framework, Backlog Maintenance and Ward Visits. "Advisory Opinions" were issued for the reviews performed on the General Data Protection Regulation (GDPR) and on the Information Governance Toolkit pending further developments. As of the end of March 2017, the Trust achieved a Level 2 in the IG Toolkit. Preparatory work is ongoing to implement the General Data Protection Regulations (GDPR) at the Trust by 25 May 2018.

The Lessons Learnt review received a rating of "Partial Assurance". The review identified a high proportion of missing action plans for complaints and incidents and corrective actions which were overdue. As such, without action plans in place, there was limited evidence of lessons learnt. There were instances where there was a lack of oversight of Root Cause Analysis investigations and a lack of regular thematic review of incidents and complaints, which further prevented lessons from being drawn from the incident/complaint. Furthermore, high risk incidents and complaints were not captured on Risk Registers. The Trust is expanding on the Complaints Policy to outline responsibilities for the analysis of lessons learned across divisions. Additionally, the policy will be updated to ensure that within the Monitoring section, there is a clear reference to the identification and communication of lessons learned and the methods available to staff to do this.

The Temporary Staffing review is due to be reviewed in the summer of 2018.

The Head of Internal Audit opinion for 2017/18 is that the organisation has an adequate and effective framework for risk management, governance and internal control. The opinion stated that there are further enhancements required to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. An Internal Audit Strategy and action plan has been agreed and further work in this area will form part of the 2018/19 audit plan.

The Statutory Breakeven Duty was not achieved in 2016/17 and the External Auditors notified the Secretary of State through the issue of a Section 30 report. This duty is interpreted as requiring breakeven over a 3 year period. The Trust has a deficit outturn in 2017/18 so has not achieved the Statutory Breakeven Duty in this financial year.

During the year, the Audit Committee reviewed how it gained assurance from management in relation to fraud, internal control, ethical behaviour and compliance with regulations:

a) The Trust assesses the risk of material misstatement in the financial statements due to fraud:

- Internal audit conduct an annual schedule of planned internal audit work including consideration of the core financial systems which provide the information used to prepare the financial statements, on a rotational basis. The outcome of these audits has been satisfactory.
- The Trust outsources LCFS to an external firm to provide expertise, and there has been no evidence of material actual or potential fraud during the year.
- External audit undertake a systems audit to test the design and effectiveness of internal controls over the financial reporting process and to identify areas of weakness that could lead to material misstatement. They also test whether the controls have been implemented as intended. The external audit work in this area dovetails with the testing undertaken by internal audit.
- Monthly financial statements are reviewed each month by both the Finance Committee and the Board, so any significant adverse variances can be discussed and explanations sought.
- Control systems within the Trust ensure that there is appropriate segregation of duties within the Finance Department in order to reduce the risk of fraud.

b) The Trust uses the following processes to identify and to respond to risks of fraud:

- Proactive and reactive fraud prevention and investigation is undertaken by the Trust's outsourced Local Counter Fraud Service (LCFS) provider, RSM. This includes a slot on the induction programme for new staff, and a visible presence within the Trust through both

physical presence and articles in the Trust newsletter, as well as a counter fraud week each year.

- Internal audit review of financial systems, which includes testing the design, efficacy and compliance with controls, including those which are intended to prevent fraud. Internal control weaknesses and control breaches identified by internal audit are reported to management and the Audit Committee. Internal audit also test if recommendations arising from each audit have been implemented, and report their findings to management and the Audit Committee.
- The LCFS produces regular progress reports to the Audit Committee that include local and national emerging risks as well as progress in accordance with the workplan. Regular liaison meetings with senior staff is undertaken and evidenced in the form of agendas and minutes. As part of the review of the Annual work plans for Internal Audit and LCFS, the current level of risks and issues in from of the Audit Committees is discussed in depth and these discussions form part of the planning of work for the year ahead.
- During the year, weaknesses have been identified in the Trust's risk reporting framework and these are being addressed. There has been no evidence that these weaknesses indicate increased risk of potential overstatement to the financial statements as a result of fraud and this is consistent with information obtained from Internal Audit and LCFS.

c) Where specific fraud risks, or areas with a high risk of fraud have been identified, the following is done to mitigate these risks:

- All intelligence reports from NHS Protect and fraud alerts with emerging risks received from other LCFSs are, where relevant, disseminated to the organisations relevant contact/department in order to highlight, prevent and detect potential areas of weakness. Local pro-active exercises (LPEs) were undertaken during the year. The findings are reported to the Director of Finance, management of the relevant department(s) and the Audit Committee. All management comments in respect of highlighted risks are tracked, monitored and reported to the Audit Committee for compliance purposes.

d) There aren't any areas where there is a potential for misreporting:

- It is considered that there are no areas which have significant risk of material misreporting. This view reflects the assurance gained from reports from internal audit on the key financial systems as well as reports received from Grant Thornton on the outcome of testing undertaken during interim statutory audits.

e) The following arrangements are in place to report fraud issues and risks to the Audit Committee:

- The LCFS produces an update report to each Audit Committee which incorporates :
    - work undertaken on actual/suspected frauds
    - a description of new actual or suspected frauds
    - considerations of emerging fraud risks
    - Update on progress of management actions
- The LCFS reviews fraud risks in the LCFS annual report to the Audit Committee.
- The Trust alongside the LCFS produces and submits an annual SRT declaration to NHS Protect in accordance with the NHS Standards for Providers. This is authorised by Director of Finance and the results are reported to the Audit Committee.
- There is evidence that this responsibility is discharged effectively. Anti-fraud, bribery and corruption objectives are discussed and reviewed at a strategic level within the organisation and this is documented through regular liaison meetings with Director of Finance and other senior employees.

- The Audit Committee evaluates the LCFS function on an annual basis via a questionnaire and comments on performance are fed back during Audit Committee meetings. Where additional or corrective action is necessary, this is discussed and the appropriate actions taken and documented.

f) The Trust communicates and encourages ethical behaviour of its staff and contractors as follows:

The following policies are in place and are available to all staff via the Trust's intranet:

- Conduct Policy
- Anti-fraud and Bribery Policy
- Declaration of Interests Policy
- Losses and Special Payments
- Sponsorship and Fundraising policy
- Whistleblowing Policy

Members of staff and off-payroll contractors are required to adhere to these policies.
All new employees at the Trust receive presentations on counter-fraud and anti-bribery as part of the Trust's induction programme. This is presented by the LCFS.

There are also joint working protocols in place between the LCFS and the following functions to encourage and promote effective working:

- LSMS;
- HR
- Communications
- Metropolitan Police Service

g) The Trust has the following arrangements in place to prevent and detect non-compliance with laws and regulations:

- All staff are required to work within the framework of the Trust's policies and procedures which have been drafted to ensure compliance with relevant laws and regulations. Any failure to comply is a disciplinary offence.

- The Trust's advisors, in particular its internal auditors, advise management of new legal requirements with which the Trust must comply.

- Any non-compliance with laws and regulations would be reported to management through the Trust's incident reporting system.

- The systems for maintaining the Board Assurance Framework ensure that any significant non-compliance with laws and regulations would be made known to management. The risk reporting processes within the Trust are currently being improved to give better quality assurance and to embed processes more efficiently.

h) The Audit Committee is provided with assurance that all relevant laws and regulations have been complied with as follows:

- Inspection of the Trust by the CQC checks compliance with the essential standards of quality and safety required by legislation. Any significant adverse issues resulting from the CQC review would be reflected in the Board Assurance Framework which is presented to every Audit Committee.

- Legal or regulatory cases, where they arise are (and have been) reported to the Board where applicable.
- A report of all losses and special payments is presented to every Audit Committee.
- The Trust's advisors, in particular its internal auditors, advise management and the Audit Committee of new legal requirements with which the Trust must comply.
- Potential legal cases against the Trust have been discussed at the Board during the year. The Board has not been made aware of any other specific instances of non compliance with law and regulation.

i) The Trust has the following arrangements in place to identify, evaluate and account for litigation or claims:

- Reports are received at every Audit Committee setting out losses and special payments. Trust management also receive letters from the Trust's legal advisors in April/May setting out any litigation claims against the Trust at the end of the financial year. Any significant litigation claims notified in these letters will be included in the losses and special payments report to the May Audit Committee at which the draft financial statements are considered.

Based on the work undertaken by the Head of Internal Audit on the Trust's system on internal control, I do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement.

Signed ..... Chief Executive Officer

25/05/18

Date.....

h. NHS PROVIDER LICENCE

NHS Trusts are required to self-certify that they comply with Condition G6 and Condition FT4 of the provider licence which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution.

The Board's schedule of business and reporting cycle allows for good corporate governance practice. The Trust's Standing Orders have been reviewed during the year and regular Board and Committee reports about the organisation's establishment, recruitment and retention initiatives, safe levels of staffing and succession management and leadership training are also received. The Board Committee Structure has been regularly updated during the year and Committees' Terms of References have been or are being reviewed on a regular basis. The Board is satisfied that the Trust has established and effectively implements systems and processes as evidenced in the Annual Governance Statement, Quality Account and the Annual Report all of which document compliance with the regulatory requirements. There are regular Board and Sub-Committee meetings which undertake reviews of planned work and include

regular oversight of performance information, financial information and the BAF. Robust external and internal audit processes have confirmed that there are not any material concerns about key internal controls and processes.

Quality issues are standing items on Board agendas by way of reports from the Quality Committee and/or substantive items being presented to it. The Quality Committee is a Board Committee which meets every other month to consider and to oversee quality issues. It also receives an Integrated Quality Report. There is an established governance framework below the level of the Quality Committee which considers clinical and quality governance and information governance. The Board receives frequent reports from the Patient Group at its meetings and patient involvement and experience is gauged by surveys and other forms of feedback.

i. CARE QUALITY COMMISSION

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

j. SINGLE OPERATING FRAMEWORK 2017/18

On 1 April 2016, NHS Improvement (NHS I) became the operational name that brought together Monitor and the NHS Trust Development Authority (TDA). The specific legal duties and powers of both Monitor and the TDA continued under the NHS I. The Single Oversight Framework sets out how NHS I oversees NHS trusts and NHS foundation trusts. It is designed to help NHS providers to attain and to maintain the Care Quality Commission's ratings of 'Good' or 'Outstanding'. The framework applied from 1 October 2016 and replaced Monitor's Risk Assessment Framework and the TDA's Accountability Framework. The Single Oversight Framework works within the continuing statutory duties and powers of Monitor with respect to NHS Foundation Trusts and of TDA with respect to NHS trusts.

The five themes of the Single Oversight Framework include:

- Quality of care (safe, effective, caring, responsive);
- Finance and use of resources;
- Operational performance;
- Strategic change; and
- Leadership and improvement capability (well-led).

By focusing on these five themes, NHS I aims to support providers to improve, attain and/or maintain a CQC 'good' or 'outstanding' rating.

Under the Single Oversight Framework, NHS I categorises providers into segments based on the level of support that each provider needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability. The RNOH has been categorised in the second from highest segment. There are four segments. This segment offers providers targeted support where there are concerns in relation to one or more of the themes.

The Trust publishes a monthly Balanced Scorecard which measures key performance data across seven key areas; Clinical Quality, Access to Services, Workforce, Research and Innovation, Information Management and Technology, Finance and Children's Services and uses this as a tool towards monitoring performance towards achieving the Single Oversight Framework. Performance is monitored and reviewed on a monthly basis and is considered in detail at the Executive Committee, Quality Committee and at the Trust Board. Where performance is considered to be below a standard, action is instigated to remedy the performance.

k. USE OF RESOURCES

The RNOH has established processes and governance systems to ensure that the Trust Board and its Board Committees are focused on high quality sustainable care, improved outcomes for patients and ensure that resources have been used economically, efficiently and effectively. The Trust Balanced Scorecard encompasses a wide range of key indicators which are used monthly by the Board, its sub committees and by the Executive Team to monitor performance. The Trust Board, Quality Committee and Executive Team scrutinise quality dashboards regularly; workforce metrics are reviewed in detail by the Board, Workforce and Organisation Committee and by the Executive Team; and finance performance is considered by the Board, the Finance Committee and by the Executive Team. A programme of internal audits is agreed by the Trust's Audit Committee which evaluates a wide range of clinical and corporate support services and the results are reported to the Audit Committee which also monitors progress against actions.

The Trust is able to demonstrate that it has used resources economically, efficiently and effectively. During 2017/18, the Trust achieved its financial targets and spent £1.1m less on agency than the ceiling set by NHS Improvement. Other achievements include e-rostering, which was successfully rolled out to all nursing staff in the Trust. This included both prospective rostering of staff duties, safecare monitoring of daily staffing demands and the approval of unsocial hours payments via payroll. Significant manual controls for nurse staffing were in place prior to the roll out of e-rostering however the system will ensure that these systems are more efficient, less time consuming and will ensure that financial control can be maintained in relation to nurse pay budgets during 2018/19 and beyond. During the year, the organisation undertook a review of its spinal services in line with GIRFT methodology and with GIRFT support.

Another key strategic priority for the Trust is its Stanmore site redevelopment projects, which will modernise and improve our facilities in a reduced footprint, releasing surplus land in the process. This programme of work is overseen by Trust Board, the Redevelopment Programme Board and the Executive team.

The Trust delivered significant progress for the second year in its Staff Survey:

- The RNOH however has improved in 23 of 32 key findings, often significantly.
- In 3 of the Key Findings, the Trust had the best score of any Acute Specialist Trust (AST) in the country. The Trust was also very close to the best score in 4 other key findings – just 0.2% behind.
- The Trust was above average when compared to other Acute Specialist Trusts on 17 of the 32 key findings.
- The Trust has improved in its overall staff engagement score from 3.97 to 4.04. The national average for Acute Specialist Trust is 3.95 and the best score for Acute Specialist Trusts was 4.07.

The organisation has made progress in establishing and delivering a programme (underpinned by project management and improvement methodologies) to ensure every consultant participates in job planning on an annual basis.

The Trust has a number of Quality Improvement Programmes underway; Model Hospital and other key data sources underpin our work on Length of Stay and Theatre Utilisation. More detail on these priorities can be found in the Trust's Quality Account 2017/18.

l. ANNUAL QUALITY ACCOUNT

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

Quality assurance is part of the annual reporting cycle and culminates in the production of the Quality Account. The Quality Account is co-ordinated through the Quality Team with a clear timetable of milestones, including:

- Reviewing 2017/18 Quality priorities and KPIs
- Developing a long list and supporting data for 2017/18 quality priorities
- Collecting patient and public comments and views on areas of focus via the external website and the Patient Group
- Socialising quality priorities with commissioners, patients and public
- Presenting to the CQGC for clinicians' and management's input
- Presenting drafts at the Quality Committee and the Trust Board
- External audit review of draft/work in progress at the end of April 2018
- Circulation to stakeholders including commissioners, Harrow Health & Safety Scrutiny Committee, local CCG and Healthwatch Harrow for formal comment
- Formal submission via NHS Choices on 30 June 2018

Data accuracy contained in the Quality Account is ensured as it is subject matter experts who are responsible for extracting the data from NHS digital or using from the Trust's own information system known as Insight. A clinical coding error audit is also performed.

During 2018/19 the Trust's Quality Priorities will be:

- Safer Medical Staffing
- Reducing unwarranted Length of Stay
- Building the capacity and capability for improvement in the trust
- Improving theatre productivity
- Implementation of e-Referrals (GPs to consultant led outpatient services)

m. VALUE FOR MONEY OPINION

On the basis of the External Auditor's work, having regard to the guidance issued by the Comptroller & Auditor General in November 2016, except for the effects of the matter described in the Basis for qualified value for money conclusion, they were satisfied that, in all significant respects, the Royal National Orthopaedic Hospital NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

n. TRADES UNION (FACILITY TIME PUBLICATION REQUIREMENTS) REGULATIONS 2017

The Trades Union (Facility Time Publication Requirements) Regulations 2017 took effect on 1 April 2017. This meant that NHS employers are now required to publish certain information about Trades Union Officials and facility time. As part of this new regulation, facility time will cover duties carried out for the Trades Union or as a Union Learning Representative, for example, when accompanying an employee to a disciplinary or grievance hearing. It will also cover training received and duties carried out under the Health and Safety at Work Act 1974.

The requirement to publish information includes being:

- placed on a website maintained by or on behalf of the employer before 31st July in the calendar year in which the relevant period to which the information relates ends; and
- included in the employer's annual report which covers the relevant period.

At the time of publishing this Annual Report the data was not available however it will be uploaded on to the RNOH website by 31st July 2018 (www.rnoh.nhs.uk).

o. FRAUD DETERRENT

RNOH is committed to tackling fraud, corruption and bribery. An Anti-Fraud and Anti-Bribery policy is in place to provide advice to all employees, suppliers, contractors, stakeholders in dealing with fraud or suspected fraud and there is an accredited local counter fraud specialist in place.

The Trust does not tolerate fraud and bribery anywhere in the organisation. The intention is to eliminate fraud and corruption as far as possible. The aim of the Trust's policies and procedures is to protect the property and finances of the Trust and patients in RNOH's care. The Trust takes a risk based approach to its counter fraud measures, thereby ensuring that the maximum impact is achieved by the use of resource. To assist with this a Fraud and bribery risk assessment was conducted to identify the inherent risk position, the controls and assurances already in place at the Trust and to identify specific measures to further reduce the remaining level of fraud risk.

The Trust is committed to taking all necessary steps to counter fraud and corruption. To meet its objectives, it has adopted the four-stage approach developed by NHS Counter Fraud Authority and as set out in the NHS standards for Providers:

1. Strategic Governance (This sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation);
2. Inform and Involve (This sets out the requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS);
3. Prevent and Deter (This sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised);. And
4. Hold to Account (This sets out the requirements in relation to detecting and investigating economic crime, obtaining sanctions and seeking redress).

The Trust will take all necessary steps to counter fraud and corruption in accordance with the Trust's Anti-fraud and bribery policy, the NHS anti-fraud manual, the policy statement 'Applying Appropriate Sanctions Consistently' published by NHS Counter Fraud Authority and any other relevant guidance or advice issued by NHS Counter Fraud Authority. The Counter fraud team have conducted three investigations this year into allegations of fraud, bribery or corruption, one of which remains ongoing. These related to the three separate allegations of staff carrying out private work while on NHS time, two when the individual involved was on sickness absence and one during their NHS contracted hours.

It is the responsibility of NHS providers to demonstrate that adequate counter fraud provisions are in place in line with NHS Counter Fraud Authority Standards. Compliance with the standards is demonstrated through the completion of the self-review tool (SRT), detailing activity undertaken against each standard. The SRT enables organisations to produce a summary of the counter fraud work they conducted over the previous financial year. A red, amber or green rating is given to each standard to indicate the level of compliance. Any areas requiring additional actions are noted within the SRT are followed-up as part of the annual counter fraud work plan. The SRT is provided to the Audit Committee on an annual basis for review and assurance purposes. RNOH's overall rating during 2017/18 was Amber. This meant that it was not fully compliant with the standards for providers. This declaration was approved and issued to NHS Counter Fraud Authority on 27 March 2018.

p. CAPACITY TO HANDLE RISK

The Trust's Risk Management Strategy and policy outlines the Trust's approach to managing risks in relation to strategic, organisational and operational risks across the Trust. Risk is assessed at all levels of the organisation. The Trust is continuously working to strengthen its risk management processes. It is focussed on improving the format and mechanism of risk reporting with the aim of implementing a robust flow of risk information from "Ward to Board". The Trust has continued to develop its risk management system which will improve access and transparency of the risk registers across the Trust.

q. EQUALITY AN DIVERSITY

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. During 2017/18, the Trust has increased its focus on ensuring equal opportunities for all and has identified this as a key area of work for 2018/2019. We have established systems and processes to ensure that we comply with our legal obligations under relevant Equality and Human Rights legislation by incorporating Equality and Diversity legislation as it relates to staff into our Organisational Development Team. Our Organisational Development Manager is now formally responsible for leading Equality & Diversity initiatives and chairs our Equality Achievement Network. In 2017/2018, we complied with obligations under the Workforce Race Equality Standard (WRES), Gender Pay Gap Reporting, and the Public Sector Equality Duty. Data is available on our website to support our reporting on each of these issues.

r. CARBON REDUCTION DELIVERY PLAN

The Climate Change Act of 2008 established a legally binding target of reducing the UK's greenhouse gas emissions by at least 80% by 2050 and by 34% by 2020. The UK's route map for achieving this was set out in the Government's Low Carbon Transition Plan, published in July 2009.

The Trust is planning to undertake 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. This is to ensure that the organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. It is expected these risk assessments will be completed by December 2018.

s. ELECTIVE WAITING TIMES

The Trust assures itself of the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of this data. All patient cohorts are validated daily by the Validation Team which ensures that adherence to the relevant standard operating procedures pertaining to each cohort is achieved. There is a validation spreadsheet for each specialty containing all relevant information including waiting times. This is the spreadsheet on which the Validation Team records all the validation outcomes and error codes (if any) for each pathway that is validated. The saved validation information is updated weekly to the Patient Tracking List (PTL) for tracking and visibility for all divisions. The Information Team is responsible for ensuring that the data is taken for the relevant cohorts and that the Validation Spreadsheet is set up as agreed.

The General Managers also use the validation spreadsheet to undertake and to record outcomes for their quality assurance checks each week.

The Trust is producing more detailed standard operating procedures in relation to a number of scheduling and validation processes.

t. KEY PERFORMANCE INDICATORS (WAITING LIST VALIDATION)

- Every validation for each cohort must have a validation outcome (and an error code if applicable) recorded.
- Where a non RTT pathway is converted to an RTT pathway, the weeks' wait must be recorded.
- Quality assurance checks must be undertaken for 10% of validations each week, with outcomes recorded.

All Booking teams are responsible for ensuring that patient appointments are booked within clinically determined timeframes and escalated if there is insufficient clinic capacity.

In addition to this, divisional teams validate and review waiting times in speciality PTL meetings which are held weekly, and then again at the weekly Access Improvement Task Force meetings which are chaired by the Chief Operating Officer. The General Managers attend this meeting and are held to account for waiting times in their divisions. If there are any anomalies in waiting times data then this is investigated, discussed with relevant staff and processes implemented if necessary to mitigate against future recurrence.

u. NHS PENSION SCHEME REGULATIONS

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.

v. STATUTORY FUNCTIONS

During the year, the Trust has been legally compliant and has discharged its statutory functions. The Board has a collective responsibility for the setting of the strategic direction and the effective stewardship of the Trust's affairs and ensures that it complies with the constitution, mandatory guidance and contractual and statutory duties.

w. SIGNIFICANT ISSUES

My review has highlighted the following significant issues.

1. Care Quality Commission (CQC) rating – the RNOH received a rating of "Requires Improvement"

Following the CQC CIH visit of May 2014 which identified that the Trust needed improvement in safety, responsiveness and being well led, a Quality Improvement Plan was put in place to address the following:

- The design and layout of the Stanmore location is suitable for all service users.
- To continue to significantly focus on culture, values and behaviours of all staff.
- Robust governance systems are in place for managing risk.
- Learning from incidents is widely shared.
- Outpatient clinic appointments start on time and patients do not experience avoidable delays.
- The World Health Organisation (WHO) Surgical safety Checklist is used and completed at each stage of surgery and radiology.
- The paediatric resuscitation equipment is checked regularly to assure it is ready for use if and when required.
- Staff that treat children and young people are up-to date with the appropriate level of safeguarding training.
- The needs of children and young people are considered in scheduling operations.
- Develop the services across seven days.
- Review its use of opioids prescribed for pain relief for older people.
- Consider the mechanisms in place for identifying if equipment including mechanical ventilators, cardiac monitors and mattresses used to prevent pressure ulcers are clear to all when testing is needed.
- Ensure all staff is aware of support mechanisms such as the employee assistance programme. The RCN recommends there should be formal support mechanism available due to the challenging and highly specialised nature of the service provided, particularly with children and young people.
- Consider carrying out formal proactive audits of cleanliness and infection control in the outpatient's clinics.

The Board is satisfied that the plans in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements. However, the CQC and NHS I are aware of a significant backlog of maintenance risks existing at the Trust. An Estates Action Plan has been shared

with the CQC and the Redevelopment Programme is being implemented. The CQC visit of May 2014 and subsequent report of August 2014 went further to state that the Stanmore location was not fit for purpose. As a result, the Trust Board agreed a Quality Improvement Plan which was presented to the CQC, TDA and to the Commissioners. In July 2015 the TDA, Commissioners and the CQC agreed that the Quality Improvement Plan would be incorporated into "business as usual" risk monitoring within the RNOH. The key headline issues that remained at this time were the quality and sustainability of the estate and the Organisational Development programme, which required that the Trust turned listening to staff into action and continued to focus on supporting all staff to complete mandatory training in areas such as safeguarding children on a regular basis.

The RNOH has a robust approach to Clinical Governance and its leadership and has worked hard to sustain the many areas of outstanding care identified by the CQC in its visit in May 2014 and August 2014 report. The Trust has also addressed the weaknesses identified by the CQC team and material progress has been made in areas including the responsiveness of children's services, the focus on culture, values and behaviours of all staff, sharing learning from incidents, outpatient clinic appointments and the World Health Organisation (WHO) surgical safety checklist use.

2. Failure of current estate or infrastructure.

The CQC and NHS I are aware of significant backlog maintenance risks at the Trust. The CQC CIH visit of May 2014 and subsequent report of August 2014 stated that the Stanmore location is not fit for purpose.

Control issues have been recognised by the Care Quality Commission and identified in the Trust's self-declaration. Non-compliance to Outcome 10 (Safety and suitability of premises) has been identified, which states that:

People using the service and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing. This is because providers who comply with the regulations will:
- Make sure that people using services, staff and others know they are protected against the risks of unsafe or unsuitable premises by:
  - the design and layout of the premises being suitable for carrying out the regulated activity
  - appropriate measures being in place to ensure the security of the premises
  - the premises and any grounds being adequately maintained
  - compliance with any legal requirements relating to the premises

- Take account of any relevant design, technical and operational standards and manage all risks in relation to the premises.

- The TDA approved the Outline Business Case (OBC) for the site redevelopment in March 2015. The Trust is entering an important phase of the Sustainability Plan and Redevelopment Programme as it moves towards the final phase of Full Business Case approval process with the Trust Development Authority. This is dependent on the Trust achieving sustainability in the longer term and on receiving support from the Commissioners, in particular the host Commissioner, NHS England.

3. Finance

The Trust reported an adjusted deficit of £11.807m for the financial year ended 31st March 2018, after adjusting for donated asset transactions (comprising of £1.482m charitable donations less £232k depreciation on donated assets). Prior to these adjustments, a headline deficit of £10.557m was recorded for the financial year. The Trust's underlying financial position, before Sustainability & Transformation Funding (STF) and other non-recurrent gains, remained very similar to 2016/17. Increased Private Patient income, overachievement of CQUIN, and reduced premium working costs

through tightened control of agency expenditure offset a shortfall against the Cost Improvement Plan (CIP).

x. CONCLUSION

The system of internal control has been in place in the Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

With the exception of these internal control issues that I have outlined in this statement, my review confirms that the Royal National Orthopaedic Hospital NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those deficiencies in control issues have been or are being addressed.

Signed_____

Chief Executive Officer Date 25/05/18

E. REMUNERATION AND STAFF REPORT

i. REMUNERATION REPORT

Remuneration Policy

The Remuneration Committee, in line with NHS guidance, determines remuneration and terms of service for the Chief Executive and other Executive Directors. The Trust Chairman chairs the Committee and the remaining membership comprises the other Non-Executive Directors.

The Chief Executive annually agrees personal objectives with each Executive Director, against which his or her performance is measured in a formal appraisal process. All remuneration is conditional upon satisfactory performance, as measured by the appraisal process.

Remuneration of the Chairman and other Non-Executive Directors is determined by the Secretary of State for Health.

There are no elements within the employment contracts for remuneration based on performance.

Neither the Chief Executive nor any other Executive Director has earnings as a Non-Executive Director in any other organisation.

Full details of Directors' remuneration and pension entitlements are given below. The pension scheme referred to is the NHS Pension Scheme, which is described in more detail in Notes 1.6 and Note 7 in the Financial Statements. As Non-Executive Directors do not receive pensionable remuneration, there are no entries in the pension entitlements table in respect of Non-Executive Directors.

No "golden hellos" or compensation for loss of office was paid by the Trust to any of its Directors during 2017/18.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The median salary has been calculated using employees in post in March 2017. The individual salaries have been converted to full-time equivalents and annualised. The median salary is that lying in the middle of the linear distribution.

The banded remuneration of the highest paid director in the Trust in the financial year 2017-18 was between £180,000 and £185,000 (2016-17, £155,000-£160,000). This was 5.2 times (2016-17 4.6 times) the median remuneration of the workforce, which was £35,357 (2016-17 £33,562).

In 2017-18, no employees (2016-17, 8 employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £7 up to the remuneration of the highest paid director which is within the £180,000 - £185,000 banding as shown in the Directors' Salary Entitlements table below (2016-17 £21 to £267,159).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Directors' Salary Entitlements			2017/18						2016/17					
Name	Title	Start/Leave Dates	Salary (bands of £5000) £'000	Expense Payments (Taxable) total to nearest £100 £	Performance pay and bonuses (bands of £5000) £'000	Long term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2500) £'000	Total (bands of £5,000) £'000	Salary (bands of £5000) £'000	Expense Payments (Taxable) total to nearest £100 £	Performance pay and bonuses (bands of £5000) £'000	Long term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2500) £'000	Total (bands of £5,000) £'000
M Rosehill	Non-Executive Director	Start Oct-17	0-5	-	-	-	-	0-5						
K Murphy	Non-Executive Director	Start Sep-17	0-5	-	-	-	-	0-5						
Professor D Isenberg	Non-Executive Director	Start Jun-11	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Dr N A Macdonald	Non-Executive Director	Start Aug-13 - Left Oct-17	0-5	-	-	-	-	0-5	5-10	-	-	-	-	5-10
R Whitby	Non-Executive Director	Start Aug-13	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Cllr J Carlebach	Non-Executive Director	Start Jan-14	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
I A Dolan	Non-Executive Director	Start Oct-15 - Left Oct-17	0-5	-	-	-	-	0-5	5-10	-	-	-	-	5-10
A C Finkelstein	Non-Executive Director	Start Oct-15 - Left Jan-17	-	-	-	-	-	-	5-10	-	-	-	-	5-10
G A Silver	Non-Executive Director	Start Oct-15	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
M A Leigh	Non-Executive Director	Start Oct-15	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Professor A Goldstone	Chairman	Start Feb-11	15-20	-	-	-	-	15-20	15-20	-	-	-	-	15-20
R Hurd	Chief Executive	Start Oct-08	155-160	900	-	-	45-47.5	205-210	155-160	200	-	-	100-102.5	255-260
J A Skinner (See Note 4)	Director of Research and Innovation Centre	Start Jan-17	125-130	-	-	35-40	55-57.5	220-225	25-30	-	-	5-10	20-25	55-60
L Davies	Chief Operating Officer	Start Apr-15	115-120	-	-	-	25-27.5	140-145	115-120	-	-	-	35-37.5	150-155
M Shaw	Deputy CEO/ Medical Director	Start Aug-10 - Left Jan-17	-	-	-	-	-	-	120-125	-	-	0-5	30-32.5	155-160
Professor P Fish	Director of Nursing, Quality & Patient Experience	Start Feb-15	115-120	-	-	-	30-32.5	145-150	115-120	-	-	-	20-22.5	135-140
J Wilson	Director of Finance	Start Jan-11 - Left Jul -16	-	-	-	-	-	-	40-45	100	-	-	0-2.5	40-45
A Hashemi-Nejad	Medical Director	Start Jan-17	180-185	-	-	35-40	172.5-175	390-395	35-40	-	-	5-10	7.5-10	50-55
HL Witty	Director of Finance	Start Sep-16	120-125	-	-	-	25-27.5	145-150	60-65	-	-	-	12.5-15	75-80
M Masters	Director of Estates and Facilities	Start Dec-03	100-105	-	-	-	25-27.5	125-130	100-105	-	-	-	35-37.5	135-140
Dr S Patel	Director of IM&T and Innovation	Start Mar-05	120-125	400	-	-	15-17.5	135-140	120-125	400	-	-	20-22.5	140-145
Dr Z Huma	Director of Children's Services	Start Sep-15	140-145	-	-	15-20	27.5-30	185-190	140-145	-	-	10-15	107.5-110	260-265
F Hennessey	Director of Redevelopment	Start Jul-15	80-85	-	-	-	20-22.5	100-105	100-105	-	-	-	22.5-25	125-130
T Nettel	Director of Workforce & Organisational Development	Start Apr-15	110-115	-	-	-	50-52.5	160-165	100-105	-	-	-	67.5-70	165-170
A Stephens (Note 2)	Director of Finance	Start Aug-16- Left Sep-16	-	-	-	-	-	-	30-35		-	-	-	30-35
Professor A Hart (Note 3)	Director of Research and Development	Start Jun-12 - Left Jan-17	-	-	-	-	-	-	50-55	-	-	5-10	-	60-65
Band of highest-paid Director's total remuneration			180-185						155-160					
Median total remuneration			£35,357						£33,562					
Ratio			5.16						4.62					

Notes

Note 1: Where directors have worked for part of the year in other capacities this remuneration has been excluded.

Note 2: Agency arrangement

Note 3: Professor Hart was not a member of the NHS Pension Scheme. In the year ending 31 March 2017 the Trust reimbursed University College London £5,703 for pension contributions to another scheme.

Note 4: The 2016/17 pension benifts for JA Skinner has been restated

Directors' Pension Entitlement 2017/18

Name	Title	Start/Leave Dates	Real increase in pension at pension age during 2017/18 arising while employed by Trust	Real increase in pension lump sum at pension age arising while employed by Trust	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017 (note 1) (note 2) (note 3)	Cash Equivalent Transfer Value at 31 March 2018 (note 1) (note 2)	Real increase in Cash Equivalent Transfer Value (note 1) (note 2)	Employer's contribution to stakeholder pension
			(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
ROBERT HURD	Chief Executive	Start Oct-08	2.5-5	0-2.5	50-55	130-135	732	811	71	0
HANNAH WITTY	Director of Finance	Start Sep-16	0-2.5	0-2.5	0-5	0-5	8	25	17	0
LUCY DAVIES	Chief Operating Officer	Start Apr-15	0-2.5	(0-2.5)	35-40	95-100	568	633	59	0
PAUL FISH	Director of Nursing, Quality & Patient Experience	Start Feb-15	0-2.5	(0-2.5)	10-15	0-5	83	106	21	0
MARK MASTERS	Director of Estates & Facilities	Start Dec-03	0-2.5	0-2.5	30-35	80-85	531	589	53	0
ZILLA HUMA	Director of Children's Services	Start Sep-15	0-2.5	5-7.5	50-55	160-165	1017	1125	99	0
SAROJINI PATEL	Director of IM&T and Innovation	Start Mar-05	0-2.5	2.5-5	25-30	75-80	-	-	-	0
FRANK HENNESSY	Director of Redevelopment	Start Jul-15	0-2.5	0-2.5	5-10	0-5	57	89	31	0
TOM NETTEL	Director of Workforce & Organisational Development	Start Apr-15	2.5-5	2.5-5	15-20	35-40	135	175	38	0
ARESH HASHEMI-NEJAD	Medical Director	Start Jan-17	7.5-10	25-27.5	65-70	195-200	1186	1415	217	0
JOHN ANDREW SKINNER	Director of Research and Innovation Centre	Start Jan-17	2.5-5	5-7.5	55-60	165-170	1009	1097	78	0

Notes

Note 1 : Cash Equivalent Transfer Values are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Note 2 : Valuation factors are not available for members over 60 (1995 section).

Note 3 : The CETV as at 31/3/17 for J.A. Skinner has been restated

ii. STAFF REPORT

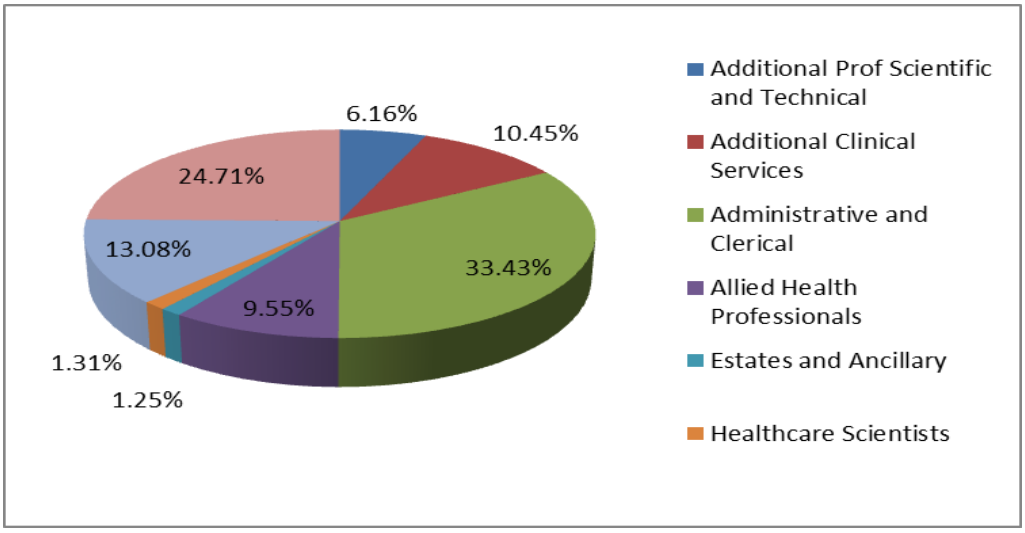
Our staff

As at 31 March 2018, the Trust employed 1,445 WTEs of staff, 87 WTEs higher than last year.

The table below provides a breakdown by staff group.

RNOH Staff WTE and Headcount as at 31st March 2018

Staff Group	Headcount	WTE	%
Additional Prof Scientific and Technical	85	89	6.16%
Additional Clinical Services	156	151	10.45%
Administrative and Clerical	454	483	33.43%
Allied Health Professionals	163	138	9.55%
Estates and Ancillary	17	18	1.25%
Healthcare Scientists	21	19	1.31%
Medical and Dental	197	189	13.08%
Nursing and Midwifery Registered	398	357	24.71%
Grand Total	1,491	1,445	100%



Average number of employees 2017/18

Average Staff Numbers	2017/18 Total YTD	2017/18 Permanently Employed	2017/18 Other	2017/18 Total Employees Costs (£000s)	2016/17 Total Prior Year	2016/17 Permanently Employed	2016/17 Other	Total Employee Costs (2017/18) £k
Medical and dental	184	178	6	24,510	192	184	8	24,510
Ambulance staff	0			0	0	0		0
Administration and estates	486	449	37	20,661	453	406	47	20,661
Healthcare assistants and other support staff	152	118	34	6,191	149	120	29	6,191
Nursing, midwifery and health visiting staff	457	388	69	20,727	464	388	76	20,727
Nursing, midwifery and health visiting learners	0			0	0			0
Scientific, therapeutic and technical staff	281	257	24	11,552	272	248	24	11,552
Social Care Staff	7	2	5	179	5	2	3	179
Healthcare Science Staff	3	3		109	3	3		109
Other	1	1		24	1	1		24
TOTAL	**1,571**	**1,396**	**175**	**83,953**	**1,539**	**1,352**	**187**	**83,953**
Staff engaged on capital projects (included above)	7	6	1	680	8	7	1	680

Gender	Very Senior Managers (incl. Non-execs)	Consultants	Senior Managers Band 8a	Senior Managers Band 8b	Senior Managers Band 8c	Senior Managers Band 8d	Senior Managers Band 9	Other Grades	All Staff
Female	7	39	67	15	19	7	5	936	1,049
Male	12	97	38	8	11	5	8	217	442
Total	**19**	**136**	**105**	**23**	**30**	**12**	**13**	**1,153**	**1,491**

Staff Sickness absence

The Trust's average sickness absence rate for 2017/18 is 2.96%, which remains below the Trust target of 3%. This is slightly worse than last year's figure of 2.70%.

	2017-18
Average Sickness Rates 2016/17	2.96%
FTE calendar days lost to sickness	15,161
FTE calendar days available	471,351
Average working days lost per FTE	7

Staff policies applied during the financial year

Equality and diversity (including equal opportunities and disability)

During 2017/18, the Trust has increased its focus on ensuring equal opportunities for all and has identified this as a key area of work for 2018/2019. Our 2016 Workforce Race Equality Standard - a mandatory report for all NHS organisations designed to demonstrate progress against a number of indicators of workforce equality – showed an improving position and a narrowing of the gap between perceptions of white and BME staff. On 5 of the 9 indicators, we had better than average scores but this does not mean that we don't have more to do.

In 2017/18, we also reported on our Gender Pay Gap for the first time, as required by legislation. Our gender pay analysis shows that at RNOH, there is a difference of 29.52% between the average hourly rate of men and women. However, if we were to remove our medical staff, where 74% of employees are male, the gender pay gap reduces to 8.36%. Whilst the results of the gender pay gap analysis are disappointing, there are not necessarily surprising for a specialist orthopaedic hospital as the data show that the RNOH overall gender pay gap is largely a consequence of medical staff pay and the fact that the majority of our medical staff are male. The average pay rate for medical staff at RNOH is double that of the Trust average pay rate of, so this distorts the overall position.

RNOH has chosen to progress actions on the WRES, Gender Pay Gap and other Equality and Diversity issues as part of the wider Organisational Development (OD) strategy. "Doing the right thing" is a key tenant of our OD strategy and one in which the work around Equality fits well.

Our Equality Achievement Network has continued to develop during the past year. This is a staff-led initiative with the aim of engaging in projects and initiatives that will support and enhance the drive for equality at the RNOH. The group has board directors attending and reports directly into the Workforce and Organisational Development Committee, a sub-committee of the Trust board. One of their major achievements was the second annual diversity and equality festival in 2017 with food, music, dance and dress from the broad cultural range of staff at the Trust. Allan Seraj, RNOH Equality Diversity Network member who helped to organise the event said at the time, *"At the heart of equality and diversity is the spirit of developing communities. When people come together in a spirit of sharing and brotherhood regardless of their differences they create a positive vibe. Today, this positive vibe and spirit of community was felt by all who attended the diversity festival. This is our starting point as we at RNOH celebrate differences."*

Partnership Working

The Trust continues to work in partnership with union representatives to develop workforce policies, strategies for resolving employee relations issues, and change/transition projects with a monthly Partnership Committee taken place with our Union colleagues. Various updates to policies and procedures have been made over the last year with valuable contributions from unions to ensure these represent improvements for all staff. Union and staff representatives also continue to key stake-holders in the Redevelopment Programme.

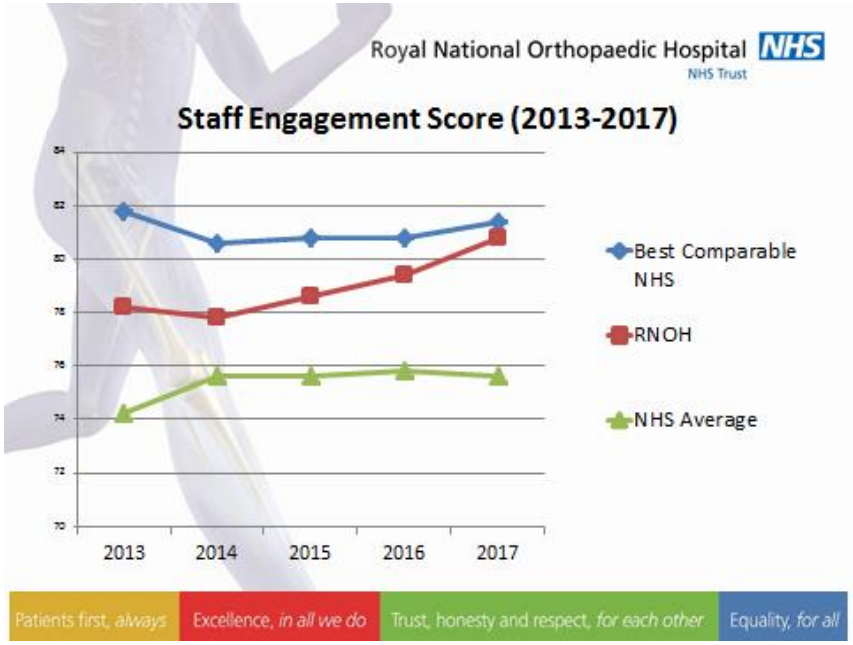
Staff Experience:

The Trust has delivered the second phase of our Workforce & Organisational Development Strategy over the last 12 – 18 months. Amongst the highlights are; the introduction of a leadership development offering including bespoke RNOH leadership programmes; a refresh of the Trust appraisal process aligning it with our Values and Behaviours; the establishment of an Equality Achievement Network and Listening into Action Group, providing staff with opportunities to work collaboratively to improve staff and patient experience and; the development of an extensive range of tools and products to provide managers with 'just in time' support, and also help them to take a proactive role in setting an effective and compassionate workplace culture.

We are particularly proud of the launch of our Freedom to Speak Up Guardians. We currently have three Guardians located in frontline services, their role is to provide encouragement and support to staff wishing to speak up about concerns, and to provide the organisation with feedback to help us improve our systems and processes and identify development needs. We are already seeing an increase in staff utilising internal processes rather than escalating outside of the organisation, and have made adjustments to our leadership offering to reflect the findings of the Guardians.

The evidence of the direct causal link between staff experience and patient experience and outcomes continues to grow, as does evidence about the financial benefits of a highly motivated and engaged workforce. We have also seen internal evidence of the return of investment into our Organisational Development programme through significant gains in our Staff Survey findings for 2017/18. For the third year we have improved our engagement score and have seen increases in 23 of 32 Key Findings (against an NHS backdrop of declining staff experience). We achieved a national best score in staff believing their role makes a difference and had a further 11 Key Findings in the top 10 scores nationally against comparable NHS Trusts.

The chart below shows the Trust's staff engagement score (measured through the annual Staff Survey) over the last four years, against the NHS average and best score year on year amongst NHS Trust's. The RNOH has seen a consistent improvement since 2014, and is close to achieving the best score in the NHS.



Our focus this year will be on continuing to embed the Values Charter and the tools and products that have been developed and continuing to develop the Trust culture through a well-supported and developed Leadership cohort. We will also focus on delivering an improved experience for staff from minority groups and/or who have a protected characteristic, as this is one area we did not see improvement in the staff survey scores. Some key activities to help us achieve this will be the

strengthening of the Equality Achievement Network, the roll out of unconscious bias training across the Trust and the piloting of a reverse mentoring programme.

Our key objectives will be;

- **Do the right thing** – support our staff to live excellent, values based behaviour everyday
- **Develop inclusive, inspirational and effective leaders** – setting high standards while providing the support and development required to help leaders meet the needs of their teams
- **Share the important stuff** – share a clear vision and goals for the Trust and support staff to make this meaningful in their roles
- **Value our People** – listen to, communicate with and care about our people by giving them opportunities to make their experience, and that of their patients better

Employee Consultation

In order to further enhance patient care and experience and improve services, there have been a number of formal organisational change programmes over the past financial year. These formal employee consultation programmes have included restructures of administrative support teams in the Medicine and Therapies Division and restructure of scheduling staff within spinal services, to establish dedicated service based teams.

There have also been restructures to support the role redesign of senior nursing leadership within the divisional triumvirate structure and a restructure of the Transformation team, which was re-established as the Improvement team.

To improve access to services for patients, consultations took place with radiology staff in relation to the rotation of qualified staff between Bolsover Street and Stanmore sites and a consultation to introduce an extended working day in theatres has also taken place over the past year.

All formal change programmes involve partnership working between managers leading change programmes and staff side representatives, to enhance staff engagement and involvement.

Annual staff achievement awards

This year, we again expanded our Annual Staff Achievement Awards to give a well-deserved thank you to our staff. Over 300 employees gathered at the Village Hotel to celebrate the event with Prof Noel Fitzpatrick, aka TV's Supervet, as our special guest host. Noel has been working with the RNOH for several years on development of implants and prostheses for animals and we're currently undertaking significant work around the 'One Medicine' philosophy, cross-learning between veterinary and human medicine.

Winners of the 2017 awards were as follows:

Achieving Excellence:

Winner: Ivana Trihlikova

Runner up: Lucy Swift

Advocating Equality & Fairness for all:

Winner: Andrew Crerar

Runner up: Lynsey McClean

Championing Trust, Honesty & Respect in the Workplace

Winner: Kelly Easton

Runner up: Edwina Neumann

Innovator of the Year:

Winner: Bela Haria

Runner up: Laura Mitham

Newcomer of the Year:

Winner: Jon Newman

Runner up: Menard Ryan Ong

Patient Choice Award:

Winner: Maria Digweed

Runner up: Jubilee Rehabilitation Ward

People's Champion – Clinical:

Winner: Anthony Gilbert

Runner up: Sue Vithanage

Peoples Champion – non-clinical:

Winner: Lisa Haig

Runner up: Antony Watson

Putting Patients First

Winner: Anastasia (Stacey) Evangelides

Runner up: Francesca Dudley

Team of the year – Clinical:

Winner: Plaster Theatre

Runner up: LSCIC Therapies team

Team of the year – non-clinical:

Winner: Involvement and Volunteering Team

Runner up: IM&T Service Desk Team

Volunteer of the year:

Winner: Pat Jones

Runner up: Sue Wonghen

Expenditure on Consultancies

During the year consultancy expenditure amounted to £3,841,538 (2016/17, £2,159,749). This included costs associated with site development, national orthopaedic initiatives and the Getting It Right First Time initiative.

Off Payroll Engagements (Table 1)

Table 1 below lists all off-payroll engagements of more than £245 per day and that last longer than six months as at 31 March 2018:

Table 1	**Number**
Number of existing engagements as of 31 March 2018	7
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	1

Confirmation that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Off Payroll Engagements (Table 2)

Table 2 shows all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

Table 2	**Number**
Number of new engagements between 1 April 2017 and 31 March 2018, or those that reached six months in duration during the time period.	4
Of which:	
No. assessed as caught by IR35	4
No. assessed as not caught by IR35	
No. engaged directly (via PSC contracted to the entity and are on the departmental payroll)	4
No. of engagements reassessed for consistency assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following consistency review	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. (1)	0
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements. (2)	2

Severance payments

There were 2 compulsory redundancy in the financial year 2017/2018.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	No.	£s	No.	£000	No.	£s	No.	£s
<£10,000					0	0		
£10,000 - £25,000	1	13,905			1	13,905		
£25,001 - 50,000	1	39,927			1	39,927		
£50,001 - £100,000					0	0		
£100,001 - £150,000					0	0		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total	2	53,832	0	0	2	53,832	0	0

Royal National Orthopaedic Hospital NHS Trust

Financial Statements for the Year Ended 31 March 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	2	120,042	124,333
Other operating income	3	23,611	16,254
Operating expenses	4, 6	(152,197)	(145,319)
Operating deficit from continuing operations		**(8,544)**	(4,732)
Finance income	9	16	11
Finance expenses	10	(776)	(304)
Public Dividend Capital dividend		(1,253)	(1,628)
Net finance costs		**(2,013)**	(1,921)
Other gains	11	-	6
Deficit for the year		**(10,557)**	(6,647)
Other comprehensive income			
Revaluations of property, plant and equipment	15	4,901	(1,930)
Total comprehensive expense for the period		**(5,656)**	(8,577)

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	12	3,046	4,074
Property, plant and equipment	13	109,477	75,619
Trade and other receivables	17	1,148	655
Total non-current assets		**113,671**	80,348
Current assets			
Inventories	16	2,578	2,574
Trade and other receivables	17	25,889	14,952
Cash and cash equivalents	18	8,732	5,876
Total current assets		**37,199**	23,402
Current liabilities			
Trade and other payables	19	(26,348)	(19,827)
Borrowings	21	(5,116)	(5,664)
Provisions	22	(83)	(79)
Other liabilities	20	(2,878)	(2,625)
Total current liabilities		**(34,425)**	(28,195)
Total assets less current liabilities		**116,445**	75,555
Non-current liabilities			
Borrowings	21	(69,457)	(23,191)
Provisions	22	(546)	(573)
Total non-current liabilities		**(70,003)**	(23,764)
Total assets employed		**46,442**	51,791
Financed by			
Public dividend capital		30,089	29,782
Revaluation reserve		29,167	24,266
Income and expenditure reserve		(12,814)	(2,257)
Total taxpayers' equity		**46,442**	51,791

The notes on pages 8 to 48 form part of these accounts.

The financial statements on pages 1 to 48 were approved by the Board on and signed on its behalf by :

Name ROB HURD

Position CHIEF EXECUTIVE

Date 25/05/18

Statement of Changes in Equity for the year ended 31 March 2018

	Public Dividend Capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**29,782**	**24,266**	**(2,257)**	**51,791**
Deficit for the year	-	-	(10,557)	(10,557)
Revaluations	-	4,901	-	4,901
Public Dividend Capital received	307	-	-	307
Taxpayers' equity at 31 March 2018	**30,089**	**29,167**	**(12,814)**	**46,442**

Statement of Changes in Equity for the year ended 31 March 2017

	Public Dividend Capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	29,732	26,196	4,390	60,318
Prior period adjustment	-	-	-	-
Taxpayers' equity at 1 April 2016 - restated	29,732	26,196	4,390	60,318
Deficit for the year	-	-	(6,647)	(6,647)
Revaluations	-	(1,930)	-	(1,930)
Public dividend capital received	50	-	-	50
Taxpayers' equity at 31 March 2017	29,782	24,266	(2,257)	51,791

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.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating deficit		(8,544)	(4,732)
Non-cash income and expense:			
Depreciation and amortisation	4	4,913	5,048
Net impairments	5	-	439
Income recognised in respect of capital donations	3	(1,482)	(829)
(Increase) in receivables and other assets		(11,484)	(138)
(Increase) / decrease in inventories		(4)	208
Increase in payables and other liabilties		3,799	776
Increase / (decrease) in provisions		(23)	2
Net cash generated from / (used in) operating activities		**(12,825)**	774
Cash flows from investing activities			
Interest received		16	12
Purchase of intangible assets		(102)	(578)
Purchase of property, plant, equipment and investment property		(29,876)	(15,077)
Sales of property, plant, equipment and investment property		-	65
Receipt of cash donations to purchase capital assets		1,448	829
Net cash generated from / (used in) investing activities		**(28,514)**	(14,749)
Cash flows from financing activities			
Public dividend capital received		307	50
Movement on loans from the Department of Health and Social Care		45,666	19,409
Movement on other loans		52	-
Other interest paid		(661)	(306)
PDC dividend paid		(1,169)	(1,788)
Net cash generated from financing activities		**44,195**	17,365
Increase in cash and cash equivalents		**2,856**	3,390
Cash and cash equivalents at 1 April - brought forward		**5,876**	2,486
Cash and cash equivalents at 31 March	18.1	**8,732**	5,876

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care 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 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 accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis. See further details at sections 1.2.

Note 1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Part-completed Spells
The revenue relating to patient care spells that are part-completed at the year end is apportioned across the financial years.

Valuation of Land and Buildings
The land and buildings within the area of the Stanmore hospital site known as the Western Development Zone (WDZ) have been valued on the assumption that these assets are to continue to be in use as operational assets for the provision of healthcare by a NHS provider organisation. This property was used for the delivery of healthcare in 2017/18 which is planned to continue in 2018/19. Planning permission has been obtained for the use of the WDZ to be changed to residential housing. It is anticipated that the land within the WDZ will be sold in 2018/19 for residential development, however as at 31/3/18 this property does not meet the criteria for treatment as held-for-sale under International Financial Reporting Standard (IFRS) 5 *Non-current Assets Held for Sale and Discontinued Operations* e.g. the necessary criterion that the WDZ is subject to active marketing is not met. As a result of this critical judgement, there has been no change to the basis of valuation of the WDZ property compared to the prior-year.

Consolidation of Financial Statements
IFRS 10 C*onsolidated Financial Statements* requires that accounts are consolidated where an entity controls another entity. The Trust's arrangements with charities has been reviewed and it has been established that the Trust does not have control of any charities where control is defined in accordance with IFRS 10. No charities have therefore been consolidated within the Trust's financial statements.

Accounting for the Getting It Right First Time (GIRFT) Initiative - Gross/Net Accounting

The Getting It Right First Time (GIRFT) programme aims to bring about higher-quality care in hospitals, at lower cost, by reducing unwanted variations in services and practices. It uses national data to identify the variations and outcomes, shares that data with all those concerned with a service – clinicians, clinical and medical directors, managers and Chief Executives – and monitors the changes that are implemented. GIRFT is a joint programme between the Trust Development Authority (TDA - part of NHS Improvement) and the Trust. There is an agreement between the TDA and the Trust under which the Trust provides services under the GIRFT programme and the TDA pays the Trust for the services delivered.

The GAM states that:

'revenue income and expenditure must be recorded gross unless the transaction is of a non-trading nature and an organisation is deemed to have transferred risks and rewards and be acting solely as an agent'.

The Trust bears the following significant risks:

i) Operational delivery and the related income risk
ii) Liquidity risk
iii) Reputational risk

As significant risks are borne by the Trust, the Trust is not acting solely as an agent. Therefore gross accounting for GIRFT transactions has been applied for the 2017/18 financial statements.

Going Concern

Deficits Incurred and the 2018/19 Financial Plan

The Trust has incurred in-year adjusted deficits for the 3 years 2015-16 - 2017/18. The Trust has been in a cumulative deficit position for the last two financial years 2016/17 - 2017/18 which follows a cumuative surplus in 2015/16. The revenue control total of a £7.0m deficit for 2018/19 has been agreed with NHS Improvement.

Financing the Planned Revenue Deficit

The 2018/19 financial plan includes the drawdown of £22.7m in Revenue Support Loans from the Department of Health to cover the cash impact of the underlying planned deficit and working capital loan repayments of principal. Funding of £4.1m has been received from the Department of Health in April and May 2018 in aggregate to part-fund the 2018/19 deficit which was in the form of Revenue Support Loans. During 2017/18 the Trust drew down revenue support funding of £18.8m in the form of Revenue Support Loans as well as funding from the Revenue Support Working Capital Facility. The Trust's Board of Directors has a reasonable expectation that, consistent with 2017/18, adequate revenue support funding will be provided in 2018/19 from the range of revenue funding sources for which the Trust can apply.

Continuation of the Provision of the Trust's Services

The Department of Health Group Accounting Manual (GAM) highlights that the continuation of the provision of services is a key criterion when determining the application of the going concern concept. This is set out in the extract from section 4.12 of the GAM below:

'For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.'

During 2016/17 NHS Improvement approved the business case for a new in patient ward block with planned capital expenditure of £49.9m which is currently under construction, due to complete in 2018/19. This business case includes loan funding from the Department of Health of £48.0m and draw down of this loan commenced in September 2016. For 2018/19 the Trust has agreed baseline contract values with NHS commissioners representing over 70% of planned NHS patient income. The move towards out of hospital NHS healthcare services set out in the NHS Five Year Forward View (FYFV) is very unlikely to reduce demand for the Trust's services and furthermore demand is likely to increase as specialist activity coalesces around specialist providers. Market analysis highlights that the Trust also has opportunities to pursue growth strategies for the provision of private patient services. There has been no notification from NHS Improvement or the Department of Health that the services the Trust provides are to cease.

Overall Assessment by the Trust Board

Taking the factors above into consideration with particular reference to the likelihood that the Trust's services will continue to be provided the Trust Board has concluded that the Trust's financial statements should be prepared on a going concern basis.

Note 1.3 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 amounts of assets and liabilities within the next financial year:

Valuation of Land and Property
The carrying value of the Trust's land and buildings is based on the valuation undertaken during the year by the Trust's valuers Gerald Eve. Non-specialised properties (eg staff accommodation) were valued at market value and specialised properties (healthcare buildings) were valued at depreciated replacement cost on a modern equivalent asset principle. These valuations rely on a number of assumptions and estimates which introduce uncertainty. The main estimation techniques were:

- Land was valued on the assumption that the existing Green Belt designation and associated planning restrictions remain in force.
- For non-specialised buildings estimates were to market value, however few buildings of this type would be sold in the locality.
- For specialised buildings, the valuation relied upon Royal Institute of Chartered Surveyors Building Cost Information Service indices of the cost of construction for appropriate building types which are averages. The base valuations were discounted on an estimate of the remaining useful life of each building, and space requirements for service delivery were assumed to remain the same in a modern equivalent asset as in the present buildings. Finally, in accordance with IAS16, the component parts of each building were ascribed values as a proportion of the total, based on average proportions, with a different assessed life applied to each.

The carrying values at 31 March 2018 are: non-specialised buildings £2,055,000 specialised buildings £43,533,000, land £14,320,000.

NHS Injury Recovery Scheme
The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS 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.

Note 1.4 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 health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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

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

The NHS Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS 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.

Note 1.5 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 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.

Note 1.6 Expenditure on 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. Staff are not permitted to carry forward leave from one accounting year to the next, but must use up their entire entitlement in the year in which it is earned.

Pension costs
NHS Pension Scheme
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 Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore the schemes are accounted for as though they are defined contribution schemes.

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 the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Note 1.8.1 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
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have 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.
- 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, or
- where computer equipment (e.g. personal computers and computer peripherals) are purchased which have a cost individually of £250 or more and are connected to the Trust's intranet

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.8.2 Measurement

Valuation

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

All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value in existing use at the date of revaluation less any impairment.

Revaluations 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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and borrowing costs which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

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

Assets in the course of construction are not depreciated until the asset is brought into use.

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

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

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

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

Note 1.8.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:

  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.8.5 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	1	55
Dwellings	1	28
Plant & machinery	5	10
Information technology	5	5
Furniture & fittings	5	41

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.9 Intangible assets

Note 1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably and where the cost is at least £5000 or where software licences are purchased which have a cost individually of £250 or more and are used in connection with the Trust's intranet.

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

Note 1.9.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Note 1.9.3 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9.4 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Software licences	5	5

Note 1.10 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Note 1.13 Financial instruments and financial liabilities

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

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

Loans and receivables are recognised at fair value net of transactions costs.

Interest on loans is credited to the Statement of Comprehensive Income.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

The amount of the impairment loss is measured as the difference between the asset's carrying amount and the value of the revised future cash flows. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

Note 1.14 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.

Note 1.14.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
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.

Note 1.14.2 The Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. 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 22.2 but is not recognised in the Trust's Statement of Financial Position.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme (LTPS). Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 23 where an inflow of economic benefits is probable.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent liabilities are not recognised, but are disclosed in note 23, unless the probability of a transfer of economic benefits is remote.

Note 1.17 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. HM Treasury has determined that 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.

A charge, reflecting the cost of capital utilised by the Trust, is payable as Public Dividend Capital Dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value Added Tax

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

Note 1.19 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 in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

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

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

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.22 Standards, amendments and interpretations issued but not yet effective or adopted

IFRS 9 Financial Instruments
This standard becomes effective for the 2018/19 financial statements. No material impact expected.

IFRS 15 Revenue from Contracts with Customers
This standard becomes effective for the 2018/19 financial statements. No material impact expected.

IFRS 16 Leases
This standard will become effective for the 2019/20 financial statements. The impact may be material. This impact is expected to be clarified following the issue of the 2019/20 HM Treasury Financial Reporting Manual (FReM) which is expected to be published in December 2018.

IFRS 17 Insurance Contracts
This standard becomes effective for the 2021/2 financial statements. No material impact expected.

IFRIC 22 Foreign Currency Transactions and Advance Consideration
This standard becomes effective for the 2018/19 financial statements. No material impact expected.

IFRIC 23 Uncertainty over Income Tax Treatments
This standard becomes effective for the 2019/20 financial statements. No material impact expected.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Elective income	48,285	54,983
Non elective income	2,312	3,347
First outpatient income	3,519	3,202
Follow up outpatient income	15,934	16,914
Other NHS clinical income	42,446	39,135
Private patient income	6,682	6,352
NHS Injury Cost Recovery Scheme	864	400
Total income from activities	**120,042**	124,333

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2017/18**	2016/17
	£000	£000
NHS England	53,569	49,198
Clinical commissioning groups	55,608	65,734
Department of Health and Social Care	27	-
Other NHS providers	-	135
Non-NHS: private patients	6,682	6,351
Non-NHS: overseas patients (chargeable to patient)	-	(14)
NHS injury scheme	864	400
Non NHS: other	3,292	2,529
Total income from activities	**120,042**	124,333

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	-	(14)
Amounts added to provision for impairment of receivables	17	(14)

Note 3 Other operating income

	2017/18	2016/17
	£000	£000
Patient Transport Services	3,865	3,786
Research and development	920	795
Education and training	2,298	2,439
Receipt of capital grants and donations	1,482	829
Charitable and other contributions to expenditure	75	50
Non-patient care services to other bodies	398	290
Sustainability and transformation fund income	3,901	1,532
Other income*	10,672	6,533
Total other operating income	**23,611**	16,254

* The principal components of other income are :
Funding for the Getting It Right First Time initiative £8,165k (£2,900k 2016/17)
Vanguard initiative funding £694k (£649k 2016/17)
Workforce funding £342k (£372k 2016/17)
Accommodation income £324k (£346k 2016/17)
Income related to training courses £56k (£154k 2016/17)
Clinical Excellence Award funding £137k (£136k 2016/17)
NHS Trust Development Authority support funding £NIL (£600,000 2016/17)
Compensation from a supplier relating to a system implementation (£NIL 2017/18, £200,000 2016/17)

Note 4 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	765	610
Purchase of healthcare from non-NHS and non-DHSC bodies	2,666	2,321
Staff and executive directors costs	82,162	79,049
Remuneration of non-executive directors	63	70
Supplies and services - clinical (excluding drugs costs)	28,526	28,074
Supplies and services - general	5,725	5,295
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,405	2,443
Inventories written down	138	237
Consultancy costs	3,842	2,160
Establishment	1,894	1,349
Premises	5,008	5,448
Transport (including patient travel)	4,918	4,239
Depreciation on property, plant and equipment	3,670	3,785
Amortisation on intangible assets	1,243	1,263
Net impairments	-	439
Increase/(decrease) in provision for impairment of receivables	(277)	(567)
Increase/(decrease) in other provisions	30	-
Change in provisions discount rate(s)	5	39
Audit fees payable to the external auditor:		
audit services- statutory audit	48	61
other auditor remuneration (external auditor only)	10	12
Internal audit costs	48	47
Clinical negligence	4,594	4,177
Legal fees	231	162
Research and development	1,072	989
Education and training	1,696	1,041
Rentals under operating leases	943	1,350
Redundancy	72	17
Hospitality	93	41
Other	607	1,168
Total	**152,197**	145,319

Note 4.1 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	10	12
Total	**10**	12

Note 4.2 Limitation on auditor's liability

The limitation on liability is £2.0m (unlimited liability 2016/17)

Note 5 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating deficit resulting from:		
Unforeseen obsolescence	-	203
Changes in market price	-	236
Total net impairments charged to operating deficit	**-**	439

Note 6 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	66,219	61,238
Social security costs	7,147	6,369
Apprenticeship levy	310	-
Employer's contributions to NHS pensions	7,472	6,935
Pension cost - other	2	1
Termination benefits	72	17
Temporary staff (including agency)	3,411	6,543
Total gross staff costs	**84,633**	81,103
Of which		
Costs capitalised as part of assets	680	815

Note 6.1 Retirements due to ill-health

During 2017/18 there were no early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (0k in 2016/17).

The cost of ill-health retirements are be borne by the NHS Business Services Authority - Pensions Division.

Note 7 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.

Other Pension Schemes

The Trust also makes pension contributions towards a small number of the Trust's employees (11 employees in 2017/18, 9 employees 2016/17) who are members of the National Employment Savings Trust. The NHS Trust's contribution to this scheme was £1,971 (£1,280 in 2016/17).

Note 8 Operating leases

Note 8.1 Royal National Orthopaedic Hospital NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Royal National Orthopaedic Hospital NHS Trust is the lessee.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	943	1,350
Total	**943**	1,350

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	721	788
- later than one year and not later than five years;	2,885	2,930
- later than five years.	9,316	9,860
Total	**12,922**	13,578
Future minimum sublease payments to be received	-	-

The Trust has an agreement with Homeview Properties Ltd for the lease of an outpatient clinic in a building at Bolsover Street, London W1 for 25 years commencing November 2009. The rental was £856,228 per annum including VAT in 2017/18. There is no provision in the lease agreement for extension of the lease nor for the purchase of the property by the Trust. The Trust is responsible for the insurance and maintenance of the building and for the payment of service charges to the Landlord.

The Trust had a lease agreement with Moduleco Healthcare Ltd for three modular buildings on the Stanmore site commencing December 2009 for a minimum period of 7 years. The rental in 2016/17 was £38,206 per month including VAT. The rental was subject to annual adjustment for RPI changes and six months' minimum notice of termination. If terminated before the end of the minimum period, the Trust had to pay the rentals which would have been paid to the end of the minimum period. At the end of the minimum period, the Trust could extend the lease by further periods of one year at not more than the rental in the last quarter of the minimum period. There was no purchase option in the agreement. Maintenance was provided by PKL as part of the agreement. These 3 modular buildings were purchased from the lessor in December 2016 at which point the operating lease was terminated.

Note 9 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	16	11
Total	**16**	11

Note 10.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	776	303
Interest on late payment of commercial debt	-	1
Total finance expenditure	**776**	304

Note 10.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest expense arising from claims made under this legislation	-	1

Note 11 Other gains

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	6
Total other gains	-	6

Note 12.1 Intangible assets - 2017/18

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	7,207	-	7,207
Additions	-	215	215
Reclassifications	215	(215)	-
Gross cost at 31 March 2018	7,422	-	7,422
Amortisation at 1 April 2017 - brought forward	3,133	-	3,133
Provided during the year	1,243	-	1,243
Amortisation at 31 March 2018	4,376	-	4,376
Net book value at 31 March 2018	3,046	-	3,046
Net book value at 1 April 2017	4,074	-	4,074

Note 12.2 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	6,808	-	6,808
Additions	-	399	399
Reclassifications	399	(399)	-
Valuation / gross cost at 31 March 2017	7,207	-	7,207
Amortisation at 1 April 2016 - as previously stated	1,870	-	1,870
Provided during the year	1,263	-	1,263
Amortisation at 31 March 2017	3,133	-	3,133
Net book value at 31 March 2017	4,074	-	4,074
Net book value at 1 April 2016	4,938	-	4,938

Note 13.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	12,040	42,539	2,019	11,798	23,894	6,799	258	99,347
Additions	-	-	-	32,627	-	-	-	32,627
Revaluations	2,280	556	36	-	-	-	-	2,872
Reclassifications	-	483	-	(1,448)	523	442	-	-
Valuation/gross cost at 31 March 2018	14,320	43,578	2,055	42,977	24,417	7,241	258	134,846
Accumulated depreciation at 1 April 2017 - brought forward	-	41	-	-	17,473	6,109	105	23,728
Provided during the year	-	1,941	92	-	1,316	310	11	3,670
Revaluations	-	(1,937)	(92)	-	-	-	-	(2,029)
Accumulated depreciation at 31 March 2018	-	45	-	-	18,789	6,419	116	25,369
Net book value at 31 March 2018	14,320	43,533	2,055	42,977	5,628	822	142	109,477
Net book value at 1 April 2017	12,040	42,498	2,019	11,798	6,421	690	153	75,619

Note 13.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	12,040	42,753	2,244	2,883	22,297	6,672	258	89,147
Additions	-	-	-	14,802	-	-	-	14,802
Revaluations	-	(4,279)	(260)	-	-	-	-	(4,539)
Reclassifications	-	4,065	35	(5,887)	1,660	127	-	-
Disposals / derecognition	-	-	-	-	(63)	-	-	(63)
Valuation/gross cost at 31 March 2017	12,040	42,539	2,019	11,798	23,894	6,799	258	99,347
Accumulated depreciation at 1 April 2016 - as previously stated	-	7	-	-	16,251	5,771	90	22,119
Provided during the year	-	2,106	98	-	1,228	338	15	3,785
Impairments	-	434	5	-	-	-	-	439
Revaluations	-	(2,506)	(103)	-	-	-	-	(2,609)
Disposals/ derecognition	-	-	-	-	(6)	-	-	(6)
Accumulated depreciation at 31 March 2017	-	41	-	-	17,473	6,109	105	23,728
Net book value at 31 March 2017	12,040	42,498	2,019	11,798	6,421	690	153	75,619
Net book value at 1 April 2016	12,040	42,746	2,244	2,883	6,046	901	168	67,028

Note 13.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	14,320	41,768	2,055	41,496	5,039	822	142	105,642
Owned - donated	-	1,765	-	1,481	589	-	-	3,835
NBV total at 31 March 2018	14,320	43,533	2,055	42,977	5,628	822	142	109,477

Note 13.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	12,040	40,777	2,019	11,323	5,700	690	153	72,702
Owned - donated	-	1,721	-	475	721	-	-	2,917
NBV total at 31 March 2017	12,040	42,498	2,019	11,798	6,421	690	153	75,619

Note 14 Donations of property, plant and equipment

During 2017/18 donated asset acquisitions of £1,482k were recognised (£829k 2016/17). All these donations were from the RNOH Charity. These donations are summarised below :
- Contribution towards the construction and equipping of the New In Patient Ward Block (£1,328k)
- Contibution towards the extension to the Spinal Cord Injury Centre (£154k)

Note 15 Revaluations of property, plant and equipment

Land, Buildings and Dwellings

During 2017/18, the Trust engaged Gerald Eve LLP, an independent firm of Chartered Surveyors, to undertake a valuation of its land and buildings as at 31 March 2018. The firm had previously undertaken a similar valuation as at 31 March 2017. The partner in charge of the valuation was Mr Richard Ayres MRICS.

In accordance with IAS16, assets are required to be carried at fair value.

The Trust's specialised buildings, those used for the provision of services, are valued at depreciated replacement cost. The non-specialised buildings, such as residential properties, are valued at market value.

The valuation of the Stanmore Hospital land assumed that its Green Belt designation would continue and that the Trust would continue to occupy the Stanmore site.

In general, the valuation assumed that buildings have a maximum life expectancy from new of 60 years, with the buildings depreciated on a straight line basis from 100% at completion of construction to zero, once their life span has been met. The valuation has given consideration to the remaining useful life of the buildings.

Plant and Equipment

Plant and machinery is categorised as either long term, medium term or short term, with the assumed lives of these categories being fifteen, ten and five years respectively.

Information Technology equipment is generally assumed to have a life of five years.

Furniture and fittings are categorised in the same way as plant and machinery into long, medium and short-term life assets.

Note 16 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	174	155
Consumables	2,376	2,363
Energy	28	56
Total Inventories	**2,578**	2,574

Inventories recognised in expenses for the year were £15,847k (2016/17: £17,330k). Write-down of inventories recognised as expenses for the year were £138k (2016/17: £237k).

Note 17.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	14,011	5,262
Accrued income	11,104	9,322
Provision for impaired receivables	(1,106)	(1,474)
Prepayments (non-PFI)	961	988
PDC Dividend receivable	-	54
VAT receivable	866	757
Other receivables	53	43
Total current trade and other receivables	**25,889**	14,952
Non-current		
Accrued income	1,148	655
Total non-current trade and other receivables	**1,148**	655
Of which receivables from NHS and DHSC group bodies:		
Current	20,161	10,286
Non-current	-	-

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	1,474	2,041
Increase in provision	(277)	(567)
Amounts utilised	(91)	-
At 31 March	1,106	1,474

Note 17.3 Credit quality of financial assets

	31 March 2018	31 March 2017
	Trade and other receivables	Trade and other receivables*
Ageing of impaired financial assets		
	£000	£000
0 - 30 days	51	28
30-60 Days	51	28
60-90 days	51	85
90- 180 days	103	85
Over 180 days	325	836
Total	581	1,062
Ageing of non-impaired financial assets past their due date		
0 - 30 days	2,278	801
30-60 Days	4,944	115
60-90 days	839	741
90- 180 days	2,675	364
Over 180 days	2,161	1,119
Total	12,897	3,140

* Prior-year values restated for non-impaired financial assets past their due date

Note 18.1 Cash and cash equivalents movements

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.

	2017/18	2016/17
	£000	£000
At 1 April	**5,876**	2,486
Net change in year	2,856	3,390
At 31 March	**8,732**	5,876
Broken down into:		
Cash at commercial banks and in hand	47	47
Cash with the Government Banking Service	8,685	5,829
Total cash and cash equivalents as in Statement of Financial Position and Statement of Cash Flows	**8,732**	5,876

Note 18.2 Third party assets held by the trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Cash in hand	-	2
Total third party assets	-	2

Note 19 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	5,017	6,377
Capital payables	5,707	2,892
Accruals	12,155	7,574
Social security costs	1,030	873
Other taxes payable	880	815
PDC dividend payable	30	-
Accrued interest on loans	142	15
Other payables	1,387	1,281
Total current trade and other payables	**26,348**	19,827
Of which payables from NHS and DHSC group bodies:		
Current	6,514	4,471
Outstanding pension contributions included in current payables	1,143	1,006

Note 20 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	2,878	2,625
Total other current liabilities	**2,878**	2,625

Note 21 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	5,064	5,664
Other loans	52	-
Total current borrowings	**5,116**	5,664
Non-current		
Loans from the Department of Health and Scoial Care	69,457	23,191
Total non-current borrowings	**69,457**	23,191

Note 22.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Total
	£000	£000	£000
At 1 April 2017	631	21	652
Change in the discount rate	5	-	5
Arising during the year	27	19	46
Utilised during the year	(59)	(15)	(74)
At 31 March 2018	604	25	629
Expected timing of cash flows:			
- not later than one year;	58	25	83
- later than one year and not later than five years;	234	-	234
- later than five years.	312	-	312
Total	604	25	629

The provision for early departure costs provides for enhancement of pension entitlements of early retirees. It is based on the present value of the Trust's annual contribution projected in accordance with average life expectancy tables published by the Government Actuary.

The provision for legal claims relates to claims made by staff and others which are covered by the LPTS scheme referred to in note 1.15. The amounts are based on assessments by the NHS Litigation Authority up to the Trust's policy excess (£10,000) in the case of each claim. Potential additional liabilities up to the policy excess, where successful claims exceed the NHSLA's estimate, are disclosed as contingent liabilities.

Note 22.2 Clinical negligence liabilities

At 31 March 2018, £45,460k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal National Orthopaedic Hospital NHS Trust (31 March 2017: £40,282k).

Note 23 Contingencies

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims *	(17)	(22)
Gross value of contingent liabilities	**(17)**	(22)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(17)**	(22)

The contingent liability represents the Trust's potential additional liability for claims against which the Trust is insured under the LTPS scheme in the event that a settlement, where liability is established, exceeds the NHS Resolution estimate. However, the Trust's maximum liability in any case cannot exceed the policy excess.

* Description for prior year re-stated.

Note 24 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	8,895	32,713
Intangible assets	44	-
Total	**8,939**	32,713

Note 25 Financial instruments

Note 25.1 Financial risk management

International 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 Trust has with commissioners and the way those commissioners are financed, the Trust 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 Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the NHS Improvement and the Department of Health. The capital loans are for 5 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust also borrows from the government to ensure liquidity remains adequate when the Trust has a revenue deficit - the interest on this borrowing is also fixed for the life of the borrowing. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the NHS Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with NHS England and Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. External funding required by the Trust for capital expenditure is usually obtained as loans from the Department of Health - requests for these loans are subject to a prudential borrowing assessment carried out by NHS Improvement and Department of Health. The Trust has historically had access to revenue support loans and/or a working capital facility from the Department of Health which ensure that the Trust's liquidity remains adequate when revenue deficits are incurred. In 2017/18 the Trust drew down £0.9m from the DH Interim Revenue Working Capital Facility and £17.9m in the form of DH Interim Revenue Support Loans. There is a reasonable level of assurance that access to adequate DH revenue support funding will be available in 2018/19. The Trust is not, therefore, exposed to significant liquidity risks.

Note 25.2 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	23,555	**23,555**
Cash and cash equivalents at bank and in hand	8,732	**8,732**
Total at 31 March 2018	**32,287**	**32,287**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	14,524	14,524
Cash and cash equivalents at bank and in hand	5,876	5,876
Total at 31 March 2017	20,400	20,400

Note 25.3 Carrying value of financial liabilities

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	74,573	**74,573**
Trade and other payables excluding non financial liabilities	26,327	**26,327**
Total at 31 March 2018	**100,900**	**100,900**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	28,855	28,855
Trade and other payables excluding non financial liabilities	19,827	19,827
Total at 31 March 2017	48,682	48,682

Note 25.4 Fair values of financial assets and liabilities

Carrying value is a reasonable approximation of fair value.

Note 25.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	31,443	25,491
In more than one year but not more than two years	564	564
In more than two years but not more than five years	67,737	11,098
In more than five years	1,156	11,529
Total	**100,900**	48,682

Note 26 Losses and special payments

	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				
Overpayment of salaries*	1	136	1	27
Bad debts and claims abandoned	18	91	-	-
Total losses	**19**	**227**	1	27
Special payments				
Ex-gratia payments	1	7	8	23
Extra-statutory and extra-regulatory payments	1	-	-	-
Total special payments	**2**	**7**	8	23
Total losses and special payments	**21**	**234**	9	50

* The overpayment of salaries recognised in 2017/18 reflects incorrect bank payments to a range of members of staff working within several of the Trust's clinical services.

Note 27 Related parties

The Department of Health and Social Care (DHSC) is the parent department of the Trust. During 2017/18 the Trust has had a significant number of material transactions with entities for which the Department is regarded as the parent department. Those DHSC entities with which the Trust has had income or expenditure of greater than £1.0m in 2017/18 or have receivables or payables balances greater than £1.0m as at 31st March 2018 are set out below:

Barnet CCG
Bedfordshire CCG
Brent CCG
Ealing CCG
East and North Hertfordshire CCG
Enfield CCG
Haringey CCG
Harrow CCG
Herts Valleys CCG
Hillingdon CCG
NHS England
Royal Free London NHS Foundation Trust
St George's University Hospitals NHS Foundation Trust
NHS Resolution (formerly NHS Litigation Authority)
NHS Improvement (Trust Development Authority)
Health Education England

During the year none of the DHSC 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 Trust.

The RNOH Charity (formerly the Special Trustees of the Royal National Orthopaedic Hospital) exists to administer endowment and other charitable funds in the interests of the Trust's patients. The charity publishes its financial statements separately. This charity reimbursed the Trust £342,000 (2016/17 £335,000) in respect of financial and other administrative duties undertaken on behalf of the charity by staff employed by the Trust. The RNOH Charity also funded capital expenditure of £1,482k by the NHS Trust in 2017/18 (£829k 2016/17). During 2017/18 one Trustee of the RNOH Charity has also been a member of the NHS Trust Board.

Note 28 Events after the reporting date

One material event has taken place after the end of the reporting period. Two debtor invoices which were issued to the Trust Development Authority (part of NHS Improvement) in October 2017 and January 2018, aggregating to £6.5m, were settled in April 2018. These invoices were included within trade receivables in note 17.1.

Note 29 Better Payment Practice Code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	25,606	112,961	29,945	99,387
Total non-NHS trade invoices paid within target	20,669	94,582	5,063	48,089
Percentage of non-NHS trade invoices paid within target	**80.72%**	**83.73%**	16.91%	48.39%
NHS Payables				
Total NHS trade invoices paid in the year	850	11,123	860	10,227
Total NHS trade invoices paid within target	578	8,721	146	4,675
Percentage of NHS trade invoices paid within target	**68.00%**	**78.41%**	16.98%	45.71%

The Better Payment Practice code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 30 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	43,169	16069
External financing requirement	**43,169**	16,069
External Financing Limit (EFL)	45,684	19,459
Underspend against EFL	**2,515**	3,390

Note 31 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	32,842	15,201
Less: Disposals	-	(57)
Less: Donated and granted capital additions	(1,482)	(829)
Charge against Capital Resource Limit	**31,360**	14,315
Capital Resource Limit	32,930	15,082
Underspend against CRL	**1,570**	767

Note 32 Breakeven duty financial performance and compliance with the Control Total agreed with NHSI

	2017/18 £000	2016/17 £000
Adjusted financial performance deficit (control total basis)	(11,807)	(6,796)
Breakeven duty financial performance deficit	**(11,807)**	(6,796)
Control Total agreed with NHSI	**(16,207)**	**(7,372)**
Beneficial variance compared to agreed Control Total	**4,400**	**576**

Independent auditor's report to the Directors of Royal National Orthopaedic Hospital NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Royal National Orthopaedic Hospital NHS Trust (the 'Trust') for the year ended 31 March 2018, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and Notes to the Accounts, including Accounting policies and other information. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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 Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including 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.

Who we are reporting to

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the 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.

Other information

The Directors are 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. 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 course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource 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.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual 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

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine 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 Directors are responsible for assessing the 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 Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit Committee is Those Charged with Governance.

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 Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and

deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Royal National Orthopaedic Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Iain Murray

Iain Murray
Director
for and on behalf of Grant Thornton UK LLP

30 Finsbury Square
London
EC2A 1AG

27 May 2018

NHS
Royal National Orthopaedic Hospital
NHS Trust

QUALITY ACCOUNT 2017/18

CONTENTS

PART 1
STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Delivering the best quality of patient care for all the RNOH patients remains the key focus of the organisation. The dedication and professionalism of the staff at the RNOH is fundamental to this focus. I commend the determination and commitment of those staff who work tirelessly to ensure that we make continuous improvements to our services and demonstrate learning from situations when we recognise that things have gone wrong.

We know that the highest quality of care is delivered by motivated and happy staff. We are committed to improving the experience of our staff at RNOH to ensure that they can improve the safety and experience of our patients. In 2017/18 we have continued to make real progress in improving the experience for our staff at the RNOH – our positive staff survey results and resultant quality of care for patients are real evidence of this progress.

We are thrilled to see the progress that continues to be made with the improvement in our infrastructure – particularly the redevelopment of the site and investment in equipment and our digital technology investments. The opening of the new inpatient building is on track for October 2018. This will help will ensure that we are able to deliver high quality care in a setting that our patients and staff deserve.

The RNOH continues to make great strides in our aim to be a world leading learning centre of excellence - patient participation in research higher than ever before and research and our partnership projects with our academic partners, particularly University College London, continue to generate innovation and knowledge that translates into both a learning culture and improvements in the quality of patient care.

The RNOH, like many other NHS Trusts, continues to face significant financial challenges. However, our vision remains to continue our vision to be a world leading Orthopaedic Hospital with the best patient care and staff experience in the NHS.

I confirm to the best of my knowledge that the information contained in this report is accurate.

Rob Hurd
Chief Executive

NEW INPATIENT WARD BLOCK

CONSTRUCTION OF THE NEW INPATIENT WARD BLOCK IS SET TO BE COMPLETED AND OPEN IN **AUTUMN 2018**.

The brand new building will mean the RNOH are able to offer patients the very best ward facilities and allow staff to work in an environment that matches their skill and dedication. The major portion of the project will be funded from a land sales receipt when the surplus land on the West of the site is sold for residential redevelopment.

The Inpatient ward building will accommodate 119 beds in total, which will comprise of a 27 bed Children's unit (Sir William Coxen Children and Young People's Unit) with embedded therapy and education functions and an external play area.

There will also be new Adult Acute Wards comprising 64 beds over two floors, (London Irish Ward and the Duke of Gloucester Ward) with embedded therapies and socialisation spaces to replace several of the current outdated adult wards.

There will also be a Private Patients Unit (Royal National Orthopaedic Hospital Private Care) accommodating 28 beds that includes 10 day case beds and a Therapy gym.

Alongside the clinical spaces, the new block will include a main entrance that will provide reception and waiting space, in addition to a refreshment and seating area adjacent to the children's activity centre which will be fitted with interactive activities for our paediatric patients and visitors, funded from a charitable donation of £500,000.

2.1 INTRODUCTION

The Royal National Orthopaedic Hospital is the UK's leading specialist Orthopaedic Hospital. We provide a comprehensive and unique range of Neuro-Musculoskeletal healthcare, ranging from acute spinal injuries to Orthopaedic Medicine and Specialist Rehabilitation for chronic back sufferers.

As a National Centre of excellence, the RNOH treats patients from across the country, many of whom have been referred by other Hospital Consultants for second opinions or for treatment of complex or rare conditions.

Over 20% of all UK Orthopaedic Surgeons receive training at the RNOH, and our patients benefit from a team of highly Specialised Consultants many of whom are internationally recognised for their expertise.

The RNOH has a long track record of innovative research, and our research projects are pertinent to patient needs. Research is focused on musculoskeletal as well as Neuro-Musculoskeletal conditions, Rehabilitation, Peripheral Nerve Injury Repair, Sarcoma Detection, Surgical Treatments and much more. Together with our research partner, University College London's Institute of Orthopaedic and Musculoskeletal Science, our work has led to new devices and treatments for some of the most complex orthopaedic and musculoskeletal conditions.

2.2 WHAT IS QUALITY?

High quality care in the NHS means that patients have a good overall experience of care which is clinically effective and delivered safely.

AN ORGANISATION **COMMITTED** TO **DELIVERING HIGH QUALITY CARE** IS ONE WHICH WILL ALWAYS STRIVE TO BE EVEN BETTER.

The RNOH is committed to being a world leading Orthopaedic Hospital with the best patient care and staff experience in the NHS. **This means:**

- ACHIEVING **EVEN BETTER** CLINICAL OUTCOMES
- PROVIDING **EVEN SAFER** CARE
- **EXCEEDING THE EXPECTATIONS** OF OUR PATIENTS AND THEIR FAMILIES

Knowing that we are delivering the best care requires continuous measurement. We do this in many different ways including comparison with our peers through participation in National Audits and benchmarking our practice against guidance from the National Institute for Health and Care Excellence (NICE). We also undertake many local clinical audits based on best practice guidelines. This helps us understand more clearly what we do really well and what we could improve. We are also able to understand the impact of our Clinical Interventions from our patient's perspective through our Patient Reported Outcome Measures (PROMS) and Patient Outcome Data (POD).

SAFE CARE

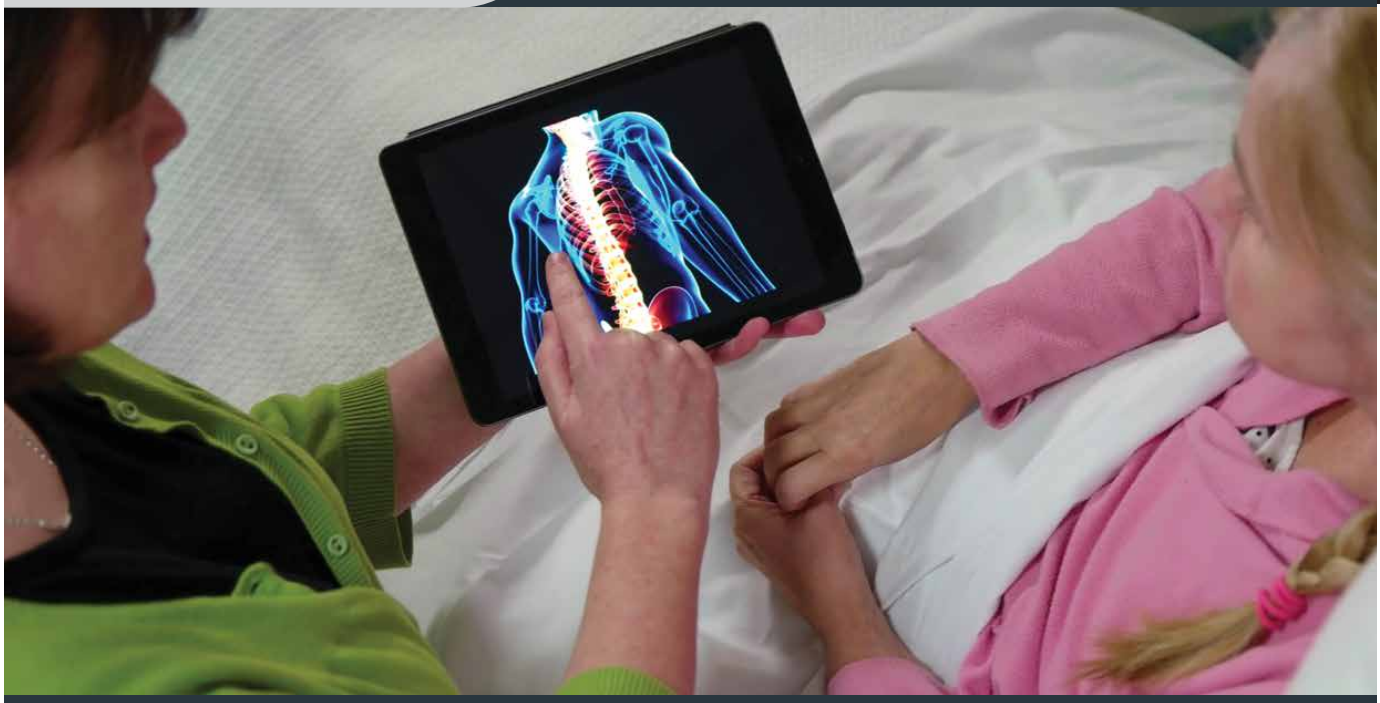
Safe care is care in which avoidable error and harm has been effectively removed. Safe care can be measured by looking at our rates of hospital acquired infections, thrombosis, pressure damage and falls. It can also be analysed in relation to the rates of incident reporting within the hospital. We know that when staff is focussed on improving the safety of care provided, we can expect to see high levels of incident reporting. Each incident report provides further opportunity for quality improvement and learning within the hospital.

Ensuring that patients and their families have a good experience while at the RNOH is incredibly important to us. We continue to work to find better ways of enabling our patients to give us feedback in order to improve the services that we provide. We were really pleased to be identified in the 2016 National Inpatient Survey as the best Trust in the country for seeking view from our patients.

DELIVERING HIGH QUALITY CARE

Delivering high quality care means being able to recognise that in the provision of complex specialist services we do not always get it right. Being open and honest with our patients, our regulators and ourselves when we get things wrong is the most important step we can take to improving the quality of our care and being even better.

2.3 THE QUALITY ACCOUNT



Every year the Trust is required to produce an account of the quality of the services it provides. This is an important way for NHS services to provide information to the public about the quality of care it provides as well as demonstrating what work it being undertaken to improve services

The RNOH is committed to continuously reviewing and improving the quality of its services to ensure our patients have the very best experience of care and successful clinical outcomes. Within this document the Trust provides information about how we have performed against National Quality Indicators for Patient Safety, Clinical Effectiveness, and Patient Experience. We also outline our Quality Improvement Priorities for 2018/19 as well as reviewing our progress against last year's priorities.

- **Friends and Family Test Performance**
  We have maintained a high level of approval from both our inpatients and outpatients. 95% of our patients would recommend our services to their family and friends.
- **Introduction of Medical Emergency Team**
  In 2017/18 a number of incident investigations were undertaken which looked at care of the deteriorating patients. It was recognised that early identification and escalation of the deteriorating patients are essential if we are to 'rescue' them and prevent serious illness and death. One of the key actions from this learning was to introduce a Medical Emergency Team, which allows for immediate assessment of unwell patients. The Medical Emergency Team was launched on Monday 19th February 2018 to add in a layer of safety for patients who are unwell and/or deteriorating throughout the trust. The team can be called by dialling 7777.
- **Roll out of MEND Initiative**
  Staying physically and mentally active after surgery can help patients recover faster from surgery, help them regain their independence, shorten their stay in hospital and reduce the chance of problems when they go home. The 'On The MEND' initiative has been rolled out to all adult wards and a programme of audit commenced to measure the effectiveness. This initiative aims to support patients in 4 main areas to aid post-operative recovery: Medicines, Exercise, Nutrition, Daily Activities. Initial results are encouraging and patient feedback has been very positive. To keep the momentum going The Trust has signed up to participate in the national 'End PJ Paralysis' 70 day challenge commencing the 17th April to encourage patents across the country to be up and dressed on hospital wards. Clinical criteria for the admission of patients the day prior to surgery has been established and signed off in the two largest clinical specialities and further work will be undertaken to extend this to all areas.
- **Letter from Jeremy Hunt**
  We delivered the best improvement in referral to treatment performance in the UK in the year to June 2017 – from 87.6% to 93.1%. This was recognised by the Secretary of State for Health who congratulated us on this 'exceptional improvement' by writing a personally-signed letter.

- **New Adult Preoperative Intravenous Iron Service**
  We piloted a new adult preoperative intravenous (IV) iron service in the trust from December 2016 to December 2017. During this period we successfully treated 57 patients who had preoperative anaemia in the Jubilee Rehab infusion suite with IV iron. This pilot is an important further development on the recently implemented adult preoperative anaemia pathways at the RNOH. Preoperative patients with untreated anaemia have worse outcomes. Certain patient groups with anaemia do not respond well to oral iron. These groups have always poised a clinical problem when trying to correct preoperative anaemia at the RNOH. In our pilot we successfully treated this group with IV iron and demonstrated an increase in haemoglobin preoperatively and a trend towards decrease transfusion rates and length of stay. The service along with our preoperative anaemia pathways will continue to improve patient outcomes and reduce length of stay and transfusion rates in addition to significant cost savings.
- **Perfect week in theatres**
  A 'Perfect week' in The Operating Theatres was organised in the last week of September 2017 – looking at the entire peri-operative process end to end in detail from booking operating lists, patients arriving on the day, to ensuring that lists start on time and utilise the operating hours safely and efficiently. Many improvement actions were identified during the process, including the 'Golden Patient' Methodology, which involved identifying the first patient on the list, and where appropriate, admitting them direct to the operating theatres. Additionally focussing on the 'Triumvirate of Optimisation' which includes booking efficiency, reducing lists being left fallow, and improving intra-session utilisation which includes prompt starts to operating lists. Additionally revamping the weekly Theatre Scheduling meeting to be more robust and effective, and introducing the 'daily Theatre Huddle', which facilitates a daily meeting to review the day's activity and plan for the next. Going forward the impact on Patients is a much improved patient experience on the day, and better access to essential surgery, by reducing waste, optimising through-put and reducing waiting times for surgery. In addition it provides opportunity to utilising every possible minute, pound and time of expert Surgeons, Anaesthetists, Nursing and AHP staff. Additional patient benefit is a safer, happier more aware workforce, which is linked to evidence that suggests this reduces patient mortality and improved patient outcomes overall. Current outcomes have been - Start times to operating lists, booking efficiency, and intra-session utilisation have improved overall since the initiative. Next steps are to build a dedicated central 'Theatre Admissions & Day Case Unit', which will further enhance the patient experience and efficiency/ productivity process.
- **The Volunteer Patient Buggy Service**
  Amongst many fantastic interventions to improve patient experience at RNOH, 'Buggy Service', and its intrepid team of drivers, who are out in all weathers, transport patients around some incredible difficult terrain. The visitor numbers continue to increase month on month. Averaging 2200 visitors a month, many of whom suffer from mobility problems, it is hard to recall how we ever managed without them!

2.4 QUALITY HIGHLIGHTS OF 2017/18 CONT'D

- **'I delivered great care' Gold badge award**
  "I delivered great care" badge is part of the RNOH patient Welcome Pack and is awarded by the patient to member of staff who they feel have delivered great care to them during their stay. To receive a bronze badge, staff must receive five 'I Delivered Great Care' badges from patients. Five bronze badges results in one silver, and five silver badges gain a gold award. So that's 125 in total! This initiative was started in 2016 and the following staff members have received the Gold badges:
  - **Maya Benny**, staff nurse on Short Stay Unit
  - **Lyn Apiag**, Healthcare Assistant, Duke of Gloucester ward
  - **Rose Symons**, Staff Nurse on Margaret Harte Ward
- **Redevelopment started on new Inpatient Ward Block**
  Work is underway on our new building and it is set to be completed and opened by autumn 2018. The new building will include a Children's unit, new Adult Acute Wards and a Private Patients Unit.
- **RNOH Val-You charter**
  In 2016, the RNOH made a commitment to its staff to become the best place to work in the NHS. To make this goal a reality, the Trust launched 'RNOH VAL-YOU' as our concerted effort to enhance the experience our staff have at work and continue to improve the already excellent care we provide to our patients. Essentially, we want to afford our staff the same care and support we give to our patients every day. Using conversations and stories from staff the RNOH VAL-YOU team developed a Charter of Behaviours, based on our values, Patients First, Excellence, Trust, Honesty and Respect, and Equality, which was launched in February 2017. The Charter has been supported by the development of a number of tools to help staff and managers to have even better conversations, to challenge each other respectfully and to celebrate examples of excellence.

2.5 VOLUNTEER SERVICE

SINCE ITS INCEPTION TWO YEARS AGO, THE VOLUNTEER SERVICE HAS TRULY BECOME EMBEDDED IN THE CULTURE OF THE RNOH. IT NOW OFFERS OVER 40 ROLES FOR A 100+ VOLUNTEER FORCE ACROSS THE TRUST, SUPPORTING PATIENTS AND STAFF IN AREAS AS DIVERSE AS BUGGY DRIVERS, WORKING IN THE HIGH DEPENDENCY UNIT (HDC) TO PHARMACY SUPPORT.

This year has seen a substantial increase in the number of volunteers applying to us and a 30% increase in volunteering numbers.

Our volunteers come from all walks of life. We aim to utilise the skills, knowledge base and personal characteristics of each individual and, due to our reach across the Trust, we can match the person to the available volunteer role to ensure both the volunteer and the area being supported are fulfilled. Volunteers often have a wealth of expertise and knowledge they have developed throughout their lives. This is utilised and welcomed by the various departments in the Trust. Our current volunteer force includes; senior lecturers, barristers, solicitors, ex-RNOH employees, nurses, company owners, police officers and even a doctor!

Staff in departments supported by volunteers feel more organised and able to use their time more productively. An additional benefit is Volunteer Services are able to offer placements to volunteers who don't want patient facing roles.

2.5 VOLUNTEER SERVICES CONT'D

16-18 Year old Project

We have developed, in partnership with Haberdashers girls' school, a project to allow the pupils to volunteer after school. The school transports the pupils to us in their mini bus each Wednesday. This allows the pupils to build experience for their CV's whilst establishing links between our two prestigious organisations. We have a variety of roles which our young volunteers can undertake and we hope to offer more places to encourage pupils from other schools and colleges, build on this valuable resource and encourage more young people (and their families) to volunteer at RNOH.

The Volunteer Patient Buggy Service

Our buggy service and its intrepid team of drivers who are out in all weathers, transport patients around some incredible difficult terrain. The visitor numbers continue to increase month on month. Averaging 2200 visitors a month it is hard to recall how we ever managed without them!

Patient feedback about the buggy service

> Excellent experience yesterday in using buggy service. Not only was it comfortable and efficient but the driver was particularly nice and most helpful.

Thanking volunteers

Volunteer services aims to be "the place to volunteer" in the local area and we are always looking for new and inventive ways to thank our volunteers for the incredible input they have.

- In September we held a "thank you" BBQ and music event for all the volunteers, and on site charities, as a chance to meet other volunteers
- During the summer we were able to take 20 volunteers to the House of Commons for a tour around this splendid building
- Victor the volunteering "achievement badge"

All volunteers on passing their first or third volunteering anniversary with us will receive a little "Victor Volunteering" badge in the shape of our logo and the number of years volunteering with us. As with all things in life ……it's the little things that matter like saying thank you!

Volunteer feedback:

> Just to say thank you so much for the lovely letter and badge which I received today. Things like this make it so rewarding to volunteer for RNOH.

> Thanks so much for my "1 year badge" and the lovely letter accompanying it. I was really chuffed to receive this unexpected token and it really touched me.

2.5 VOLUNTEER SERVICES CONT'D

Corporate Volunteering

This year has seen a dramatic increase in the number of organisations wanting to undertake their corporate social responsibility volunteering days with us – probably because we treat them so well and really make them feel welcome!

A volunteer force of 30 people from the Hindu Shree Swaminarayan temple and Stanmore Synagogue tackled the LCSIC gardens, tidying up trees and shrubs undergrowth and planting a vast amount of donated bulbs and plants and compost in the numerous containers. They filled a skip with debris and even cleaned the windows. Publicity around the event saw an increase in volunteer applications from friends and neighbours of those who took part.

- Both Hunters and Lloyds returned to us this year to help with gardening projects
- National Rail undertook some fantastic work in the spinal garden and Lloyds group decorated our Prosthetics waiting room
- Cincera totally transformed one of the nurses flats and made a video promoting volunteering at RNOH

Feedback from Corporate Volunteers

> We were made to feel incredibly welcome by the team. We are looking forward to working with the hospital again in the future.

> We did feel our time was extremely worthwhile. All in all it was a very good and enjoyable day.

Meal Time Buddies

Following the successful introduction of meal time buddies on Duke of Gloucester Ward last year, to support patients during the lunch and dinner times, we have successfully rolled this out to two other wards.

Volunteers are able to increase the social aspect of meal times offering patients someone to chat to, to ensure they had everything they needed to enjoy their meal. Volunteers also offer assistance with cutting up food or opening packets if required. In addition, volunteers are able to ensure fresh water is readily available therefore encouraging hydration of patients.

Feedback about Meal Time Buddies

> They're amazing! The volunteers appear on the ward and refill your water jug without asking. Nothing is too much for them. They even popped over to the shop in Outpatients and picked up some mousse for my hair. My favourite newspapers are delivered with a smile. They'd do anything for you.

Female patient
Duke of Gloucester Ward June 2017

> Overall, I'd give the volunteers 11 out of 10 for their attention to detail, care and enthusiasm.

Duke of Gloucester Ward

The service has been nominated for the Team of the Quarter staff recognition award .The nominator wrote that the team demonstrated **"an outstanding contribution to patient experience and teamwork"**. The Meal Time Buddies (MTB) campaign has had direct benefit to staff, the personal development of the volunteers, and not least to the welfare of the patients. In addition, the nominator noted that the **"gentle, unassuming role of the Volunteer Meal Time Buddies, with the support, encouragement and acceptance of the staff on Duke of Gloucester ward, [has made] this programme truly wonderful".**

2.5 VOLUNTEER SERVICES CONT'D

Bedside Trolley

The bed side trolley service, affectionately known as "The Chocolate Chariot" was introduced and visits all the main wards and was extended to support theatre staffs as they are unable to access the hospital shop with ease.

"I've been here over a month. The trolley is great. It comes every day with lovely chocolates and papers and the volunteers are so sunny and friendly. " Patient October 2017

> I've been here over a month. The trolley is great. It comes every day with lovely chocolates and papers and the volunteers are so sunny and friendly.

Patient October 2017

Pharmacy Delivery Volunteers

Our team of volunteers are working with the Pharmacy department to ensure the timely delivery of non-controlled drugs to wards and patients prior to their discharge. The hospital is working to improve patient experience at discharge and volunteer services are providing part of the solution to achieve this goal.

> There is a gentleman that brings things from pharmacy to the ward. Let him know that he is very polite, very professional and always smiling!

> It all seemed to slot in smoothly and I was touched by the level of appreciation from all those in Pharmacy.

Patient Involvement

The Patient Group have continued to undertake a variety of supportive tasks at the Trust alongside their role as the Trust's "critical friend". This included:

- Taking part in the Trust wide mock CQC visits and the "Perfect week in Theatres" exercise
- Critically assessing written literature sent out by the Trust
- Developing their role in co-production of new services including many aspects of the new build

Members of the Patient Group attend meetings, sit on a variety of committees to give the patients perspective and ensure the patients voice is heard and involved.

Award Winners

Involvement and Volunteer Services team won the Team of the Year (non-clinical award).

Lisa Haig, Volunteer Coordinator, the winner of the Peoples Champion (non-clinical award) and Pat Jones, Chair of the Patient Group was named Volunteer of the Year.

Volunteer Services were thrilled to win these prestigious awards. This highlights the importance of the work we undertake and the impact it is having across the Trust both for patients and staff alike.

The Buttercup Singers (which Volunteer Services formed for the Christmas carol concert) gave a rendition of Queen's "Don't stop me now".

2.6 VAL-YOU

At the RNOH, compassionate and excellent patient care has always been fundamental to our values and mission. As a Trust, we can be extremely proud of the quality of care and experience we provide and this quality account will demonstrate that on a number of measures we are truly a world-class orthopaedic hospital.

The main reason for safety and effectiveness of our patient services and treatment is the skills and effort of our staff. It is through their devotion and dedication that the RNOH has the global reputation and quality of patient outcomes.

In 2016, the RNOH made a commitment to its staff to become the best place to work in the NHS. To make this goal a reality, the Trust launched 'RNOH VAL-YOU' as our concerted effort to enhance the experience our staff have at work and continue to improve the already excellent care we provide to our patients. Essentially, we want to afford our staff the same care and support we give to our patients every day.

Using conversations and stories from staff the RNOH VAL-YOU team developed a Charter of Behaviours, based on our values, Patients First, Excellence, Trust, Honesty and Respect, and Equality, which was launched in February 2017. The Charter has been supported by the development of a number of tools to help staff and managers to have even better conversations, to challenge each other respectfully and to celebrate examples of excellence.

In addition to the launch and roll out of the Charter of Behaviours, the VAL-YOU campaign has been working on other ways to improve the experience of staff at the Trust.

A summary of the key achievements of the programme are:

- The introduction of a suite of bespoke Leadership Development programmes available to leaders at all levels in the organisation
- In addition to the Employee of the Month and Team of the Quarter awards, the Trust also launched Staff Appreciation Cards, providing staff with the opportunity to recognise and reward the examples of excellence that happen every day
- Ongoing development of the role of the Freedom to Speak Up Guardians providing staff with support and encourage to speak up about concerns
- Launch of free exercise classes for staff
- Highly successful delivery of our third 'Diversity Festival' to celebrate equality and inclusivity of staff from across the Trust

For more information about RNOH VAL-YOU and our work to become the best place to work in the NHS please visit the RNOH's website, internal grapevine page (for staff only) or email **VALYOU@rnoh.nhs.uk**

2.7 PHARMACY AND MEDICINES OPTIMISATION 2017/18

THE RNOH PHARMACY CONTINUES TO ENSURE HIGH QUALITY MEDICINES OPTIMISATION FOR PATIENTS. MEDICINES OPTIMISATION IS ABOUT SUPPORTING PATIENTS TO GET THE RIGHT CHOICE OF MEDICINE AT THE RIGHT TIME. THIS HELPS TO IMPROVE PATIENT OUTCOMES, SUPPORT PATIENTS IN TAKING THEIR MEDICINES, AVOID TAKING UNNECESSARY MEDICINES, REDUCE MEDICINES WASTAGE AND IMPROVE PATIENT SAFETY.

Some of the ways in which this continues to happen is through:

Medicines Safety

Medicines have the potential to cause harm to patients, and medicines optimisation aims to improve medicines safety. Also, in the unfortunate event that mistakes have been made by staff, patients are informed of the learning that has been undertaken and an apology is offered. Duty of candour is applied.

The RNOH has a medicines safety committee which meets bi-monthly, where medicines-related incidents are discussed, trends found, and steps taken to prevent such incidents recurring. The committee comprises of pharmacists, doctors, nurses and the RNOH patient safety team. In 2017 – 18 we helped identify trends in medicines-related incidents involving controlled drugs. We put additional training into place for doctors, nurses and pharmacy staff, reviewed the use of some controlled drugs. Subsequently we have seen a reduction in these types of incidents occurring.

Venous thromboembolism (VTE) is known to as fatal in hospitalised patients who had surgery. Pharmacists routinely complete majority of 24 hour VTE re-assessments for all inpatients at the RNOH. This is innovative practice in the NHS and aims to ensure patients receive evidence based VTE prevention in accordance with national guidelines.

As a national centre, RNOH sees patients from all over the country, and abroad. There have been instances where patients have had

2.7 PHARMACY AND MEDICINES OPTIMISATION 2017/18 CONT'D

medicines incorrectly prescribed and supplied when at home, and these instances have been picked up when the pharmacy staff undertake medicines reconciliation between the hospital prescription, GP prescription, and the medicines the patient brings in. This has led to further harm being prevented to patients, and improvements in their health and well-being.

Medicines Safety Newsletter

Publication of this newsletter twice a year provides staff with updates on local, national and international guidance related to medicines safety, with a focus on local developments to improve medicines safety for patients. Routine updates are provided in between directly to doctors and nurses as appropriate.

RNOH Formulary

A list of medicines that have been approved for use at RNOH is available for patients and staff alike to access. It is web-based, and can be accessed at www.rnohformulary.nhs.uk

It is updated on a monthly basis and is the output of the quality and governance processes around introducing new medicines and reviewing existing medicines used by RNOH staff in treating our patients.

We also work closely with other hospitals and CCGs local to us in ensuring high quality medicines-related services are provided and the quality and governance forum through which we do this is known as the North Central London Joint Formulary Committee (www.ncl-jfc.org.uk).

Medicines optimisation clinics and telemedicine clinics

Pharmacy work closely with the rheumatology department in ensuring medicines optimisation for patients seen by the rheumatologists. These are expensive and complex medicines. Once the rheumatologist has seen the patient and recommended treatment, the pharmacist will have a face to face consultation with the patient. This is to ensure the patient understands what side effects to look out for, how to administer the medicine and how to store it. This discussion also involves the provision of ongoing support patients once treatment has started through homecare. We have received positive feedback from patients who now call and speak directly to the pharmacist about any problems or concerns they have. These clinics have seen improved outcomes for patients and closer working relationships between the RNOH rheumatology department and pharmacy in ensuring safe and improved patient care.

Pharmacist and pharmacy technicians are routinely providing ongoing access to medicines and advice, monitoring for adverse effects through telephone clinics to specialist clinical services e.g. Bone and joint infection and long-term pain. These telephone clinics take place on a weekly basis. In long-term pain clinics, a pharmacist also facilitates trial of analgesics to determine their usefulness in individual patients and deprescribing as appropriate. These telephone clinics have received positive feedback from patients and clinical staff.

Pharmacy staff also contact patients two

weeks in advance of their surgery dates to re-confirm the medicines the patient takes, and to re-confirm the patient is aware of which medicine to stop, which medicine to continue and which medicine to bring into hospital with them. Prescriptions are written in advance of the patient arriving at RNOH, thereby enabling the doctors to spend more time discussing any other issues the patients want to discuss on the day of their procedure.

In 2018 we have implemented our plans to have a dedicated medicines helpline. This is accessible to all our patients through switchboard and is a reliable source of medicines-related advice.

Antimicrobial stewardship

The RNOH has a specialist antimicrobial pharmacist who provides clinical expertise to the trust to support the optimal prescribing, administration and supply of antimicrobial to achieve the optimal clinical outcome and minimise the risk of Clostridium difficile infection and antimicrobial resistance. This also includes clinical leadership to the antimicrobial stewardship committee which is a multidisciplinary group that leads on a program of education and training, audit and feedback, quality improvement and updating of the RNOH Microguide Application which contains local antimicrobial guidance for clinical staff.

Reducing the impact of severe infections CQUIN

Anti-microbial resistance (AMR) is the single biggest threat to public health. The UK Government has taken strong leadership, by making AMR a national priority with the aim of reducing both Gram-negative bacteraemia and inappropriate antimicrobial prescribing by 50% by 2020. This is important for the RNOH, as AMR complicates the prevention and treatment of orthopaedic infection. The Trust antimicrobial stewardship committee has clinically led a program of quality improvement focusing on the prescribing, supply and administration of antimicrobials with the aim of achieving the best clinical outcomes for the patient and minimising the risk of Clostridium difficile infection and AMR. This has led to the safe reduction in antimicrobial usage and achievement of national CQUIN targets.

Pre-assessment medicines optimisation

The pharmacists work with clinical staff in pre-assessment to agree treatment plans for patients in advance of their surgery. This helps to ensure patients are provided with the right advice relating to stopping and starting medicines prior to surgery (e.g. anticoagulants and antidiabetic medicines) and provides an opportunity for patients to share preferences and concerns regarding their medicines in the perioperative period. The pre-assessment pharmacists are also prescribers who can write up the inpatient prescription chart to reflect an agreed treatment plan.

The pre-assessment team actively promotes and encourages patients to bring their

2.7 PHARMACY AND MEDICINES OPTIMISATION 2017/18 CONT'D

medicines with them for their hospital admission, and use the 'green bag scheme' (http://mymedicinesmyhealth.org.uk/) to help patients do so. Research demonstrates that one of the biggest 'let-downs' for patients and medicines is in the 'interface' between hospital and primary care (GPs and community pharmacies). The pharmacist in the pre-assessment clinic aims to bridge this gap by enabling proactive communication between the hospital and primary care, thereby minimising the impact of any medicines-related 'interface' issues that may occur after our patients are discharged from hospital.

Medicines optimisation by patients' bedsides

For patients who are admitted into hospital, pharmacists and pharmacy technicians are available on the wards to discuss any issues and concerns patients have as regards their medicines. For those patients who are staying overnight, the pharmacy staff reconcile the information between the GP, community pharmacy and patient, in ensuring that patients have the correct medicines prescribed, such that nurses can administer medicines to patients. They also make use of the 'green bag scheme' in ensuring that if a patient is moved from one ward to another then the patients' medicines are also moved. This helps ensure that medicines are available for patients to take as intended, and therefore optimise recovery time after their operation.

Self-administration of medicines

Patients most commonly take their medicines by themselves before and after they come into hospital. So why do we not empower patients to take their medicines by themselves when they are in hospital? We answered this question by evaluating a pilot involving 'self-administration' of medicines on the Jubilee Rehabilitation ward. Patients and nursing staff found this to be preferable to tradition hospital medicines rounds. In 2017 – 18 we started to roll this out to other wards where patients are able to, want to, and can self-administer their own medicines.

The 2017 inpatient survey included a new question about patients being able to self-administer medication. The RNOH performance was average compared to its peers and it is expected that this score will improve in the 2018 survey on the back of quality improvement intervention.

Improving the patient experience

Research, patient surveys and patient feedback all tell us that patients do not like to have to wait around in hospital after being declared fit for discharge. We know that some of the delays are due prescriptions not being written up on a timely basis, which then leads to delays in the dispensing of medicines to patients. In order to improve the patient experience around discharge, where possible, working closely with the doctors and nurses we have:

1. Implemented pharmacist prescribers in clinical areas to prescribe discharge medicines at least 24hours before discharge. This provides an opportunity for patients to discuss the options for analgesics 'to take away' with a pharmacist and enables the medicines to be available on the ward before discharge
2. The Pharmacy team dispenses 'to take away' medicines in clinical areas to minimise delays. To enable this there are designated spaces in treatment rooms that are fitted with computers and labellers
3. Pharmacy continue to work with the volunteering service to try and reduce the time it takes for medication to transport from the pharmacy dispensary to the clinical areas

We have received feedback from patients about having to wait inside the pharmacy reception area for their prescriptions. In response, we have worked with RNOH charity to improve patients' experience by issuing vouchers for all patients waiting for their outpatient medicines so that they can receive a complimentary cup of tea / coffee in the hospital restaurant.

Pharmacists actively contribute to joint school sessions for elective joint arthroplasty patients. The overall aim of these sessions is to prepare patients for their admission, providing insight into what they should expect and empowering patients to be involved in decisions around their care and treatment at the RNOH.

Clinical trials

Since 2015, the Pharmacy department has been actively collaborating with consultants at RNOH to increase research capacity and undertake clinical trials for new medicines. To date we have started seven new clinical trials with plans to initiate further studies in 2018. The majority of clinical trials have been for investigative medicines used for the treatment of rare bone diseases and establishes our national and international reputation as a specialist centre in this therapy area. To accommodate this high intensity workload, the Pharmacy workforce has continued ongoing training to meet the requirements of the regulatory authorities and our clinical trial sponsors.

PART 3

PROGRESS AGAINST 2017/18 QUALITY PRIORITIES

3.1 PRIORITY 1
IMPROVING LENGTH OF STAY, A QUALITY IMPROVEMENT INITIATIVE

We recognise that improving the length of stay is an important quality issue which ensures that patients are safely discharged following their treatment in the trust. Ongoing work is being undertaken with local teams to embed the care pathways for Primary Total Hip Replacement and Total Knee Replacement patients. There is improvement in the proportion of patients discharged on or before the pathway target discharge day. Improvements that have been made to date include updated patient information booklets to guide patients on activities to aim for each day and a greater focus on pre-admission planning.

Increased Therapies POA has been introduced to support the THR/TKR pathways to highlight potential problems of rehabilitation and discharge earlier in the pathway so solutions can be sought and a plan in place before admission. An interactive patient information video for the Primary THR and TKR pathways will be commissioned, so information is available in different formats. Pathways for revision THR and TKR are being drafted. The 'On The MEND' initiative has been rolled out to all adult wards and a programme of audit commenced to measure the effectiveness. This initiative aims to support patients in 4 main areas to aid post-operative recovery: Medicines, Exercise, Nutrition, and Daily Activities. Initial results are encouraging and patient feedback has been positive. The Trust has signed up to participate in the national 'End PJ Paralysis' challenge commencing the 17th April to encourage patients across the country to be up and dressed on hospital wards. Clinical criteria for the admission of patients the day prior to surgery has been established and signed off in the two largest clinical specialities and further work will be undertaken to extend this to all areas.

3.2 PRIORITY 2

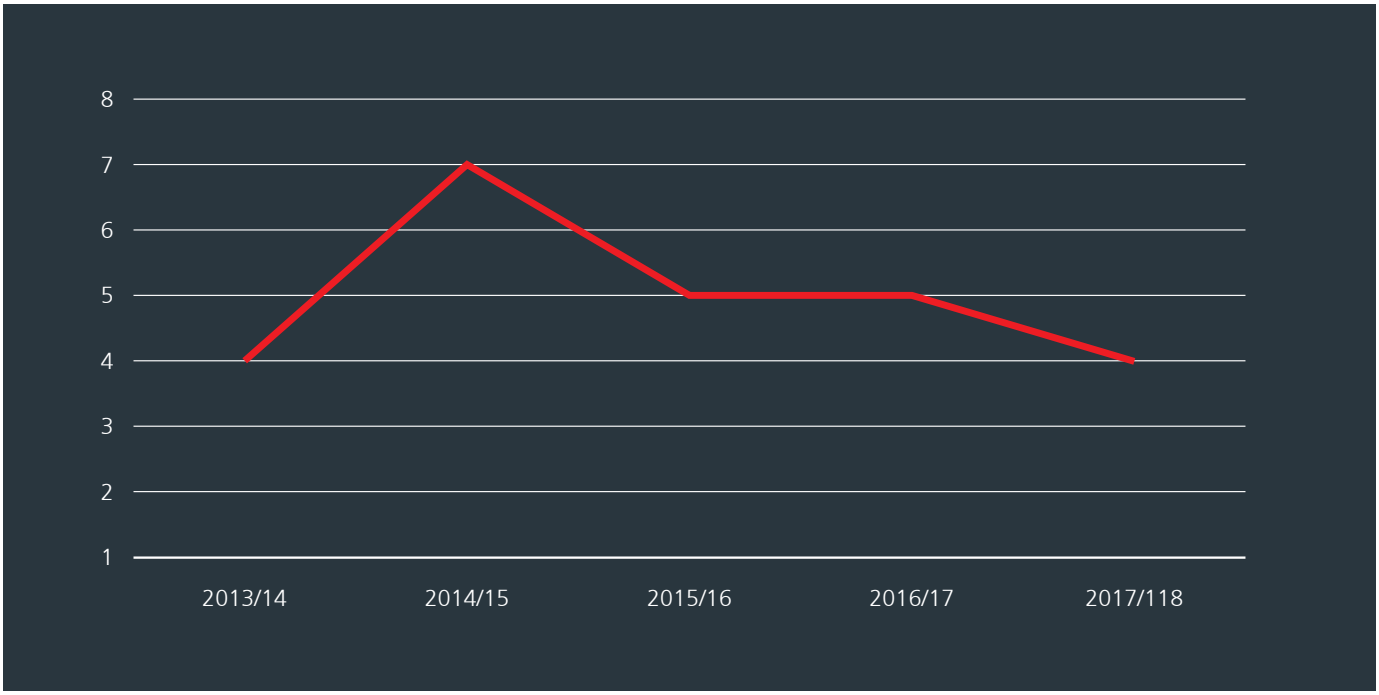
A FOCUS ON GRAM NEGATIVE INFECTIONS, IMPLEMENTATION OF A BUNDLE OF CARE TO REDUCE E-COLI

In line with the government's initiative and ambition to reduce Gram Negative Blood Stream Infections by 50% in the year 2021, the Infection Prevention and Control Team of the Trust conducts a robust monitoring of all mandatory surveillance reportable to Public Health England (PHE) including all gram negative blood steam infections in the form of E coli, klebsiella and/or pseudomonas bacteraemia.

We have initiated a 20% reduction to our internal target starting with our E coli bacteraemia from last year. To include all other gram negative organisms for this year, we have allotted the Trust an internal target of 5 cases, which is relatively lower than most acute Trust. In addition, we conduct a Root Cause Analysis of all our gram negative blood stream infection with the multi-disciplinary team whose care the patient is entrusted in order to identify any critical problems and issues, good practices and lessons learnt for improvement in practice. Results of this root cause analysis meetings are then communicated to the team involved.

Working with Clinical Audit and Effectiveness, we conduct monthly Hand Hygiene, Vascular Access and Environmental audits on all clinical areas on a monthly basis. A bi-annual Catheter Care Audit is also conducted by the Infection Control Team in collaboration with our Urology Nurse Specialists.

In addition, all our Health Care Associated Infection (HCAIs) rates are published on a monthly and quarterly basis. All medical staff undergo annual updates/trainings where Infection Control policies and procedures (ie ANTT, decontamination, etc) are discussed as part of mandatory trainings.



3.3 PRIORITY 3
REDUCING REQUEST ERRORS, A QUALITY IMPROVEMENT INITIATIVE

We identified a quality concern in relation to the requesting of diagnostic imaging within the trust, which had the potential to impact the care of circa 2000 patients per annum.

The number of request errors were reported and monitored via the trust Clinical Quality and Governance Sub-Committee Meeting in order to maintain the reduction in errors. A multi-professional team, led jointly by the Deputy Director of Quality and the Associate Medical Director coordinated the programme of improvement.

Educational support is provided and each case is discussed with the doctors where noncompliance in requesting images is identified.

Each new doctor employed by the Trust is given/directed to the RNOH polices with regards to requesting and verifying images.

The Trust's ICE system is used to track and highlight non-compliance instances which are brought to the attention of Associate Medical Director (so that he may discuss matters with individuals).

3.4 PRIORITY 4
ENHANCEMENT OF SHARED LEARNING FROM INCIDENTS AND COMPLAINTS

We recognise that in the delivery of complex specialist healthcare, we do not always get everything right. Being open and honest about this puts us in the best position to learn from what has happened so that we can prevent the same thing happening to another patient.

This year we have worked hard to improve and increase the ways in which we share learning from incidents and complaints. This includes the production of the monthly Quality Report that contains a clear focus on lessons learned from incidents, PALS, FFT, Complaints, Clinical Audits, Health & Safety, and Moving & Handling. This document is produced each month by the Quality Team. It includes Trust wide and specialty specific information about trends and outcomes for incidents, complaints and friends & family test feedback. It also includes lessons that we've learned from significant incidents that have been investigated. This document is shared widely by the Director of Nursing and the Medical Director with staff at all levels across the organisation to provide the opportunity for all staff to learn from each other and improve the quality of care in their areas. It is available for all staff on our internal intranet pages.

This Quality priority was focused on ensuring thorough investigation through implementation of the recommendations of the Healthcare Safety Investigation Branch (HSIB) and the recently published requirements related to the investigation of deaths in hospitals.

A review of the Safeguard system has been undertaken. Updates to incident reporting form have been carried out with a view to making the forms more user friendly and ultimately helping to improve incident reporting rates. Optional anonymous reporting has also been made available to all users.

Monthly Quality Improvement and Lessons Learnt Review Panel (QUILL) provides high level assurances that corrective lessons from avoidable patient safety incidents are actioned and that any relevant learning is seen to have taken place. Cross Divisional learning is also facilitated during QUILL meetings.

Shared learning updates are being shared at CQGC and also at QUILL meetings. The Divisional Performance Review meetings provide further opportunities for Divisions to share any learning outcomes arising from incidents and complaints.

QUALITY IMPROVEMENT AND AUDIT PRESENTATION MORNING

The Trust conducts a bimonthly Quality Improvement and Audit morning which all Trust staff are encouraged to attend. Lessons learnt from Mortality and Morbidity are discussed as a standing item on the agenda. This is undertaken by the Trust Audit Lead, Dr Matt Henley.

A copy of the presentations is made available to all staff via Grapevine (our intranet). Key points are also included in the Audit Round Up, which is a new newsletter which includes a summary of all the learning from presentations at the Audit Morning. It is a helpful way of sharing learning with those unable to attend the meeting, and also provides a good reminder for those who were there.

LESSONS LEARNED SESSIONS FOR JUNIOR DOCTORS

We recognise the huge contribution of our junior doctors in ensuring that the organisation delivers high quality care and how important it is that we ensure they have the opportunity to learn about how we can improve care. As a staff group who move through organisations regularly, they are a really important source of sharing good practice between NHS hospitals. We have introduced a lessons learned section within their lunchtime training sessions

3.5 PRIORITY 5

DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF 5 LOCAL SAFETY STANDARDS IN INVASIVE PROCEDURES (LOCSSIP'S)

Local Safety Standards for Invasive Procedures are a mechanism of ensuring consistent application of safety critical interventions for high risk procedures. NHS provider organisations were required to develop local procedures based on national best practice examples and this formed a major quality priority for the organisation in 2017/18.

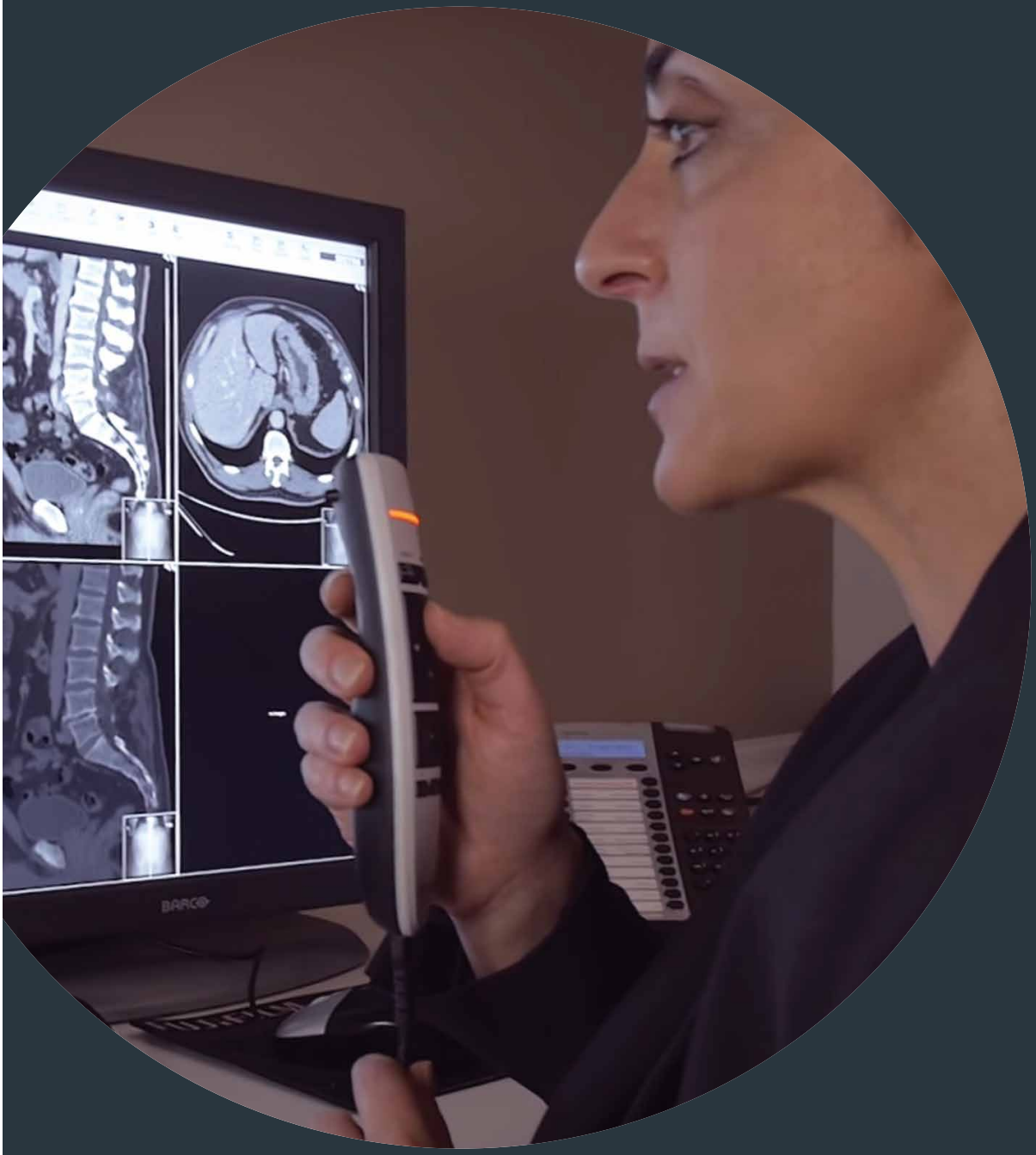
Development, testing and roll out of LocSSIP's was led by the Clinical Director of Critical Support Services, as part of a multi-professional team. A task force was established to coordinate the development of these procedures, test their effectiveness and to recommend to the clinical governance and quality sub-committee (CQGC) that they are adopted for use within the organisation.

Significant progress has been made with regards to this quality priority. The Trust is now fully compliant with NatSSIP recommendations with the LocSSIP. Additionally, regular audit compliance is now embedded in those areas where Invasive Procedures are conducted.

PART 4

QUALITY PRIORITIES FOR 2018/19 AND STATEMENT OF ASSURANCE FROM THE BOARD

4.1
QUALITY PRIORITIES FOR 2018/19



4.1.1 PRIORITY 1 IMPROVING LENGTH OF STAY

The RNOH agreed that improving the length of stay (specifically for patients who have a primary hip or knee replacement) was an important quality improvement initiative. Over the past 15 months the Trust has implemented opportunities to reduce inappropriate adult inpatient hospital stays, whilst maintaining safe, risk assessed and high quality patient care.

As part of this work, the Trust has set itself a SMART (Specific, Measureable, Achievable, Realistic and Timely) objective for reducing the length of stay for all adult inpatients having a primary total hip/knee replacement by March 2019 and reduce the average LoS by increasing the number of patients discharged on or before their target discharge date, from the 4 surgical wards.

This initiative also involves reducing the proportion of adult inpatients admitted the day before elective surgery from Joint Replacement Unit (JRU), Spinal and Sarcoma specialities and introducing On the MEND principles on wards

How we will monitor this

The Trust has been measuring progress through the following key performance indicators:

- Target Discharge Date
- Overall average length of Inpatient Spell (on the Mend group)
- Admission the day before surgery

The Trust has identified milestones to achieve this quality improvement priority and the progress against these milestones is monitored via monthly update report to Length of Stay Steering Group. The progress against each priority is also reported to the Trust Board on a Monthly basis through the Improvement Programme Board update.

4.1.2 PRIORITY 2
THEATRE UTILISATION PROJECT

RNOH recognises that the patient's surgical journey is complex and crosses many boundaries. Services to patients can only be improved if operating theatres are seen as part of a wider more complex system.

The overarching strategic aim of this initiative is to facilitate a step change in performance of theatre productivity at the RNOH for the benefit of Patients and Staff. This initiative involves consistent improvements in various areas affecting theatre productivity with a particular focus on intra-session utilisation and list pick up rates.

How we will monitor this

The Trust has been measuring the progress through the following key performance indicators:

- List order changes
- Late starts
- Early finishes
- % Utilisation
- Weekend operating
- Empty lists
- Cancellations on the day
- Booking rate (%) (booking efficiency)

The Trust has identified milestones to achieve this quality priority and the progress against these milestones will be monitored via monthly update report to Theatre Action Group. Progress is also reported to the Improvement Programme Board once every two months and monthly to the Trust Board via the Improvement Programme Update report.

4.1.3 PRIORITY 3 SAFER STAFFING

Implementing a safer clinical staffing model for the RNOH that is underpinned by equitable contractual arrangements and effective systems and processes is a key priority for 2018-19. Assessing the care needs of patients is paramount when making decisions about safe staff requirements for RNOH. RNOH recognises that assessment of patients' care needs should take into account individual preferences and the need for holistic care and patient contact time.

The Trust has set itself some SMART objectives around Safer Staffing Improvement Project which include implementing revised job planning, updating the leave policy for medical workforce, implementing consistent rates of pay for additional sessions, implementing consultant-led weekend ward rounds, implementing on-call supplement rates of pay for medical staff, implementing a sustainable non consultant doctor workforce and implementing a sustainable medical physician consultant workforce to deliver high quality patient care

How we will monitor this

The Trust has been measuring the progress through the following key performance indicators:

- Job plans
- Additional sessions arranged
- Consultant leave
- On-call arrangements
- Development of the Sustainable Safer Medical Staffing Models

The Trust has identified milestones to achieve this quality priority and the progress against these milestones will be monitored via monthly update report to the Medical Management Meeting / Safer Staffing steering Group. Progress is also reported to the Improvement Programme Board once every two months and monthly to the Trust Board via the Improvement Programme Update report.

4.1.4 PRIORITY 4

DEVELOPING CAPABILITY AND CAPACITY OF STAFF IN QUALITY IMPROVEMENT METHODOLOGY

Developing Capability and Capacity of staff in Quality Improvement Methodology is one of the Trusts key quality priorities for 2018-19. It is important for staff to build the skills set, knowledge and experience required to meet the future needs of the service.

In time this should lead to a culture or way of delivering improvement that is consistent amongst all staff delivering any type of improvement whether it is quality or service improvements, small scale change or complex transformation.

We have been working with University College London Partners to develop a bespoke training offering for the RNOH. It is intended that a programme of training is developed and delivered to all staff.

The training will be rolled out in four phases:

- People already leading prioritised improvement projects
- Executive and non-executive directors
- All staff
- RNOH senior leadership community

How we will monitor this

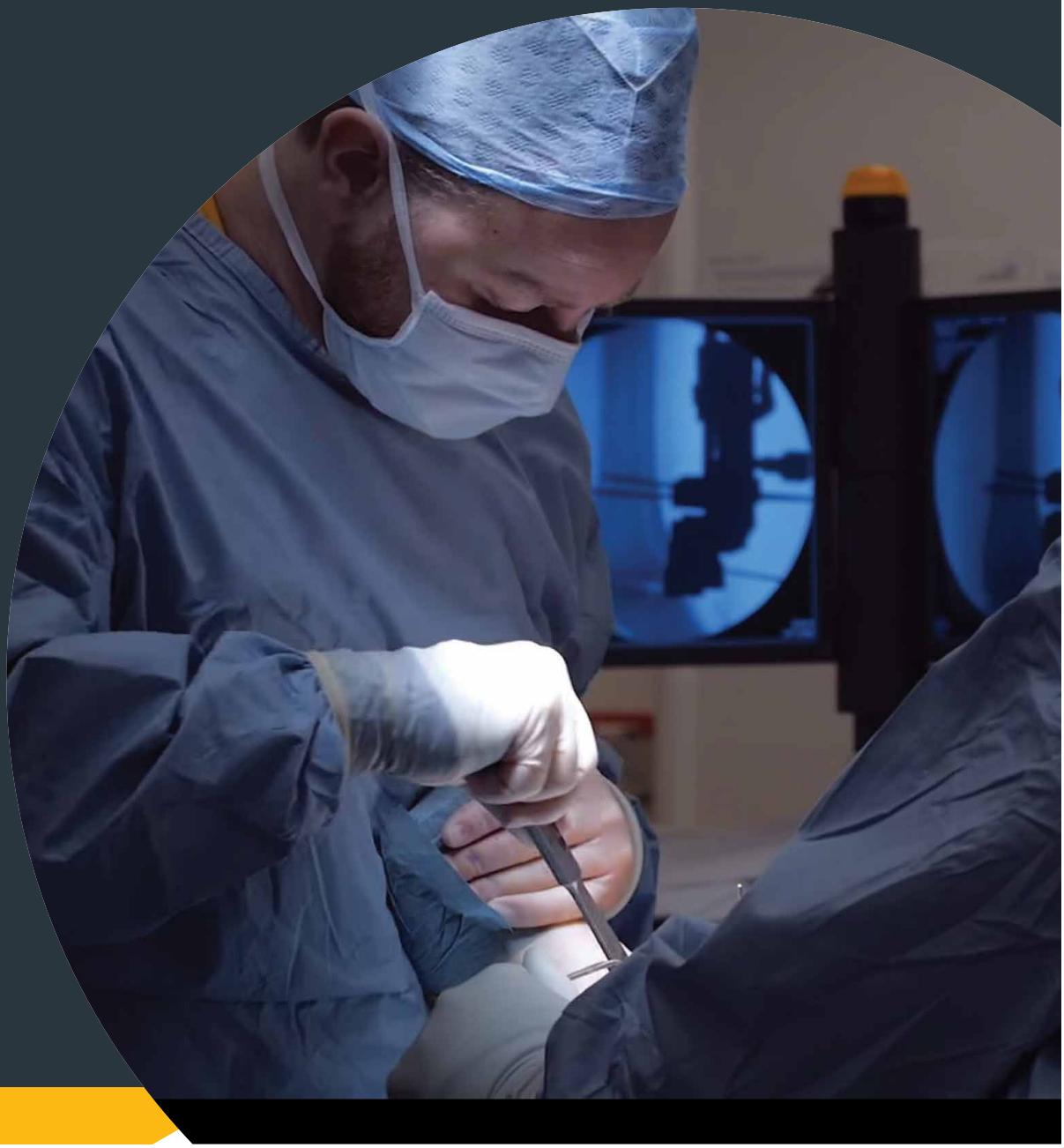
RNOH will measure the progress made against this quality priority by delivering the RNOH Improvement Leaders Programme 2018.

The programme will provide staff with the ability to increase their knowledge in building capability and capacity to improve quality, patient outcomes and experience, alongside increasing efficiency. It offers time and space to plan and have open dialogue in a safe environment, away from the usual workplace, as well as the opportunity for more tangible learning and benefits that will enable us to develop quality improvement work which delivers better results for patients and populations.

The Trust has identified milestones to achieve this priority and the progress against these milestones will be monitored via monthly update report to the Improvement Programme Board and Trust Board.

4.2 STATEMENTS OF ASSURANCE FROM THE BOARD

All providers of NHS services are required to provide certain mandatory reporting elements within their annual Quality Account. This section of the account contains the required mandatory information and, where necessary, an explanation of our quality governance arrangements relating to these indicators.



4.2.1 REVIEW OF SERVICES

During 2017/18, the RNOH provided 23 NHS services. The RNOH has reviewed all the data available to them on the quality of care in all of these NHS services.

The 23 clinical services provided by the RNOH are:

- Anaesthesia
- Bone Infection Unit
- Clinical Neurophysiology
- Clinical pharmacy and Medicines Optimisation
- Foot and Ankle
- Functional Assessment and Restoration (FARs)
- Histopathology and Pathology
- Joint Reconstruction
- London Sarcoma Unit
- London Spinal Cord Injury Centre
- Orthopaedic Medicine
- Orthotics and Prosthetics
- Paediatric and Adolescents
- Pain Management Services
- Peripheral Nerve Injury Unit
- Plastics
- Radiology
- Rehabilitation and Therapy
- Shoulder and Upper Limb
- Spinal Surgical Unit
- Urology
- Psychiatry
- Clinical Psychology

The NHS income generated by the relevant health services reviewed in 2017/18 represents 90% of the total income generated from the provision of relevant health services by the RNOH for 2017/18.

4.2.2 PARTICIPATION IN CLINICAL AUDITS

Participation in National Clinical Audits

In 2017/18, the RNOH was eligible to and did participate in 100% (4) National Clinical Audits and 100% (1) National Confidential Enquiry.

The National Clinical Audits and National Confidential Enquiry that the RNOH was eligible to participate in are listed below, alongside the number of cases submitted compared to the requirements set out by the enquiry/audit.

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES	NUMBER OF CASES REQUIRED BY THE AUDIT	PERCENTAGE SUBMITTED
NATIONAL JOINT REGISTRY:		
HIP, KNEE AND ANKLE REPLACEMENTS	**1368**	IN PROGRESS (95.5%)
HIP AND KNEE PRIMARY AND REVISION PROCEDURES (2016/17)	**1082**	100%
NATIONAL COMPARATIVE AUDIT OF BLOOD TRANSFUSION: 2017 AUDIT OF TRANSFUSION ASSOCIATED CIRCULATORY OVERLOAD (TACO	**20 CASES SUBMITTED**	100%
SERIOUS HAZARDS OF TRANSFUSION (SHOT):		
UK NATIONAL HAEMOVIGILANCE SCHEME	**7 REPORTS**	100%
NCEPOD: PERI-OPERATIVES MANAGEMENT OF SURGICAL PATIENTS WITH DIABETES STUDY	**5**	100%
CASE MIX PROGRAMME (ICNARC)	**1088**	100%

The National Joint Registry (NJR) was set up by the Department of Health and Welsh Government in 2002 to collect information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. The Trust continues to contribute to the National Joint Registry (NJR). The compliance rate for submission of Hip and Knee replacement operations is currently being analysed. Continuous work is being undertaken to ensure compliance is in alignment with the benchmark figure of 95%.

4.2.2 PARTICIPATION IN CLINICAL AUDITS CONT'D

The Trust participated in National Comparative Audit of Blood Transfusion - 2017 Audit of Transfusion Associated Circulatory Overload (TACO). There was no minimum cohort however Trusts were advised to submit data for a maximum of 20 patients. The RNOH submitted 20 (100%) cases.

The Trust participates in Serious Hazards of Transfusion (SHOT) scheme. SHOT is the United Kingdom independent, professionally-led haemovigilance scheme. Since 1996 SHOT has been collecting information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom. RNOH submitted 7 (100%) reports in 2017/18.

The **reports of 3 relevant national clinical audits** were published in 2017/18. These reports were reviewed and we intend to take the following actions to improve the quality of healthcare provided:

1

National Joint Registry: Hip, Knee and Ankle Replacements

- To continue to participate in the Registry to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards; benefiting patients including outcomes and clinicians
- Better links now established between the NJR and RNOH clinicians to understand requirements for cancer patients including endo prosthesis
- Presentation given by NJR at recent clinical audit day, enhancing understanding of consultants part in the process
- All historical data backlog has now been taken over and cleared by Theatre Admin and clinical teams
- New monthly compliance check report has been established to avoid backlog re-occurrence going forward
- Improved clinical engagement seen across all specialties

2

National Confidential Enquiry- Chronic Neuro-disability in Children, Young People and Young Adults

- To work in collaboration with Clinical coding to improve the quality of routine data
- Clinicians offering assessments to consider neurodisabling conditions as possible diagnoses have timely access to MRI, including facilities for sedation and/or general anaesthesia if required
- Patients with neurodisability condition have their weight measured as a marker of nutritional status when admitted to the ward and seen in outpatients
- Admitting team to ensure that patients with neurodisability condition who also have a learning disability should have this clearly documented in their notes
- Audit being planned on the pathway to ensure patients undergo timely review prior to major surgery to ensure optimal preparation and planning
- Pain scoring tools are used in the peri-operative/peri-procedure period for patients with a neurodisabling condition and staff are trained in the use of various tools
- Post operatively the clinicians liaise with the local community services and feed into the care plan
- All paediatric inpatients are admitted to paediatric wards, or private rooms

3

National Comparative Audit of Blood Transfusion

2016 Repeat Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery

- NICE guidance - Anaemia pathways has been established and in place since November 2016
- All patients with HB outside of the WHO guidance (deemed anaemic) are screened and seen by Consultant Anaesthetist for appropriate management
- Options are being explored for investment in POCT machines for checking Hb post transfusion
- Transfusion training is now part of the Medical induction and regular SHO teaching sessions (including single unit transfusion) are in place since January 2018
- Audit to be undertaken in 2019

4.2.2 PARTICIPATION IN LOCAL CLINICAL AUDITS

For the year 2017/18, a total of 64 local Clinical Audits were registered which are specific to RNOH. The **reports of 42 completed audits** have been reviewed during the year. This include regular monthly audits to check the standards to which we should be operating at, assessing our current practice and then implementing actions (if required) to ensure that we provide safer and more effective care.

1

The NHS Safety Thermometer

For 2017/18 the highest recorded harm free percentage has been 99.26%. We have consistent low percentage of RNOH acquired harms which includes Falls with Harm, New VTEs, New Pressure Ulcers and New UTIs.

If any new harm is identified, actions are put into place immediately by the ward. All harms are reported via the web incident reporting system and All PU's reported are escalated to the Lead TVN.

2

Safeguarding Children Knowledge

This audit was undertaken to demonstrate the impact of training on knowledge, practise and outcomes.

The audit has shown that staff members are aware of safeguarding information on Grapevine (Intranet). However, further information could be made available on notice boards and via newsletters to boost information.

Going forward the following actions will be undertaken to improve compliance:

- Contact details to be made available in key ward and department areas
- Safeguarding team to monitor outcomes – incorporating the use of PAR – and feedback to staff
- Teaching to staff via the use of newsletter and safeguarding notice board information

3

Hand Hygiene

Hand Hygiene audit is carried out to measure compliance against the National guidance by World Health Organisation (WHO) 5 Moments for Hand Hygiene approach. Devised by the World Health Organisation (WHO) it defines the key moments when health-care workers should perform hand hygiene.

The following actions were undertaken to improve compliance:

- Infection Prevention and Control Team to Continue Hand Hygiene education via periodic training opportunities and word level monitoring
- IPCT to continue monitoring hand hygiene compliance across the trust and publish audit findings to ensure awareness and encourage ownership of hand hygiene practices

4

Vascular Access Management Audit

The purpose of this audit was to reduce the risk of infection by improving the use and management of vascular access devices. NICE Clinical Guidance CG139, Prevention and control of healthcare-associated infections in primary and community care (published in March 2012) contains standards for Vascular access device site care. These devices are one of the main causes of healthcare-associated infections, and bloodstream infections associated with central venous device insertion are a major cause of morbidity.

The following actions were undertaken to improve compliance:

- Anaesthetic charts used in Theatres are reprinted to cover vascular access insertion criteria
- Awareness through education and posters are being implemented by IPCT in coordination with Clinical Educators and Theatre Link Nurse to ensure compliance to this criteria

5

Environmental Ward Spot-check and Full Compliance Audits

Monthly spot-checks are done by the Infection Control Nurse and through peer audit The checks are completed for all wards. Compliance is monitored by the Infection Control team.

A further full compliance audit is completed twice yearly for all areas, once by the Matron for the area and once by the (IPC) team.

The following actions were undertaken to improve compliance:

- Issues are immediately addressed with further monitoring done through the full compliance audit
- Senior Nurses in Wards carry out continuous education and equipment cleaning audit in Clinical Areas
- Minimise clutter given the lack of storage space and continue environmental cleaning
- Continuous observation and inspection by team composed of Estates & Facilities Administrator, ISS Domestic Manager and IPC Nurse is conducted every first Friday of the month to a specific ward/area/ department

6

Combined Nursing Audit

Combined Nursing audit is conducted on monthly basis to identify current practice of completing various aspects of Nursing practice. The audit is designed to monitor nursing documentation, slips trips & falls assessments, Pressure Ulcers, Nutritional Assessment and Care Planning.

The following actions are undertaken to improve compliance:

- Progress is monitored via clinical audit software "AuditR" and shortfalls are addressed on monthly basis via AuditR alerts to identified leads
- National Early Warning Score (NEWS) app has been trialled across certain wards. It will be fully implemented across all wards to improve compliance
- New reporting system for Combined Nursing had been introduced on AuditR to improve monitoring

4.2.2 PARTICIPATION IN LOCAL CLINICAL AUDITS CONT'D

7

Sharps Safety Audit

The Infection, Prevention & Control Team at RNOH NHS Trust commissioned an external audit on sharps safety.

This audit was undertaken to establish whether or not sharps are disposed of in a safe manner. All wards and departments were visited and existing practice was observed.

The following actions were undertaken to improve compliance:

- Training for proper assembling of sharps containers has been completed for infection control link staff. The links continue to disseminate the lessons in their respective departments.
- Teaching sessions in use to support sharps management through trust infection control training, audit and area inspection

8

Situation, Background, Assessment and Recommendation (SBAR) Reporting Audit

Use of SBAR tool results in the timely, accurate handover of information from one healthcare professional to another and reduces the risk to the patient as it results in fewer gaps in communication. This audit was undertaken focusing on the handover of care from one healthcare professional to another.

The following actions were identified to improve compliance:

- Ward managers relay to their staff the importance of using the SBAR tool on regular basis
- Outreach to insists on SBAR handover
- In depth SBAR training is provided as part of NEWS and SEPSIS training. Nurses are encouraged to book themselves for both courses.
- NEWS policy is being updated to focus on the expected standards
- A prompt to the NEWs app is being added for staff to use the SBAR tool

9

End of life Care Staff Confidence Audit

This audit was carried out to ascertain the level of confidence of Registered nurses and Health care assistants within the RNOH for caring for patient at the end of their life.

The following actions were identified to improve compliance:

- Training sessions to be delivered on the care in the last days of life, providing knowledge and skills of symptom management, communication skills with the patient and family, exploring issues around preferred place of death, care of the deceased patient.
- Training sessions on breaking bad news will be available for the MDT by May 2018
- Development and implementation of a 'Care in the last days of life' framework, which describes symptom management for patients
- Revision of policies related to the care of patients in the last days of life and care of the deceased patient
- Implementation of a quarterly End of Life Care reflective practice session where staff can come together to discuss the challenges of delivering end of life care, reflect on actual care delivered and support each other/learn
- Continue the rotational programme with UCLH for the Duke of Gloucester ward staff, to provide them with exposure of oncology and palliative care services

10

Anticoagulation status for Radiology referrals

RNOH recognises that in order to holistically care for patients, it is essential to identify any areas of concern prior to their intervention. Information exchange should be conducted in a timely manner in order to best serve the patient's needs.

This audit is aimed at finding a way to minimise the delay to patient care by having a pathway to ensure the best possible treatment for patients.

The following actions were identified to improve compliance:

- Audit to be disseminated to referring Team
- Report to be presented at the Clinical Quality and Governance Committee, following the appointment of Imaging Quality Manager
- Radiologists to identify altered haemostasis documented on referral when vetting. Radiographers to add an alarm and notify the radiologist.

11

Readmissions to Children's HDU

Readmissions to HDU within 48 hours are a standard metric of quality of High Dependency care. This audit was undertaken to measure compliance with various recommendations by NICE guidelines NG 51, CG 160 and Quality standard QS161.

The following actions were identified to improve compliance:

- Further education in the use of PEWS chart particularly since new PEWS chart was introduced to RNOH
- Hold multidisciplinary M and M to discuss one of the cases in more detail
- Re audit covering Friday readmissions and PEWS escalation guidelines

4.2.2 PARTICIPATION IN LOCAL CLINICAL AUDITS CONT'D

12

Pre-admission Service for Sarcoma/JRU

This re-audit was undertaken to improve patient pathway by reviewing the pre assessment service.

The following actions were identified to improve compliance:

- Develop a protocol for day before admissions
- Pre-operative bloods to be verified by the team during planning meetings
- Share the audit findings with the pre assessment team
- Re-audit in 12 months' time

13

Sarcoma MDT Outcomes Audit

Weekly and monthly Sarcoma MDT meetings are conducted by Sarcoma team. This audit was undertaken to assess the effectiveness of sarcoma MDT in terms of documentation, Communication and Investigation planning. The audit also looked at the communication with the referring Hospitals / GPs and discharging patients back to local follow up when appropriate.

The following actions were identified to improve compliance:

- Improve documentation during MDT and have clear communication with colleagues
- Continue to discharge patients from RNOH when appropriate
- Use of 'AdHoc Telephone Note' on NoteOn for documentation of 'out-of-MDT' discussions & updates

14

Antibiotic use in Paediatric Surgery

This audit was conducted to assess current perioperative prophylactic antibiotic usage in the under 18 year old population.

The aim was to see if antibiotics were given in accordance to the current protocol.

The following actions were identified to improve compliance:

- The audit was presented to the Paediatric surgeons in order to encourage further discussion with the microbiologists regarding adherence to the protocol
- Current protocol will be reviewed in order to improve adherence via re-audit

15

World Health Organisation (WHO) Surgical & Imaging Safety Checklist Audit

The Safer Surgery Saves Lives initiative was launched by the World Health Organisation (WHO) in 2008 to develop patient safety throughout the perioperative phase of care through a reduction in the number of surgical errors; which could lead to patient death. WHO checklist audit is completed in real-time for all the procedures carried out in theatres and interventional procedures carried out in Imaging.

The following actions were undertaken to improve compliance:

- An ongoing observational audit has been introduced to capture adherence to WHO Checklist completion policy. This will focus on the quality of the checks conducted
- Locally WHO safer surgery checklist data is analysed on monthly basis to identify any areas of improvement
- Chart identifying any missing elements / sections are provided to Head of Nursing for Critical Support Services Division. This is displayed in the Theatres notice board
- Areas of low compliance are addressed at team meeting

16

Quarterly Controlled Drugs Audit

This audit was undertaken to ensure all wards and theatres are compliant with the Medicines Policy (MP10) and Controlled Drugs legislations.

The following actions were undertaken to improve compliance:

- Quarterly CD checks to be conducted with ward pharmacist and ward Managers
- Heads of nursing to provide feedback on the results of this audit to their staff
- Heads of nursing to ensure CDs are ordered by authorised member of staff only. They should Check nurse/OPD signatures list regularly to ensure the list is up to date
- CD stock list for the clinical area to be reviewed by ward pharmacist and ward manager in order to ensure that appropriate amount of CDs are stored in the clinical area
- Ward pharmacist to review ADIoS monthly to ensure any abnormal supply of CDs are investigated immediately
- Education and training for nurses and ODPs in relation to documentation
- Ensure that the expiry dates for CDs are checked on daily basis when daily stock check is carried out and that they are removed from ward as soon as possible by the ward pharmacist
- Nursing staff to review physical state of CD registers and ensure replacements ordered if physical state is poor (Head of Nursing)

4.2.2 PARTICIPATION IN LOCAL CLINICAL AUDITS CONT'D

17

Monitoring of Blood Results

The Outpatient Parenteral Antibiotic Therapy (OPAT) service enables treatment of patients requiring antibiotics for longer duration (eg 6 weeks) in an outpatient setting, facilitating an earlier discharge from (or avoiding admittance to) RNOH.

The service has been using a dedicated online documentation tool developed by the British Society for Antimicrobial Chemotherapy (BSAC) since Jan 2015. This audit was undertaken to examine the use of this tool for documenting blood test results whilst solely under the care of OPAT.

The following actions were undertaken to improve compliance:

- Investigate the possibility of Measuring Tecioplanin levels in-house.
- Investigate the best method of documenting changes to medication and reason for change.
- Update booklet
- Patient education

18

Review and audit the Upper Limb (SEU & PNI) In-patient Adult Rehabilitation Service

This audit was undertaken to improve the clinical care for the treatment of patients with complex shoulder dysfunction and PNI during the in-patient adult rehabilitation programme.

The following actions were undertaken to improve compliance:

- Referral criteria has been created and agreed by leads
- Feedback results at team meetings and to distribute full copies of documents and summary to the Upper Limb Therapy Team and Psychology team
- Re Audit in 6 months

19

Upper Limb Therapy Annual Notes Audit and Annual Notes re-audit

Healthcare professionals are legally required to record their input when treating patients in line with guidance from the relevant professional bodies. The audit was conducted to measure compliance against the standards set by the College of Occupational Therapists (2010), the Chartered Society of Physiotherapists (2013) and the British Dietetics Association (2015).

The following actions were undertaken to improve compliance:

- Disseminate results to the team via email
- Present and discuss results at team meeting
- Develop standards for labelling, uploading and referencing of external documents
- Weekly team meetings will be held to make plans how to improve compliance and emphasis on legal requirements and Re-audit to be done in January 2018 to see compliance

20

Food brought into hospital by patients

This audit was conducted as a result of the concerns highlighted by the Nutrition Steering Committee around the safety of food brought into hospital by patients. Furthermore a QIP on Jubilee Rehabilitation unit last year (2016) prompted a review of current practice across the wards.

The following actions were undertaken to improve compliance:

- Communication team to signpost patients to guidance on food brought from home at pre-admission and during admission
- Ward managers to check fridge operating procedure are being completed by staff and reported back to Nutrition Steering Committee
- ISS to ensure adequate snacks are available at all times
- ISS to educate ward Host on appropriate storage of opened items

21

Gastrostomy Care Audit

Findings from the coroners court in 2014 and a survey of the nursing staff knowledge prompted provision of training and new documentation regarding gastrostomy tube management in the Trust.

This audit was carried out to review compliance with gastrostomy care documentation.

The following actions were undertaken to improve compliance:

- Dissemination of audit findings to nursing and nurse educator staff and NSG for action/information by dietitian
- Dietitians' to support nursing staff by prompting use of the check list when providing an enteral feeding protocol

22

Timely Referrals following Muscle injections for Spasticity

This audit was carried out in response to the NICE guidance on management of spasticity. It was felt appropriate to look at the timeliness of our therapy referrals made to local services as muscle injections do require early therapeutic intervention to maximise the benefits.

- **The following actions were undertaken to improve compliance:**
- To clarify the process for internal and external referrals
- Ensuring all members of the therapy team including Physiotherapist, Occupational Therapists, technicians, students and admin support are informed of the process fully including timely requirement of referrals being made

4.2.2 PARTICIPATION IN LOCAL CLINICAL AUDITS CONT'D

23

Patient Satisfaction Feedback for the Peripheral Nerve Injury Rehabilitation Programme

The inpatient Peripheral Nerve Injury (PNI) rehabilitation programme is a unique service aimed primarily at adult patients who have undergone recent brachial plexus surgery. Additionally the service can be accessed by PNI patients who have specific rehabilitation goals that would be best achieved via an inpatient stay.

This audit was conducted to determine patient's level of satisfaction with the PNI one week inpatient rehabilitation programme.

The following actions were undertaken to improve compliance:

The current practice met all the required standards, there were no recommendations, action points or risks identified for improvement. However following actions were proposed to continue to provide good service:

- Dissemination of audit results to all colleagues
- Re-audit in 2018

24

Adult Orthopaedic Team – Notes Audit 2017

Therapy staff have a professional and legal obligation to keep an accurate record of their interactions with patients (CSP 2017). Being able to make and maintain records is a requirement of HCPC registration.

This audit was undertaken to ensure standards of record keeping are being maintained and improved.

The following actions were undertaken to improve compliance:

- Colleagues to evaluate their adherence to the standards of record keeping and Therapy department policy
- To review the results and actions at team meeting
- Re Audit this in August 2019

25

Respiratory Function Test Assessment and Documentation Re-Audit

This re-audit was aimed at assessing whether the standards for monitoring respiratory function are being met by the physiotherapists for patients on LSCIC.

The following actions were undertaken to improve compliance:

- Inform staff that RFT's will no longer be inputted onto ICE (as physio notes now being scanned)
- Audit lead to read scanned physio notes to check RFTS are present and legible
- Staff have been reminded to perform PCF on discharge when appropriate.
- Re Audit in March 2018

26

Speech and Language Therapies Documentation Audit

As part of routine clinical practice within the therapies directorate we are required to complete an annual notes audit. The therapies directorate uses a standardised, collective notes audit proforma using standards taken from physiotherapy, Occupational therapy and dietetic professional bodies. This audit was undertaken to measure compliance with the standards.

The following actions were identified to improve compliance:

- Disseminate information to team on correct documentation of consent.
- Develop a team specific abbreviation list to adhere to for both Dietetics and Speech and Language Therapy department

27

Paediatric Therapies Notes Audit

This audit was undertaken to ensure that Therapists (Physiotherapists, Occupational Therapists and Therapy Technicians) are aware of the legal context within which they work, and comply with regulatory, national, professional body and local employer guidance on record keeping.

Compliance was measured against the standards of recording, accessing, and storing health records in line with the HCPC Standards of conduct, performance and ethics (2016), NHS Professionals CG2 Record Keeping Guidelines (2016), CSP Quality Assurance Standards (2012) and the Royal National Orthopaedic Hospital (RNOH) Trust policy.

The following actions were identified to improve compliance:

- To present findings to Paediatric Therapy team
- Re-Audit May 2018

28

Audit to improve inpatient clinical care in patients following single stage posterior scoliosis surgery at the RNOH

Spinal pathways were first rolled out in April 2016 as a length of stay initiative. They were created to help standardise and improve patient care. To develop the pathway, improved patient information was provided in the form of videos and booklets and the intermediate care plan (ICP) were developed with MDT input. MDT staff was educated on the new pathway. The pathway was then initiated for Ward 4. Activity was initially tracked for the initial 6 months (April 2016-October 2016) and then discontinued.

The audit was conducted to assess the use of RNOH inpatient pathway for single stage posterior scoliosis surgery and to identify if the standards are being met

The following actions were identified to improve compliance:

- To discuss findings with nursing staff and agree on recommended practice re TWOC
- Discuss findings with MDT and Medical team
- Re-Audit June 2018

4.2.2 PARTICIPATION IN LOCAL CLINICAL AUDITS CONT'D

29

Audit to improve inpatient clinical care in patients following low back spinal fusions at the RNOH

Spinal pathways were first rolled out in April 2016 as a length of stay initiative. They were created to help standardise and improve patient care. To develop the pathway, improved patient information was provided in the form of videos and booklets and the intermediate care plan (ICP) were developed with MDT input. MDT staff was educated on the new pathway. The pathway was then initiated for Ward 4. Activity was initially tracked for the initial 6 months (April 2016-October 2016) and then discontinued.

The audit was conducted to assess the use of the RNOH inpatient pathway for low back fusion surgery and to identify if the standards are being met.

The following actions were identified to improve compliance:

- Discuss findings with nursing staff and agree on recommended practice re TWOC
- Discuss findings relating to x-ray, TTA, Discharge and ICP with medical team and MDT
- Re –Audit in June 2018

30

Audit of the orthotic referral pathway for TLSOs in Adolescent Idiopathic Scoliosis

The audit was conducted to inform expert opinion of the indications for TLSO bracing in the literature and improve the relevance of the orthotic treatment pathway in TLSO bracing for conservative management of Adolescent Idiopathic Scoliosis.

The following actions were identified to improve compliance:

- Informing expert opinion. Presenting the audit results at the trust's audit day to encourage more timely referrals from the spinal consultants before the patient's curves progress past 40 degrees
- Changing the ICE referral criteria to make Risser sign a compulsory piece of information
- Changing the ICE referral criteria to make any surgical intervention planned a compulsory piece of information

31

Occupational Therapy Documentation Audits (Orthopaedic Oncology, LSCIC)

An audit of the LSCIC's Occupational Therapy documentation was undertaken to assess compliance with local standards and identify any areas requiring improvement.
In line with the Trust's annual record keeping audit, each team within therapies aims to audit their own documentation yearly. Accurate documentation is essential in providing clear communication, and ensuring the health and safety of patients and staff.

The following actions were identified to improve compliance:

- Introduction of staff stamps and all staff to comply
- To email Orthopaedic Oncology Occupational Team with revised new improved standards
- Patients goals, range of motion, hobbies and social history to be documented as part of Therapists daily practice
- Patient's stickers will be made available in each set of notes
- Subjective and Objective marks should be identified and a diagnosis to be recorded consistently for every patient
- Audit lead to clarify of required nature of warning

32

Physiotherapy Team Documentation Audits (Orthopaedic Oncology , LSCIC)

As part of a therapy wide strategy, documentation audit was conducted to support improvements in quality and governance compliance of clinical records.

The following actions were undertaken to improve compliance:

- Audit lead to present results at January 2018 team meeting
- Audit lead to seek clarification around documentation of frequency and warning for exercises
- Audit lead to raise awareness of audit to support integration of documentation into normal practice
- Audit lead to carry out spot checks in supervision and feedback to supervisors by clinical team
- Audit lead to clarify permissible abbreviations
- Alteration of proforma to address issues around consent for sharing information with other agencies in order to encourage documentation

4.2.2 PARTICIPATION IN LOCAL CLINICAL AUDITS CONT'D

33

Rehabilitation Discharge Audit

All patients admitted under the Shoulder and Elbow Unit and Peripheral nerve injury unit have a joint Occupational Therapy and Physiotherapy discharge report. This report is produced on C-scribe and stored in C-store/Note-on. A new agreed standard was set last year regarding time frame for completing the discharge reports. The team had endeavoured to meet this standard and an audit was completed in November 2017 with a plan to re-audit every 6 months.

This audit was carried out to measure level of compliance with agreed standard of completion of discharge report

The following actions were identified to improve compliance:

- Disseminate the findings to relevant staff
- Staff to follow fail safe process in order to improve compliance

34

Nutrition Initiatives Audit

The Nutrition & Dietetics Department have introduced a number of nutrition initiatives into the Trust, in order to support and improve the nutritional care of patients. These initiatives include revised food record charts, kitchen whiteboards (to record patients' specific dietary requirements) and updated menus.

This is a snapshot audit with an overall aim of improving the nutritional care of patients at RNOH and to determine the operational success of nutrition initiatives in place.

The following actions were identified to improve compliance:

- Ward Managers to enforce set days for weighing & completing tool
- Ward Managers to ensure nutrition screening tool completion is a routine part of admission
- Dietitians to provide laminated ready reckoner and measurement technique charts
- Ward clerks to ensure adequate supply of magnets and red trays on ward
- Heads of Nursing to ensure ward staff at every level are aware of the protected mealtime of the ward and feel confident to challenge non-adherence
- Ward Managers to remind staff to use the screening tool to identify those who need assistance and special meals, and utilise magnets and kitchen white boards
- Catering Manager to ensure Hosts have a copy of every menu for reference
- Head & Deputy Head of Nursing to raise awareness of good screening and nutritional care at nursing Forums
- Dietitians to include screening tool practical workshop in nurse revalidation training
- Dietitians to provide training session to catering manager to disseminate to Hosts
- Dietitians to offer ward based training to nurses on malnutrition screening
- Ward Managers to identify Nutrition Link Nurse and wear badge

35

Adult SLT and Dietetics - Annual Notes Audit

As part of routine clinical practice within the Therapies directorate, Adult SLT and Dietetics are required to carry out an annual notes audit. It is essential that documentation is thorough, and accurate and not open to misinterpretation. Key reasons for carrying out this audit are to comply with the requirements of clinical record keeping procedures in therapies, and RNOH medical records policy. It is also recognised that an audit will help identify areas of concern as well as area where good practice can be shared. It will also ensure that all staff involved in clinical record keeping are aware of the relevant requirements and ensure efficiency and professionalism in the clinical record keeping process and procedures. This will ensure that the quality of the health record facilitates high quality treatment and care and that subsequently a health record can justify any decisions taken if required.

The following actions were identified to improve compliance:

- Disseminate information to team on correct documentation of consent
- Develop team specific abbreviation list

36

Patient Satisfaction for Paediatric Therapy Team

Therapists ensure the service they are providing is satisfactory to the patients and their carers. The Health and Care Professions Council (HCPC) outline professional standards in the form of Standards of conduct, performance and ethics (SCPE).

This audit was conducted to learn if the patients' and carers' experience of in-patient paediatric occupational therapy and physiotherapy was satisfactory.

The following actions were identified to improve compliance:

- Audit lead to feedback to therapy team focusing on the importance of gaining consent and explanation of the role of Therapist.

37

Pain Management & Rehabilitation Notes Audit

Therapists are legally required to record their input when treating patients in line with guidance from the relevant professional bodies. The minimal requirement for the RNOH is for a notes audit to be completed once a year.

An updated notes audit tool was recently formulated based on standards from the College of Occupational Therapists (2010), the Chartered Society of Physiotherapists (2013) and the British Dietetics Association (2015).

The audit was aimed at reviewing the quality and standards of clinical notes for the Pain Management and Rehabilitation team for 2017.

The following actions were identified to improve compliance:

- Audit lead to disseminate the results via email and presentation to the team

4.2.3 PARTICIPATION IN CLINICAL RESEARCH

Clinical research is important part of improving healthcare delivery. Each year thousands of patients take part in clinical studies around the NHS. The Royal National Orthopaedic Hospital NHS Trust together with our academic and commercial partners is always looking for ways to improve patient treatment through delivery of high quality research studies.

In 2017/18 over 700 patients were recruited into wide range of clinical research studies (both NIHR Portfolio and non-Portfolio studies). Our studies are reviewed by research ethics committee (REC) as well as the Health Research Authority (HRA).

We provide opportunities for clinical research participation to our patients, and provide access to cutting edge treatments; this includes patients with rare conditions for whom treatments are currently limited. We provide individual patient solutions as part of innovative treatment, and support international studies for patients with extremely rare conditions.

Participation in clinical research demonstrates The Royal National Orthopaedic Hospital NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. We work closely with our university partners to develop new treatments for our patients and our collaborations have produced impact on patient care locally and beyond. We're committed to producing new ideas across all staff groups to deliver research, which has a potential to change the way we treat our patients. Involving staff and patients in developing and delivering is essential for gaining the benefit associated with being a research active organisation.

The Royal National Orthopaedic Hospital NHS Trust was involved in conducting 80 clinical research studies of which 24 were initiated in during the past year in the neuro- musculoskeletal specialities. There were over 100 members of clinical staff participating in research approved by a national research ethics committee at The Royal National Orthopaedic NHS Trust, and support for clinical research continues to grow.

Our engagement with clinical research also demonstrates The Royal National Orthopaedic NHS Trust commitment to testing the latest medical treatments and techniques. RNOH collaborates with universities as well as industry partners in delivering cutting edge technology to everyday care. Our engagement with clinical research also demonstrates The Royal National Orthopaedic NHS Trust commitment to testing the latest medical treatments and techniques. **Our collaborations include international projects with EU funding, and we also contribute to national projects such as the Genome 100,000, which aims to change care delivery in the UK.**

CASE STUDIES

SHORT TITLE:

ASCAT

TITLE:

Autologous Stem Cells in Achilles Tendinopathy (ASCAT) – A phase II, single centre, proof of concept study

LEAD:

Mr Andrew Goldberg

PROJECT:

The main aims of the ASACT study are:

1. To evaluate the safety of autologous bone marrow derived culture-expanded mesenchymal stem cells (MSCs)
2. To show that MSCs can improve patient outcome

SHORT TITLE:

VIBROfoucs

TITLE:

A pilot study investigating the effect of focal vibro-tactile stimulation on muscle performance as a possible technique for neurorehabilitation of spastic impaired upper limbs

LEAD:

Dr Rui Loureiro & Tijana Vojinovic

PROJECT:

The aim of the project is to research focal vibro-tactile effects on an abnormally increased muscle tone related stiffness of the connected joint for a short period of time. The second aim is to evaluate whether the combination of focal muscle vibration with subsequent robotic-assisted movement of the wrist joint can enhance functional recovery by improving volitional control of muscle activation.

4.2.4 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) PAYMENT FRAMEWORK

Commissioning for Quality and Innovation (CQUIN) scheme is intended to deliver clinical quality improvements and drive transformational change. They are intended to reduce inequalities in access to services, the experiences of using them and the outcomes achieved.

For the first time the Trust is opting for a two year CQUIN scheme which has provided greater certainty and stability on the CQUIN goals leaving more time for health communities to focus on implementing the initiatives.

The 2017/19 CQUIN schemes have been influenced by the ambitions of the Five Year Forward View (FYFV). CQUIN in isolation will not address these issues, but if aligned with the Sustainability and Transformation Plans (STPs) covering the whole health and social care systems, it can be a strong lever to help bring about changes: to deliver improved quality of care to patients through clinical and service transformation.

To deliver the FYFV, organisations will move to more place based commissioning geared towards transforming services to deliver better quality standards for patients, improving the working environment for staff, and delivering financial balance. The national indicators reflect these priorities. There is a focus on clinical quality improvements which will help achieve better outcomes for patients. There is a new standard focussed on the health and wellbeing of staff, directing collective action to develop a sustainable workforce. The CQUIN schemes are intended to deliver clinical quality improvements and drive transformational change.

During 2017/19 the Trust signed up to CQUINs with both Clinical Commissioning Groups (CCGs) and NHS England (Specialised Commissioning).

The Trust overall income target associated with 2017/19 CQUIN schemes was approximately £2.5 million per annum. Details of the agreed CQUIN schemes for 2017/19 are provided in the table below.

The Trust actual income to date for achievement of CQUINs for 2017/18 is £848,179 to date. The expected remaining £1,204,966 is currently being invoiced to our commissioners.

Monthly monitoring both within the Trust and with the commissioners has taken place to assess progress against each of the milestones. For the first year the trust has fully achieved all Specialised Commissioning CQUINs.

The trust has also achieved all Non-specialised Commissioning CQUINs. With 5 Fully Achieved and 1 Partially achieved. The Trust agreed 4 CQUIN schemes with NHS England for Specialised commissioners and 6 CQUIN schemes with Non-Specialised Commissioner CCG's.

For Specialised Commissioning:
Out of 4 schemes the outcome was as follows:

1. All CQUINs Q1: Fully Achieved
2. All CQUINs Q2: Fully Achieved
3. All CQUINs Q3: Fully Achieved
4. All CQUINs Q4: Fully Achieved - Awaiting assessment – confirmation in May 18

For the CCG schemes:
Out of 6 schemes the outcome was as follows:

1. All CQUINs Q1: Fully Achieved
2. All CQUINs Q2: Fully Achieved
3. All CQUINs Q3: Fully Achieved
4. 5 CQUINs Q4: Fully Achieved - Awaiting assessment – confirmation in May 18
5. 1 CQUINs Q4: Partially Achieved - Awaiting assessment – confirmation in May 18

SCHEME AGREED	FULL YEAR INCOME POTENTIAL £
CCG: NHS STAFF WELL BEING HEALTH & WELL BEING OF STAFF	**54,330**
CCG: HEALTH FOOD	**54,330**
CCG: FLU UPTAKE	**54,330**
CCG: TIMELY IDENTIFICATION AND TREATMENT OF SEPSIS	**162,989**
CCG: ANTI-MICROBIAL RESISTANCE	**54,330**
CCG: EMPIRIC REVIEW OF ANTIBIOTIC PRESCRIPTION	**54,330**
CCG: ADVICE & GUIDANCE	**162,989**
CCG: E REFERRALS	**162,989**
NHSE: ANTIMICROBIAL (RESISTANCE AND STEWARDSHIP)	**184,447**
NHSE: ADULT CRITICAL CARE	**227,342**
NHSE: SPINAL SURGERY NETWORK	**313,132**
NHSE: ANTIMICROBIAL (RESISTANCE AND STEWARDSHIP)	**184,447**
NHSE: TELEMEDICINE	**132,974**
TOTAL	**2,053,145**

The achievement of these CQUINs has been underpinned by the continuous engagement and work between Finance/Commissioning and CQUIN leads. This is to be embedded further in 18/19 in order for it to become RNOH standardised approach to the management of CQUINs

4.2.4 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) PAYMENT FRAMEWORK CONT'D

During 2017/18, as a result of CQUINs programme, improvements made to date include:

- Establishment and operation of regional spinal surgery networks, data flows and MDT for surgery patients
- The Pharmacy team have made considerable engagement with this CQUIN which has resulted in full achievement for all quarters
- Telemedicine services in Chronic pain and urology were implanted and further developed. Trust committed to increasing the use of telemedicine to help improve the experience of our patients by reducing the number of appointments which require physical attendance at the hospital. This recognises the challenges that many of our patients have in travelling to the site. In addition to disabilities and reduced mobility, our patients travel some of the largest distances in the country to access services at the RNOH, and we recognise that increased provision of telemedicine will promote greater accessibility of the services, while also achieving efficiency gains and cost reductions in service provision
- There has been a significant focus on Flu Vaccination within the Trust in 2017/18 which has culminated in the full achievement of this CQUIN. Work to improve the vaccine uptake has been coordinated through our Pandemic Flu group with effective collaboration between our Infection Control Team, Microbiology Team, Pharmacy Team, Nursing & Medical Colleagues, Communications Team and Quality Team. Vaccinations started in October 2017 and are still ongoing. Fixed drop-in sessions were provided, and roving vaccinators to wards and outpatient departments to increase the accessibility to the vaccine for clinical staff. We also targeted key clinical meetings including MDT meetings, Trust wide Audit Morning, Staff achievement awards night. We also capitalised on national infection control week to increase awareness and promote uptake of the vaccination
- RNOH are the only provider for NHSE doing this Critical care service redesign CQUIN. The developments of the critical service to develop and implement the; Admission and discharge policy, Acute intervention team, transfer of zero organ supported patients to ward care rather than critical care and new Integrated care pathways have made the full achievement of this CQUIN possible
- Development & implementation of Advice and Guidance service for Spinal surgery & Joint Reconstruction. Advice and Guidance (A&G) allows one clinician to seek advice from another. Advice and Guidance is a communication between GP's and RNOH consultants. A&G is a really useful mechanism that will help to reduce the number of inappropriate referrals into our two highest GP referred services; Joint Reconstruction & Spinal Surgery.

This service enables GPs to seek advice on the appropriateness of a referral for their patient, whether to refer, or what the most appropriate alternative care pathway might be. It also enables the GP to identify the most clinically appropriate service to refer a patient into

- Aantimicrobial resistance (AMR) is the single biggest threat to public health. The UK Government has taken strong leadership, by making AMR a national priority with the aim of reducing both Gram-negative bacteraemia and inappropriate antimicrobial prescribing by 50% by 2020. This is important for the RNOH, as AMR complicates the prevention and treatment of orthopaedic infection. Our antimicrobial stewardship committee has clinically led a program of quality improvement focusing on the prescribing, supply and administration of antimicrobials with the aim of achieving the best clinical outcome for the patient and minimising the risk of Clostridium difficile infection and antimicrobial resistance. This has led to the safe reduction in antimicrobial usage and achievement of national CQUIN targets.

The full list of CQUIN schemes that will run into 18/19 are below:

CCG CQUINS

- National – NHS Staff Health & Well Being - Healthy Food and Drinks Options
- National – NHS Staff Health & Well Being Improvement of health and wellbeing of NHS staff
- National – NHS Staff Health & Well Being Uptake of Flu
- National – Reducing impact of Serious Infections
- National – Advice and Guidance
- National – Preventing ill health by risky behaviours – alcohol screening
- National – Preventing ill health by risk behaviours – alcohol brief advice or referral

NHS England CQUINS

- Spinal Surgery Network
- Clinical Benchmarking – Service Re-design
- Telemedicine
- Reducing impact of Serious Infections

4.2.5 CQC REGISTRATION AND COMPLIANCE

All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain high quality care in order to retain their registration. RNOH is required to register with the CQC and its current registration status is 'without conditions'. There have been no CQC visits or reviews of the RNOH during 2017/18 and CQC has not taken any enforcement actions against RNOH in 2017/18.

4.2.6 DATA QUALITY

The oversight of data quality and its assurance falls within the remit of the Information Quality and Governance Steering Subcommittee. The Sub-Committee which is supported by the Information Governance Team has established the new Trust's Data Flow Mapping which identifies Information Asset Owners and Administrators. The Data Flow Map identifies data flows in to, through and out of the Trust's data systems. During the next year, work will be undertaken to document the internal processes that data processers use internally and assurance and validation arrangements will be put in place to ensure that data is processed accurately and correctly and that the data on which decisions are made are reliable.

4.2.7
NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

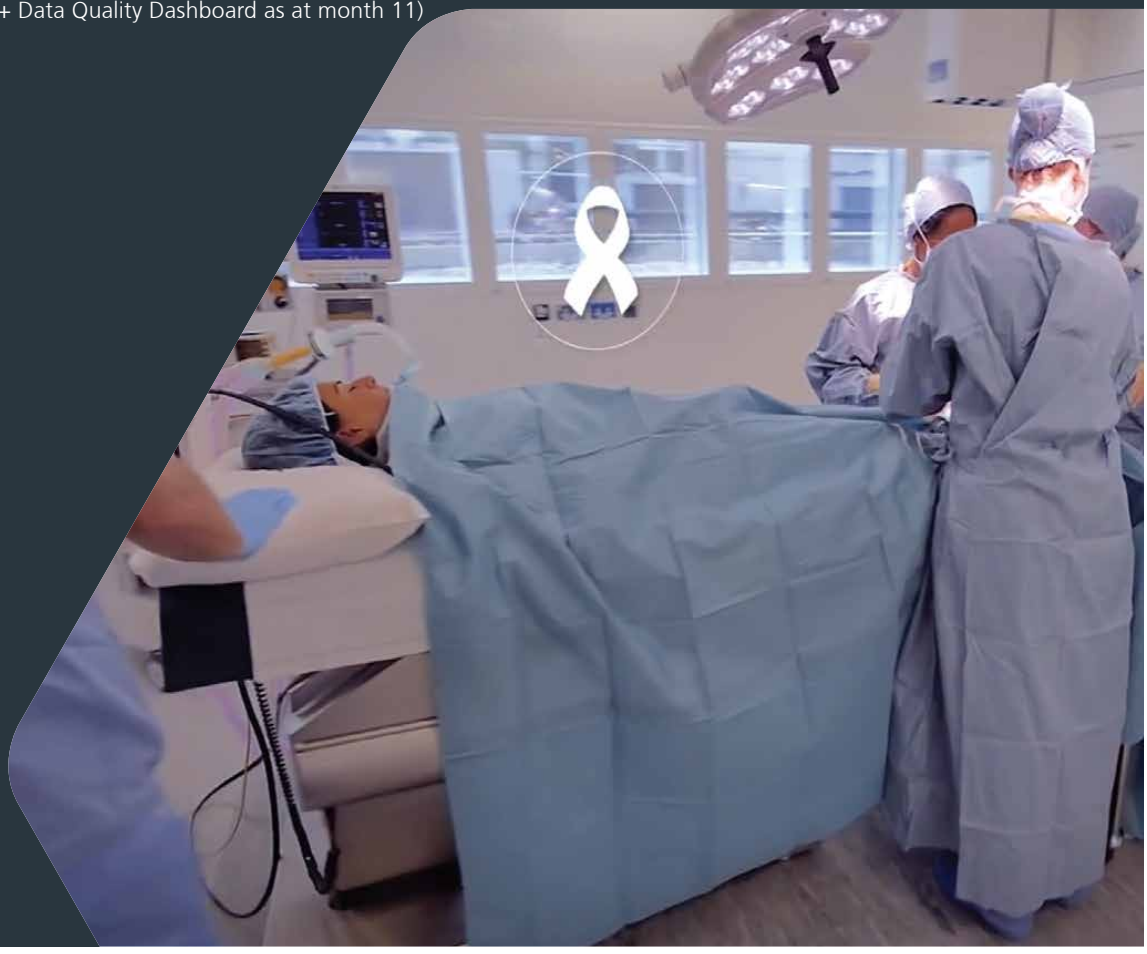
RNOH submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- **98.6%** for admitted patient care
- **99.1%** 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 patient care
- **99.9%** for outpatient care

(Source: SUS+ Data Quality Dashboard as at month 11)

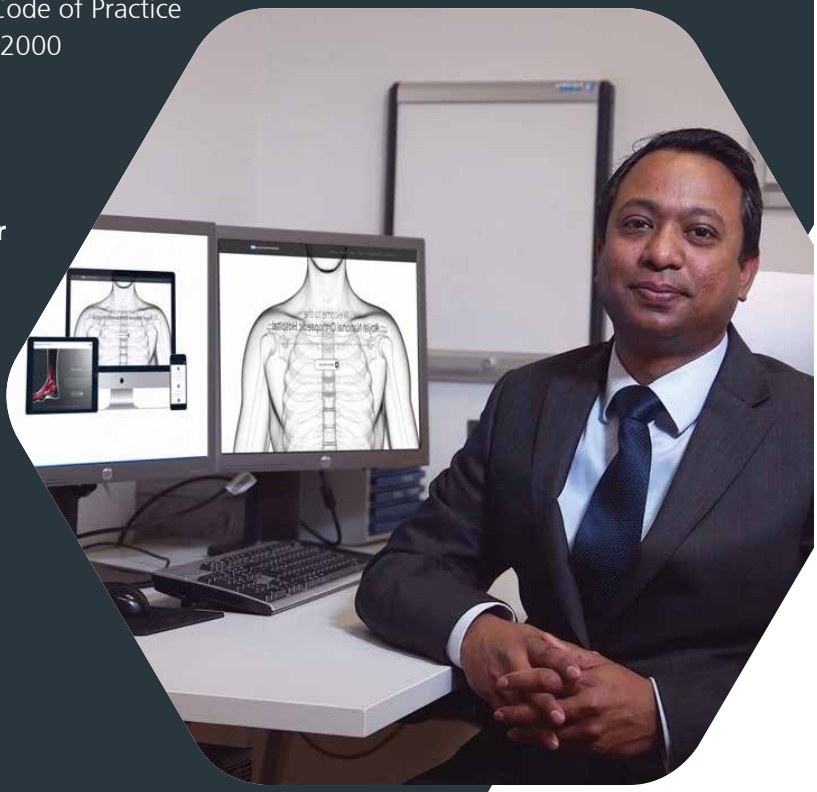


4.2.8 INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

Information Governance (IG) assesses the way organisations 'process' or 'handle' information. It covers personal information (i.e. that relates to patients/ service users and employees) and corporate information (e.g. financial records). IG provides a way for employees to deal consistently with the many different rules about how information is handled, including those set out in:

- The Data Protection Act 1998
- The common law duty of confidentiality
- The Confidentiality NHS Code of Practice
- The NHS Care Record Guarantee for England
- The Social Care Record Guarantee for England
- The International Information Security standard: ISO/IEC 27002: 2005
- The Information Security NHS Code of Practice
- The Records Management NHS Code of Practice
- The Freedom of Information Act 2000
- The Human Rights Act article 8
- The Caldicott Report

RNOH Information Governance Assessment Report final score for 2017/18 was 71%, and was graded 'Satisfactory'.



4.2.9 CLINICAL CODING ERROR RATE

RNOH was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission. However an internal formal clinical coding quality audit was completed to NHS Digital and Information Governance standards in March 2018. The audit report demonstrates that the RNOH has maintained its high standard of coding quality and has achieved excellent coding accuracy.

YEAR	PRIMARY DIAGNOSIS ACCURACY	SECONDARY DIAGNOSIS ACCURACY	PRIMARY PROCEDURE ACCURACY	SECONDARY PROCEDURE ACCURACY
17/18	96.5%	98.1%	96.3%	93.5%
16/17	95.0%	97.9%	99.0%	95.0%

The income variance for the audited sample was (variance = 0.9% for a sample total value of £505,599). The error rate was slightly higher than previous year and this was due to new trainee staff in place. Most errors were made in the interventional radiology day cases with minimal impact on income. Overall clinical coding audit findings show a high level of coding and income accuracy.

4.2.10 NHSE EMERGENCY PLANNING RESILIENCE AND RESPONSE ASSURANCE

The annual EPRR assurance process is used in order to be assured that NHS organisations in London are prepared to respond to an emergency, and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

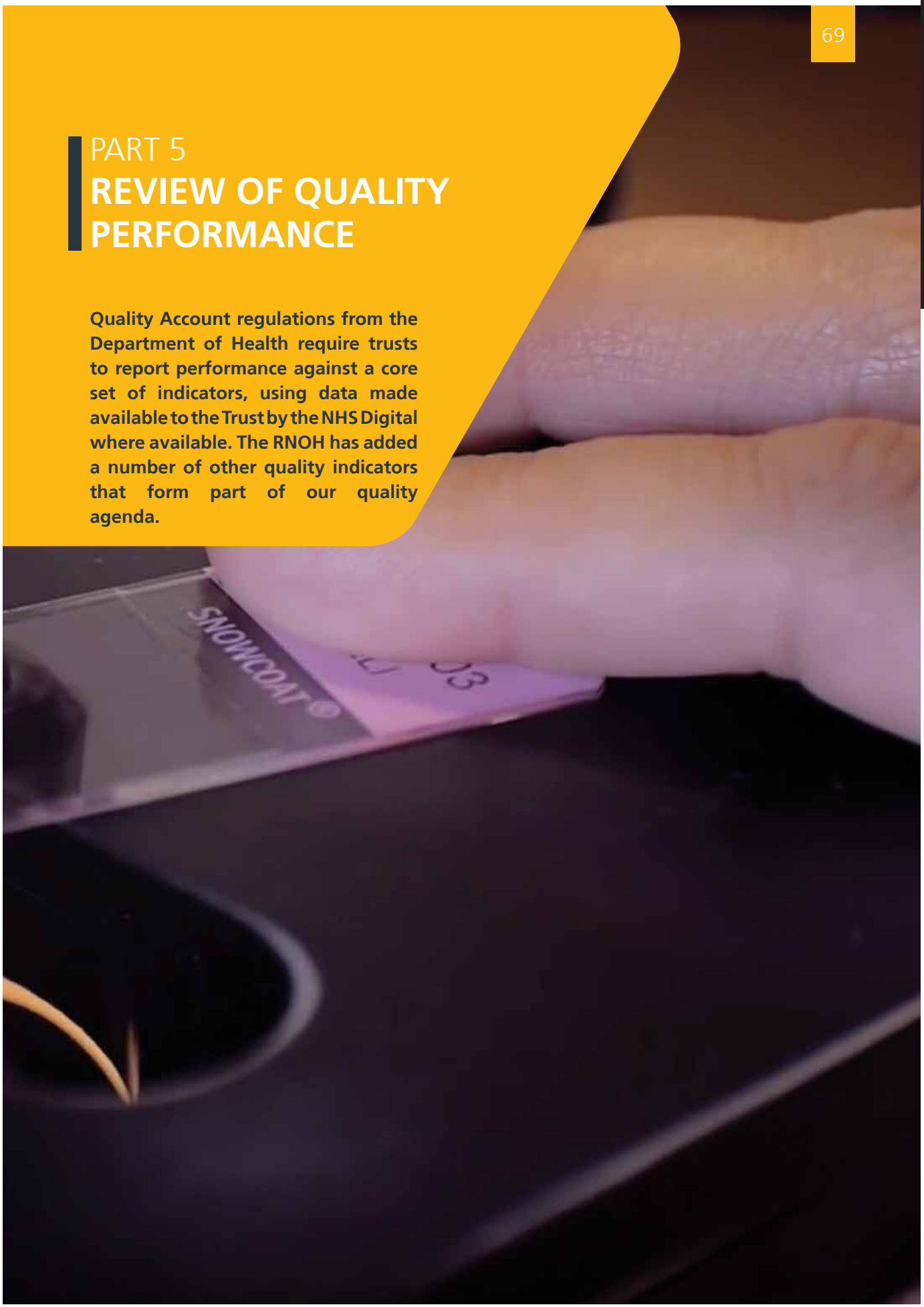
All organisations were required to carry out a RAG rated self-assessment against the NHS Core Standards for EPRR; this included the organisation's 2016-17 scores as a baseline to assess the 2017-18 position. The NHS Core Standards for EPRR remained unchanged however in 2017-18 an additional set of "deep dive" questions on organisational governance were introduced.

RNOH demonstrated full compliance against all 56 applicable standards i.e. all the standards relating to Governance, Duty to maintain plans, Command & Control, Training and Deep dive. RNOH was commended by NHS England for the substantial progress across all areas.

PART 5

REVIEW OF QUALITY PERFORMANCE

Quality Account regulations from the Department of Health require trusts to report performance against a core set of indicators, using data made available to the Trust by the NHS Digital where available. The RNOH has added a number of other quality indicators that form part of our quality agenda.



5.1 PATIENT SAFETY MEASURES

CORE INDICATOR

5.1.1 RATE OF ADMISSIONS ASSESSED FOR VENOUS THROMBOEMBOLISM (VTE)

The RNOH considers that this data is as described for the following reasons. The data is collected regularly and is overseen by the multidisciplinary VTE Group.

VTE group works to:

- Ensure that the hospital follows national guidance on VTE and meets the requirements of the All Party Parliamentary Thrombosis Group
- Keep VTE related policies and processes up to date
- Implement and review mechanisms for VTE related clinical audits
- Complete root cause analysis investigations of all cases of VTE as nationally recommended
- Collate and analyse data on VTE risk assessment, prophylaxis and events including in-depth trend analysis using RCAs finding

Set up training and education for staff including medical doctors, pharmacists, and ward staff on VTE prevention, recognition, and treatment

INDICATOR	2015/16	2016/17	2017/18
% PATIENTS ADMITTED WHO WERE RISK ASSESSED FOR VTE	99.7%	99.8%	98.5%

Source: NHS England published data except *provisional internal data

The Trust has taken the following actions to improve the rate of risk assessments and so the quality of its services:

- A clinical audit is being planned against the VTE policy and NICE guidance Quality Standard
- An up to date policy on VTE is available to all members of staff via intranet. The policy is based on the latest NICE guidance and is actively being followed by the clinicians
- VTE committee is working closely with Surgeons, Cardiologists and Haematologists to develop action plan in order to fully implement the NICE guidance on VTE

CORE INDICATOR

5.1.2 CLOSTRIDIUM DIFFICILE INFECTION RATE

The Royal National Orthopaedic Hospital NHS Trust considers that the rate per 100,000 bed days of cases of Clostridium difficile infection is as described for the following reasons: the Trust complies with the Department of Health guidance for mandatory reporting and management of positive cases of C. difficile infections acquired in the Trust. The data is submitted to Public Health England and it is benchmarked nationally against other Trusts. The RNOH board subjects outs C. difficile data to external audit for assurance purposes.

- For financial year 2017/18 the Trust had 5 cases of C. difficile infections against a target limit of 2 i.e. C-Diff incidents / 100,000 bed days is 8.44. The Trust recorded further 1 case of C. difficile carrier but toxin negative in its inpatient group within the year. The target limit is held against the number of incidents that are deemed as resulting to lapses in care. For the year, following root cause analysis conducted, only 1 of the 5 cases was regarded as a lapse in care. C. difficile infection was promptly identified resulting to patient having appropriate treatment and recovered aptly.
- Good practices, areas needing improvement and actions generated by the RCA are communicated to the multi-disciplinary team and the patient according to Duty of Candour principles. The infection control team on behalf of the Trust continues to embed the following actions targeted at reducing its rate of C. difficile infection in order to improve the quality of its services and patient experience by:
- Maintaining and monitoring standards of cleanliness in the hospital and patient's surroundings
- Continuous staff education on C. difficile infection; its causes/pathway, identification, appropriate sampling, prompt treatment, isolation precautions, handwashing and other preventive measures
- Maintaining and monitoring compliance with good infection control practice across the Trust including good hand hygiene practice and cleaning of clinical equipment as priorities
- Networking with other hospitals, professional groups and public sector stakeholders by sharing and implementing best practice in relation to management of C. difficile infection
- Ensuring robust root cause analyses of patients who develop C. difficile infection in the hospital with the aim of identifying good practice, areas for improvement and whether there are lapses in patient care. These are all taken into consideration for a learning curve
- Maintenance of the Outpatient Parenteral Antimicrobial Therapy (OPAT) service, patient monitoring via the Bone Infection clinics and assurance through the Antibiotic Stewardship group and Infection Control Committee
- Strengthening antibiotic stewardship within the Trust via consistent review of antibiotic prescribing, assessment and management of patient with or at risk of C. difficile infection in line with best practice

- The table below provides comparison of the number of C. difficile infections in the Trust last 4 years versus allocated target limits by NHS England. The target limit score is a yearly figure calculated by NHS England and is based on performance indicators of the previous year. (https://improvement.nhs.uk/resources/clostridium-difficile-infection-objectives/)

	2014/15	2015/16	2016/17	2017/18
C. DIFF INFECTIONS	3	2	2	5
TARGET LIMIT	13	2	2	2

Note: Confirmed data – Public Heath England – HCAI Data Collection System 2017/18

CORE INDICATOR

5.1.3 PATIENT SAFETY INCIDENT REPORTING

The RNOH considers that the rate of patient safety incidents reported and the number and percentage of such incidents that resulted in severe harm or death are as described for the following reasons:

- The Trust actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken
- The Trust submits patient safety incident data to the National Reporting Learning System. We are ranked against other Trusts in respect of the rate of reporting and category of harm

	2014/15		2015/16		2016/17		2017/18
	APR 2014 SEP 2014	OCT 2014 MAR 2015	APR 2015 SEP 2016	OCT 2015 MAR 2016	APR 2016 SEP 2016	OCT 2016 MAR 2017	APR 2017 SEP 2017
NUMBER OF PATIENT SAFETY INCIDENTS REPORTED[1]	501	361	347	334	343	428	633
RATE OF PATIENT SAFETY INCIDENTS REPORTED, PER 100 ADMISSIONS (AS OF 14/15 PER 1000 BED DAYS)[2]	22.15	16.33	15.9	16.05	16.3	21.37	31.76
% INCIDENTS THAT RESULTED IN SEVERE HARM (OR DEATH)	3.80%	3.90%	0.60%	0.30%	0%	0%	1.60%
% INCIDENTS THAT RESULTED IN DEATH	0.40%	0.30%	0%	0%	0.30%	0.50%	0.20%
LOWEST PERFORMING TRUST			16.34	16.05	16.3	13.67	14.82
HIGHEST PERFORMING TRUST			150.63	141.94	150.6	149.7	174.59

Data Source: (Source: NRLS Organisation data for Acute Specialist Hospitals)

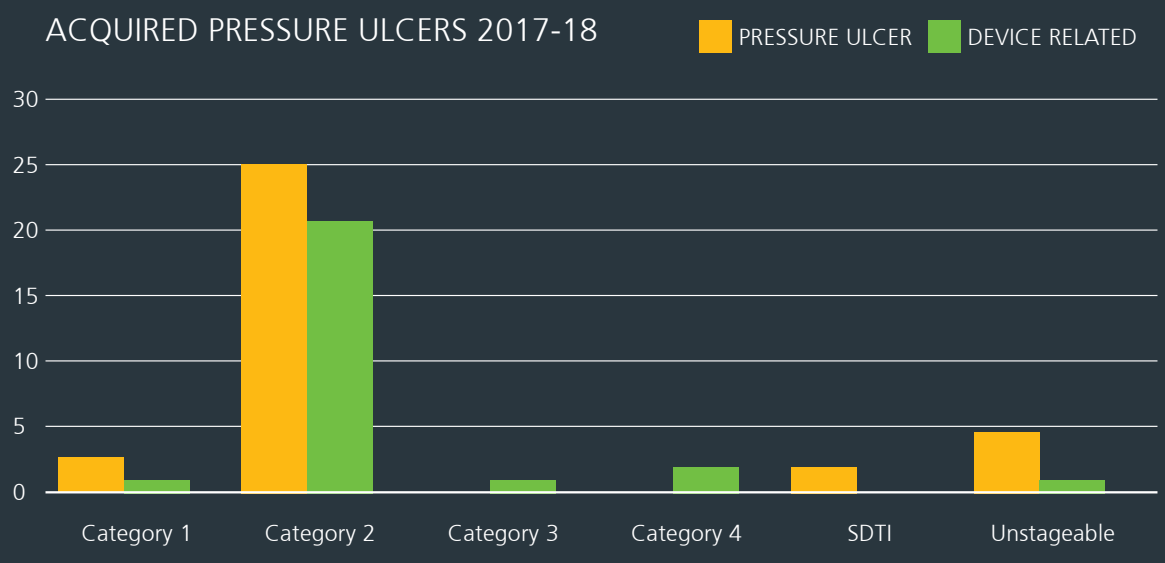
The Royal National Orthopaedic Hospital recognises that although serious incidents in health and social care are relatively uncommon, from time to time things can and do go wrong in the delivery of complex healthcare. When adverse incidents do occur the Trust has a responsibility to investigate & ensure that there are systematic measures in place for safeguarding people, property, Trust resources and reputation. This includes responsibility to learn from these incidents in order to minimise the risk of these happening again.

A combined incident and serious incident policy was approved in 2016. This policy is supported by the Complaints Policy and Being Open and Duty of Candour Policy which helps the organisation to understand why things went wrong, how we can prevent or minimise similar incidents and how we can share that learning across the organisation and externally. Serious incidents are investigated by a nominated multidisciplinary panel using the root cause methodology. Monthly reports are submitted to the Quality Improvement and Lessons Learnt (QUILL) Committee as part of the Quality Report.

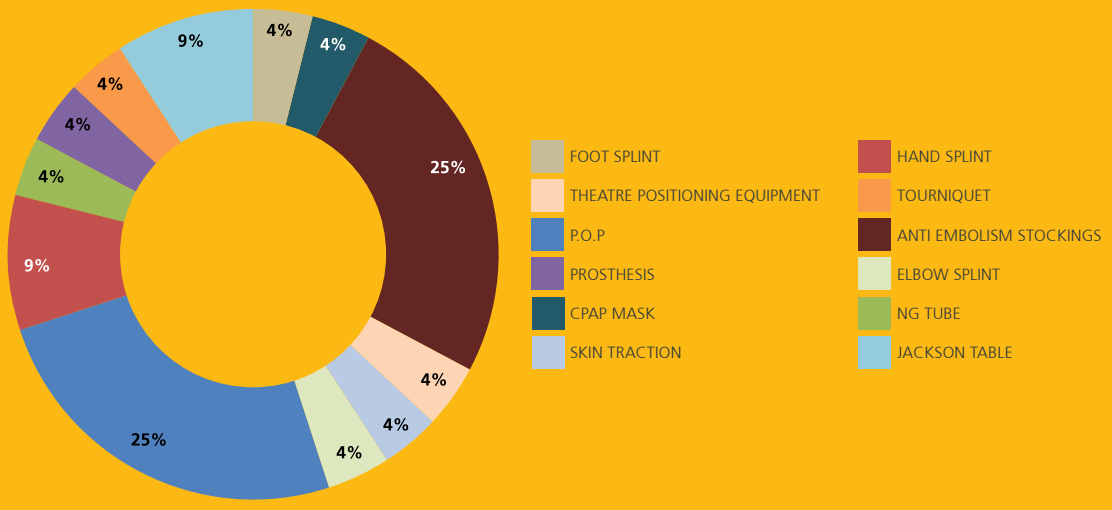
5.1.4 PRESSURE ULCERS

Pressure ulcers acquired in the Royal National Orthopaedic Hospital NHS Trust are validated by the Tissue Viability team when reported, and investigated by the rapid review panel. This consists of members of the senior leadership team to establish trends and action learning from which the clinical areas can adopt changes to practice.

This financial year (2017/2018), the trust has validated 60 acquired pressure ulcers. This is an observed improvement from last year (2016/2017) where we had 70 acquired pressure ulcers.



The collated data and actions for pressure ulcer prevention from previous investigations have seen an improvement in the reduction of medical device related pressure ulcers. Further implementations to practice continue with emphasis to minimise pressure ulcer formation through applied devices.



The rapid review panel analyses the aspects of care delivery and determines whether the pressure ulcer was avoidable or unavoidable, this also considers aspects of SCALE (Skin Changes at Life End). During 2017/2018 seven pressure ulcer acquired incidences were deemed as unavoidable. This was a consequence of all actions being in place however regardless of these the ulcers formed.

Areas identified through rapid response learning:

PROBLEM	ACTION	PROCESS
THEATRE RELATED SKIN DAMAGE	REVIEW OF DOCUMENTATION	ANALYSIS OF CURRENT PAPERWORK FOR THEATRE ENVIRONMENTS. CONSTRUCTION AND AUDIT OF DOCUMENTATION TOOL
PLASTER CAST PRESSURE ULCERS - HEELS	CHANGE OF APPLICATION PROCESS	REVIEW OF PROPHYLACTIC PADDING TO BE PLACED TO HEELS
ACQUIRED PRESSURE ULCERS ON JACKSON TABLE. THEATRE TIME EXCEEDS 3 HOURS	USE OF PROPHYLACTIC DRESSINGS TO BONY PROMINENCES	APPLICATION OF SILICONE FOAM ADHESIVE TO ILIAC CREST AND CHEST TO MINIMISE PRESSURE EFFECT

The Trust continues to raise the importance and zero tolerance of pressure ulcer prevention, demonstrating this through the Trusts values with the Tissue Viability Team exercising existing processes and introducing new initiatives. These include:

- Mandatory training through E learning for ALL Healthcare professionals
- Introduction of Pressure Ulcer Prevention Rounds
- 'React to Red' campaign
- International STOP pressure ulcer day – engagement from all in the Trust

5.2 CLINICAL EFFECTIVENESS MEASURES

5.2.1 SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)

The measure for Summary Hospital-level Mortality Indicator (SHMI) is not applicable to the Trust.

5.2.2 PATIENT REPORTED OUTCOME MEASURES

RNOH considers that the Patient Reported Outcomes Measures (PROMS) are as described for the following reasons: RNOH has a process in place to ensure that relevant patients are given questionnaires to complete and that patients are encouraged to do so. It is important to note that the Trust has no control over the completion and return of these forms.

PROMs are designed to allow patients to assess improvements to their health following surgical treatment. Patients answer questions about their quality of life before surgery and again after surgery. The two scores are compared and the difference is regarded as a health gain (or loss). These results provide an indication of the success and benefit of their surgery on their health. The responses are analysed independently by NHS digital and benchmarked against other trusts.

PROMS use three different measures to assess improvements to health following surgery. Although each measure is slightly different, a positive number means the patient has experienced an improvement to their health. The greater the number, the greater the patient reported improvement to their health.

Six procedures currently subject to PROMs are carried out at the RNOH and the table below provides RNOH performance against the three measures: EQ-5D, EQ-VAS, and the Oxford Hip and Knee Scores. EQ-5D asks questions about mobility, ability to self-care, ability to carry out usual activities, pain and discomfort, and anxiety and depression. EQ-VAS asks patients to rate their overall health on a scale (VAS = visual analogue scale). The Oxford Score is a short questionnaire designed to assess function and pain.

TOTAL HIP REPLACEMENT	NATIONAL AVERAGE 2016-17	RNOH 2016-17	RNOH 2015-16	RNOH 2014-15
EQ-5D	0.437	0.383	X	X
EQ VAS	13.112	12.577	X	X
OXFORD HIP SCORE	21.380	18.155	X	X
HIP REPLACEMENT - PRIMARY	**NATIONAL AVERAGE 2016-17**	**RNOH 2016-17**	**RNOH 2015-16**	**RNOH 2014-15**
EQ-5D	0.445	0.405	0.468	0.412
EQ VAS	13.434	12.693	11.151	10.68
OXFORD HIP SCORE	21.799	20.253	22.312	21.035
HIP REPLACEMENT - REVISION	**NATIONAL AVERAGE 2016-17**	**RNOH 2016-17**	**RNOH 2015-16**	**RNOH 2014-15**
EQ-5D	0.291	X	0.243	0.280
EQ VAS	7.155	X	4.261	6.472
OXFORD HIP SCORE	13.504	X	9.647	12.990
TOTAL KNEE REPLACEMENT	**NATIONAL AVERAGE 2016-17**	**RNOH 2016-17**	**RNOH 2015-16**	**RNOH 2014-15**
EQ-5D	0.323	0.280	X	X
EQ VAS	6.850	4.967	X	X
OXFORD HIP SCORE	16.393	12.231	X	X
KNEE REPLACEMENT - PRIMARY	**NATIONAL AVERAGE 2016-17**	**RNOH 2016-17**	**RNOH 2015-16**	**RNOH 2014-15**
EQ-5D	0.324	0.257	0.289	0.273
EQ VAS	6.977	3.072	4.175	4.921
OXFORD HIP SCORE	16.547	12.508	14.664	14.91
KNEE REPLACEMENT - REVISION	**NATIONAL AVERAGE 2016-17**	**RNOH 2016-17**	**RNOH 2015-16**	**RNOH 2014-15**
EQ-5D	0.273	0.288	X	X
EQ VAS	3.499	4.732	X	X
OXFORD HIP SCORE	12.360	10.682	X	X

Source: NHS Digital latest published data (Accessed February 2018)
X = low sample size, results not available

5.2.3 EMERGENCY READMISSIONS WITHIN 28 DAYS

The Royal National Orthopaedic Hospital NHS Trust considers that the percentage of emergency readmissions within 28 days of discharge from hospital is as described for the following reasons: every time a patient is discharged and readmitted to hospital the episode of care is coded. The Information Team continually monitors and audits data quality locally and the Trust participates in external audit which enables the Trust to benchmark its performance against other Trust.

The Royal National Orthopaedic Hospital NHS Trust considers that the percentage of emergency readmissions within 28 days of discharge from hospital is as described for the following reasons: every time a patient is discharged and readmitted to hospital the episode of care is coded. The Information Team continually monitors and audits data quality locally and the Trust participates in external audit which enables the Trust to benchmark its performance against other Trust.

The Royal National Orthopaedic Hospital NHS Trust admitted 16263 (April 2017-March 2018) NHS patients in 2017/18. Of these 78 were emergency readmissions within 28 days of discharge.

PERCENTAGE OF EMERGENCY READMISSIONS WITHIN 28 DAYS OF DISCHARGE FROM HOSPITAL OF PATIENTS:	2014/15	2015/16	2016/17	2017/18
I) 0 TO 14 YEAR OLDS (INDICATOR UP UNTIL 2016/17)	0.04%	0.04%	0.04%	-
0 TO 15 YEARS (INDICATOR FROM 2017/18 ONWARDS)	-	-	-	**0.74%**
II) 15 OR OVER (INDICATOR UP UNTIL 2016/17)	0.50%	0.52%	0.43%	-
16 AND OVER (INDICATOR FROM 2017/18 ONWARDS)	-	-	-	**0.46%**

Source: Trust Data

The Royal National Orthopaedic Hospital NHS Trust intends to take the following actions to reduce readmissions to improve the quality of its services by working to implement a process of exemplar discharge, while continuing to monitor those patients discharged from the Royal National Orthopaedic NHS Trust and readmitted to other hospitals to ensure accurate readmission rates and appropriate clinical review of any readmissions within 28 days.

5.3 PATIENT EXPERIENCE MEASURES

CORE INDICATOR

5.3.1 RESPONSIVENESS TO PERSONAL NEEDS

The Royal National Orthopaedic Hospital NHS Trust considers that the mean score of responsiveness to inpatient personal needs is as described:

- Each year the Trust participates in the National Inpatient Survey. For the 2016/17 year, 1250 patients were randomly selected and sent a nationally agreed questionnaire. A total of 664 patients responded to the survey and results were independently analysed prior to report publication by the Care Quality Commission (CQC).
- The indicator shows the average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (Score out of 100).
- The five questions are:
- i) Were you as involved as you wanted to be in decisions about your care and treatment?
- ii) Did you find someone on the hospital staff to talk to about worries and fears?
- iii) Were you given enough privacy when discussing your condition or treatment?
- iv) Did a member of staff tell you about medication side effects to watch for when you went home?
- v) Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- For the 2016/17 year, the Trust was 11th out of 150 trusts for responsiveness to patient needs. This is however a comparison for all Trusts and not just specialists NHS Trusts.

YEAR	INDICATOR SCORE	HIGHEST PERFORMING TRUST	LOWEST PERFORMING TRUST	NATIONAL AVERAGE
RNOH 2016/17	75.9	85.2	60.0	68.1
RNOH 2015/16	74.4	86.2	58.9	69.6
RNOH 2014/15	78.7	86.1	59.1	68.9
RNOH 2013/14	77.8	84.2	54.4	68.7

Source: NHS Digital (2017) National Inpatient Survey Official Statistics – Data published August 2017

The Royal National Orthopaedic Hospital NHS Trust has taken the following actions to improve this rate and so the quality of its services:

- Recognised that although it is performing above national average and in the top 11 Trusts nationally, work to improve patient experience needs to continue
- Continue to publish monthly Quality Report that provides each ward and service a breakdown of patient feedback scores and comments
- Continue to use Trust's Balanced Scorecard indicators specific to patient experience and patient needs. These include measures of length of stay, patient experience of the discharge process, staffing levels, and patient perception of staffing levels
- The Trust continues to look to improve its engagement and involvement of patients in the development of its services, ensuring that patient voices are heard and acted on

5.3.2 FRIENDS AND FAMILY TEST

The Friends and Family Test (FFT) is a single question which asks patients whether they would recommend the NHS service they have used to friends and family who need similar treatment or care. At the RNOH, the FFT question is asked in all inpatient wards, outpatients, and in therapies.

For inpatients, the FFT question is part of a longer real-time patient survey in which we ask patients to tell us about their experience of our care, services, and hospital environment.

In 2017/18, the RNOH was one of the top trusts nationally for inpatient response rate (see NHSE published FFT data). For the year, the Trust had a 50.4% response rate for the year, over double the national average for response rate.

Patients also left many thousands of free text comments during the year, and these are analysed and reported back to wards to allow improvements to be made.

Our results

INPATIENTS	RESPONSES	RESPONSE RATE	WOULD RECOMMEND	WOULD NOT RECOMMEND
2017/18	4671	48.0%	95.1%	0.9%
2016/17	5907	55.1%	96.3%	0.8%
2015/16	5536	56.6%	96.0%	1.1%
2014/15	4422	52.4%	96.0%	1.0%
OUTPATIENTS	**RESPONSES**	**RESPONSE RATE**	**WOULD RECOMMEND**	**WOULD NOT RECOMMEND**
2017/18	3180	4.1%	95.4%	1.9%
2016/17	4470	5.9%	94.5%	2.1%
2015/16	3442	4.7%	93.8%	2.0%

Source: Internal Trust Data

The RNOH has taken the following actions to improve our patient feedback and so the quality of patient experience we deliver:

Inpatient wards regularly receive patient feedback report and quarterly posters that provide staff with all of the good comments patients have made about the ward. These reports are discussed at team meetings and also displayed on the ward for patients and visitors to see. This reinforces not only the Trust's high standards of care but also allows staff to see that patients recognise and value their efforts.

When we don't get it right and we fail to deliver the experience of care our patients expect, it is important that we listen to patients to learn what we could have done to improve their experience. Senior nurses and ward managers receive a regular report on all of the less positive feedback. These reports establish common themes, and senior nurses and managers can use this feedback to formulate a plan of action to ensure issues are addressed. Each division receives a monthly Quality Report that contains the performance in the Friends & Family Test for all divisional services and wards. This helps to provide quality performance monitoring and to identify any trends or issues developing over time.

Our patient experience strategy

We have made significant progress across all our services to enhance patient experience. However, there is more we can do to strengthen our approach to listening and responding to patient's feedback.

Our vision for patient experience is one that requires all staff to provide compassionate care, so that when people access our services – as a patient or a carer – they can be confident that the care they receive will be kind, sensitive and compassionate.

We have high expectations around the improvements required in patient experience, both in terms of receiving real time feedback and on achieving measurable improvements in our results in the national surveys. We are committed to improving and enhancing patient experience and expect to see significant improvements in the experiences of patients receiving care.

5.3.2 FRIENDS AND FAMILY TEST CONT'D

Patient Feedback & Suggestions

RNOH continues to be committed to improving all communication with patients and carers, and we are well on the way to reaching our aim that all patients should feel safe, involved and able to make informed choices about their treatment and care.

PATIENT FEEDBACK & SUGGESTIONS INPATIENTS	
REHAB WARD	'EVERYONE WAS LOVELY, WAS A BRILLIANT EXPERIENCE. COULDN'T THANK THE NURSING ENOUGH.'
THE COLEMAN UNIT	'THE STAFF IN THE COLMAN WARD WERE EXTREMELY KIND, PATIENT AND VERY HAPPY TO ASSIST ME WITH MY CARE TODAY. THEY ALL DESERVE THE "PIN". MAYBE THERE SHOULD BE A WARD AWARD NOT JUST ONE PERSON. THANK YOU TO EVERYONE WHO WAS INVOLVED IN MY CARE (DOCTORS, NURSES AND PORTERS).'
DUKE OF GLOUCESTER	'THE QUALITY OF CARE WAS EXEMPLARY. I WAS OVERWHELMED BY THE CARE AND SUPPORT I WAS GIVEN BY ALL THE TEAM. THEY MADE ME FEEL AT HOME. EVERYTHING HAS BEEN FANTASTIC. THANK YOU VERY MUCH.'
WARD 4	'EVERYBODY ON THE WARD AND ALL STAFF WERE EXTREMELY KIND AND EFFICIENT, BOTH PROFESSIONAL AND FRIENDLY AND VERY CARING.'
MARGARET HARTE	'ALL THE STAFF ON THE WARD FANTASTIC. ALWAYS READY TO HELP AND DO ANYTHING THEY CAN. MADE MY STAY SO COMFORTABLE.'
PATIENT FEEDBACK ABOUT OUTPATIENTS SERVICE	
RNOH OPD	'THE DOCTOR IS A VERY GOOD DOCTOR. THE NURSES IN PRE-OP ARE FANTASTIC. THE LEVEL OF CARE IS VERY GOOD. EVERYTHING IS EXPLAINED TO YOU.'
OPD BOLSOVER	'POSITIVE ATMOSPHERE. FRIENDLY RECEPTIONIST AND PHYSIO TREATED RIGHT AWAY. EXTREMELY HELPFUL.'
OPD STANMORE	'I WAS SEEN ON TIME AND DR WAS VERY GENTLE CARRYING OUT THE PROCEDURE. HE EXPLAINED EVERYTHING VERY WELL BOTH BEFORE AND DURING MY PROCEDURE.'
OPD BOLSOVER	'THE CLINIC SEEMS EFFICIENTLY RUN AND ALL STAFFS ARE HELPFUL AND APPROACHABLE, MAKING A STRESSFUL EXPERIENCE EASIER FROM RECEPTIONIST TO CLINICIAN. THANK YOU.'
OPD STANMORE	'SUCH EXCELLENT CARE. STAFF VERY HELPFUL. VERY ORGANISED.'
OPD BOLSOVER	'EFFICIENT FRIENDLY HELPFUL STAFF. PLEASANT SURROUNDINGS.'
OPD STANMORE	'EFFICIENT, FRIENDLY, NOT RUSHED, COMFORTABLE ENVIRONMENT. CONSULTANT EXCELLENT UNIQUE EXPERTISE. FEELS LIKE PRIVATE HOSPITAL.'
OPD BOLSOVER	'GOOD CUSTOMER CARE. VERY WARM AND WELCOMING.'

CORE INDICATOR

5.3.3 STAFF RECOMMENDATION OF THE TRUST AS A PROVIDER OF CARE TO THEIR FAMILY OR FRIENDS

The RNOH considers that this data is as described for the following reasons: annual national staff survey is carried by an independent organisation.

INPATIENTS	RNOH 2017/18	RNOH 2017/18	RNOH 2017/18	NATIONAL AVERAGE FOR SPECIALIST ACUTE TRUSTS 2017/18	HIGHEST SPECIALIST ACUTE TRUST PERFORMANCE TRUST 2017/18	LOWEST SPECIALIST ACUTE TRUST PERFORMANCE TRUST 2017/18
THE PERCENTAGE OF STAFF EMPLOYED BY, OR UNDER CONTRACT TO, THE TRUST DURING THE REPORTING PERIOD WOULD RECOMMEND THE TRUST AS A PROVIDER OF CARE TO THEIR FAMILY OR FRIENDS	89%	88%	88%	89%	93%	79%

Source: Picker NHS Staff Survey 2017

767 people took part in the 2017 National staff survey at RNOH this year. This is an increase since 2016 and accounts for a response rate of 52%, which is average for acute specialist Trusts in England. We can therefore be assured that the feedback is representative of the views of our staff.

Overall the Trust achieved a third year of positive results, improving in 23 of the 32 Key Findings, against a slightly declining NHS picture. The Royal National Orthopaedic Hospital also achieved the best score nationally for staff believing their role makes a difference to patients, and achieved top 10 national best scores against other NHS Trusts for 11 other indicators.

5.3.4 COMPLAINTS

Lessons learnt from investigating complaints, as well as resolving issues and concerns through our PALS service play a key role in improving service quality and patient experience. This year we report on performance, activity and on the many policy and service changes we have implemented to ensure all our patients and service users have access to prompt local resolution and an effective complaints process if they wish to make a complaint.

In 2017/18 the RNOH received 134 formal complaints compared with 121 in the previous year.

There has been a steady rise in the number of complaints we have received each month with the average number of complaints being around 14-15 a month. The Trust continues to encourage patients to highlight their concerns to us.

5.3.5 PALS

During the last year, our Patient Advice and Liaison Service (PALS) Team has continued to provide a confidential advice and local resolution service. The team ensures that individual concerns - whether from patients, relatives or their representative - are addressed promptly and effectively and the appropriate actions are taken by Trust staff to resolve those concerns and improve services for the future. The PALS team and the central complaints team work alongside the governance staff in each of our divisions to ensure that patient concerns are heard and responded to.

During 2017/18, the PALS team dealt with 1,149 PALS enquires. This number is considerably lower than 2016/17 of 1,854 PALS enquires

5.4 MAINTAINING CONTINUOUS QUALITY IMPROVEMENT

The RNOH is committed to improving the quality of its services. This section details some of the quality improvement work currently underway at the Trust, including work addressing particular issues and concerns. Additionally, NHS England has requested each trust's 2017/18 Quality Accounts contain information on:

- Learning from deaths
- Statement regarding progress with the implementation of the priority clinical standards for seven day hospital services

These are detailed overleaf.

5.4.1 LEARNING FROM DEATHS

During 2017/18, 18 RNOH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 5 in the first quarter
- 5 in the second quarter
- 3 in the third quarter
- 5 in the fourth quarter

By March 2018, 18 case record reviews and 1 investigation have been carried out in relation to 18 of the deaths.

In 1 case, a death was subjected to both a case record review and an investigat ion. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 5 in the first quarter
- 5 in the second quarter
- 3 in the third quarter
- 5 in the fourth quarter

One, representing 6%, of the patient deaths during the reporting period is 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 1, representing 20% for the first quarter.

Key Learning

A summary of key learnings from case record reviews and investigations conducted in relation to the deaths identified the following important items:

- The importance of hand hygiene
- Recognition and escalation of sepsis
- The importance of clear documentation
- The importance of intentional rounding
- Leadership and supervision

All patients who have died within 30 days of attending the RNOH for a procedure have been subjected to a formal notes review. The data for deaths have been taken from the hospital reporting system, called Insight, which itself is fed data via the NHS Spine. This represents the most accurate source of data in RNOH. Prior to February 2018 all cases were reviewed using a structured notes review and individualised presentation to the hospital wide audit mortality and morbidity meeting. Post February 2018 cases were assessed using the structured judgment review method (Royal College of Physicians). All of these patients have been presented and discussed at either the regular bi-monthly M&M meeting or local M&M meeting. The bi-monthly meeting is hospital wide and multidisciplinary, with comments accepted from all members of staff. When issues have been raised at the M&M meetings, the cases were then proposed for a case review if this was deemed appropriate by the MDT process.

Actions taken in 2017/18

For one death in Q1 a Serious Incident was raised. There were a number of factors identified in the case. A key discovery was the failure to escalate a deteriorating patient appropriately. The Serious Incident was discussed at M&M. Significant changes in practice have been identified as a result of this review. These include:

- Introduction of an Acute Intervention Team (to replace outreach)
- Introduction of a patient observation standard
- RADAR (recognition of the deteriorating patient) training mandated for all clinical staff
- Introduction of a Medical Emergency Team
- Changes to the Patient Observation App
- Increased availability of IV antibiotics on wards
- Increased Sepsis awareness – Sepsis 6 on the 6th of each month

Duty of candour meetings have been undertaken where necessary. This has included sharing learning from reviews with relatives and discussion of actions which the trust has taken. Additionally the RNOH has reached out to the local coroner's office to improve the collaborative working with this service.

An assessment of the impact of the actions undertaken in 2017/18

Due to increased awareness of sepsis via regular education and training sessions, sepsis screening is carried out for every patient. The availability of emergency antibiotic medicines has been ensured for immediate access on all wards. The selection of antibiotics has been led by the Microbiology department. This will ensure appropriate antibiotics are available, almost immediately, for any patient that needs them. This was in part due to one of the reviews from a patient death that occurred in 2016/17 but whom the review was concluded in 2017/2018.

The new NEWS score tool/app has led to the recording of all patient observations in one central location. This improves care handover in many hospital environments, such as from the theatre recovery to ward. The score is automatically calculated in the app thereby removing a source of potential error.

Because of the introduction of new Medical Emergency Team, hospital staff can obtain a prompt review for a patient by placing a call to MET. Where they have activated an MET call, a member of the medical team from the intensive care will attend to review the patient. The MET call means they have a direct route to contact the intensive care consultant if they have concerns about a patient.

RNOH have taken all the necessary actions resulting from the mortality reviews and SUI findings.

RNOH carried out 4 case record reviews and 1 investigation after April 2017 which related to deaths which took place before the start of the reporting period 2017/18. This is in addition to 18 case reviews for deaths in 2017/18.

2 deaths, representing 10% of the patient deaths before the reporting period 2017/18, 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 taken from the hospital reporting system, called insight, which itself is fed data via the NHS Spine.

2 deaths, representing 10% of the patient deaths during 2016-17 are judged to be more likely than not to have been due to problems in the care provided to the patient. For both of these deaths a Serious Incident investigation was undertaken.

5.4.2 IMPLEMENTING SEVEN DAY HOSPITAL SERVICES

Seven Day Services Clinical Standards are being introduced in the NHS to improve outcomes of patients who are admitted to hospital as emergencies at weekends. Ten clinical standards were developed by Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. These standards define what seven day services should achieve, no matter when or where patients are admitted, with an aim to end the variation in outcomes.

In response to these clinical standards, the RNOH has designed a pathway in collaboration with medical, nursing, AHP and operational staff. The aim is for patients to be able to access hospital services in a timely fashion.

With the support of the Academy of Medical Royal Colleges (AoMRC), four of the 10 clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- **Standard 2**
  Time to first consultant review
- **Standard 5**
  Access to diagnostic tests
- **Standard 6**
  Access to consultant-directed interventions
- **Standard 8**
  Ongoing review by consultant twice daily if high dependency patients, daily for others

Outlined below is the progress RNOH has made to achieve these priority standards:

Standard 2
Time to first consultant review

This standard states that all emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

RNOH has made significant progress against this standard. On site Medical cover and Out of hours /weekend Consultant on call rotas are in place now. Spine, Surgery, Anaesthetics and Paediatrics have 24/7 Consultant cover in place.

Clinical on-call rotas are managed for: Orthopaedics, Spinal surgery, Sarcoma, HDU/ ITU, Paediatrics, Pharmacy, Physiotherapy and Occupational Therapy. All transfers are seen by the appropriate non ITU consultant within 14 hours of admission - an integrated management plan and estimated discharge are set.

RNOH is a specialist Orthopaedics hospital and critical patients are rarely transferred to RNOH as most would be managed at local referring hospitals. Patients with risk factors are transferred to ITU and seen by consultant anaesthetists.

RNOH has very few emergency transfers but accepts emergency admissions for:

1. Spinal trauma
2. Spinal Infection
3. Metastatic Spinal cord compression
4. Admissions from outpatient clinic

All emergency admissions accepted/ transferred to RNOH under a named consultant. Risk factors for emergency admissions are triaged prior to acceptance by admitting consultant and ITU - site/ outreach team. The condition and location of all emergency admissions are kept under continuous review by the acute outreach team.

All emergency admissions are reviewed by therapy teams within 14 hours of admission. Baseline function is assessed and functional criteria for discharge are set.

Medicines reconciliation is undertaken and completed by a pharmacist within 24 hours of admission.

Appropriate staff are available to facilitate the treatment/management plans relating to emergency admissions. Including, but not limited to anaesthetists, theatre staff, ODPs, neurophysiology/spinal cord monitoring, on-call pharmacist.

There is a 24 hour Medical Emergency Team that can be called in case of deteriorating patients with low NEWS scores. The team consists of an ITU consultant (day time only), ITU registrar, orthopaedic SHO, paediatric SHO for children and a Critical Care Outreach nurse.

There is an Outreach team from the nursing staff from ITU who proactively attend wards out-of-hours

Standard 5

Access to diagnostic tests

This standard states that hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

RNOH has made significant progress against this standard. The RNOH currently offers 24/7 access to the following consultant directed MSK diagnostic imaging services:

- Ultrasound
- CT and
- MRI

This arrangement is supported by 24/7 radiographer cover. A Consultant Radiologist is on call 24/7 and accessible through switchboard.

Urgent Non MSK scans / opinions are currently reported via an informal agreement with the Royal Free NHS Trust. We aim to have this agreement formalised by July 2017. Microbiology - Is provided via the Royal Free Hospital and is a 24/7 service. Echocardiography - is provided via the Royal Free Hospital and is a 24/7 service.

5.4.2 IMPLEMENTING SEVEN DAY HOSPITAL SERVICES CONT'D

Standard 6
Access to consultant-directed interventions

This standard states that hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency general surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis
- Percutaneous Coronary Intervention
- Cardiac pacing (either temporary via internal wire or permanent)

We are not an acute trust and do not provide emergency services but have critical care for inpatients post operatively and have SLA with Barnet Royal free for transfer of care and other interventions. SLA is regularly reviewed and protocols are agreed.

Standard 8
Ongoing review by consultant twice daily if high dependency patients, daily for others

This standard states that all patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

RNOH has made significant progress against this standard. Two consultant ward rounds are conducted a day including Saturday and Sunday in HDU/ITU and CHDU.

All patients discharged from critical care are done so when it is felt appropriate by the ITU consultant and this implies that they do not need daily consultant review but if there are any concerns, then they will be reviewed by an outreach nurse who has direct access to both the ITU SpR and Consultant if they wish to escalate the level of care or seniority of review.

There is an outreach system from HDU to review any potential at risk patient led by medical and nursing team daily and weekends

Clinical on-call rotas are managed for: Orthopaedics, Spinal surgery, Sarcoma, HDU/ ITU, Paediatrics, Spinal Cord Injury, Pharmacy, Physiotherapy and Occupational Therapy. Each surgical unit is responsible for daily consultant board and ward round of patients.

Weekend On call consultant conducts ward or board round meeting (recorded on electronic or handover sheets by junior) and will organise appropriate review by surgical, medical and or anaesthetic team or use of SLA as needed.

A Consultant Paediatrician is on call 24/7 and accessible through switchboard. A ward round takes place every weekday and at least once over the weekend. A paediatric registrar is on site 8am - 8pm every day. An anaesthetic registrar provides cover from 8pm - 8am. There are daily physio and nursing, reviews.

There is a rota in place for Physiotherapists, Occupational therapists and therapy technician to cover Saturday and Sunday in-patient Adult and Paediatric acute post-surgical wards. SCIC beds and any other Rehab beds are not covered apart from Respiratory care input on SCIC from physiotherapy team.

One physiotherapist is on emergency on-call duty from 5pm to 8.30am to cover the hospital including SCIC over 7 days.

There is an on call pharmacist available throughout the weekend. Pharmacy is open from 9 am to 3 pm on Saturdays.

5.4.3 IMPLEMENTATION OF DUTY OF CANDOUR

The Duty of Candour requirements follows Sir Robert Francis' QC's call for a more open and transparent culture following the failures in patient care at Mid Staffordshire NHS Foundation Trust. From October 2014 NHS providers are required to comply with the Duty of Candour. Providers must be open and transparent with service users about their care and treatment, including when it goes wrong. Compliance with Duty of Candour is a legal requirement and the Care Quality Commission is able to take enforcement action when it finds breaches.

Under the Duty of Candour requirements clinical professionals should;

- speak to a patient, or those close to them, as soon as possible after they realise something has gone wrong with their care that appears to have caused or has the potential to cause moderate/ significant harm
- apologise to the patient – explain what happened, what can be done if they have suffered harm and what will be done to prevent someone else being harmed in the future
- provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification
- advise the relevant person what further enquiries the provider believes are appropriate
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries
- Keep a written record of all communication with the relevant person

Our Duty of Candour Compliance research has revealed that RNOH Clinicians are exemplary at having Duty of Candour discussions with patients who have suffered levels of harm. However, that there is room for improvement with compliance in sending written Duty of Candour letters to patients and their families, where appropriate, identifying the fact that a full investigation into the circumstances of the harm occurring will take place and that they will be sent a copy of the report when it is completed.

The Patient Safety team are progressing work with Divisions under the auspices of the Divisional Performance Reviews to provide written updates, as per the Duty of Candour requirements, to patients / families.

5.4.4 OUR CQC RESULTS

OVERALL RATING FOR THIS HOSPITAL	Requires improvement
MEDICAL CARE	Outstanding
SURGERY	Good
CRITICAL CARE	Good
SERVICES FOR CHILDREN AND YOUNG PEOPLE	Requires improvement
OUTPATIENTS	Requires improvement

The Care Quality Commission (CQC) monitors, inspects and regulates health and social care services in England to ensure they meet fundamental standards of quality and safety. Performance ratings and findings from the CQC on the quality and safety of services are published regularly. The CQC asks a number of key questions to inform their view on the quality and safety of services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain high quality care in order to retain their registration. RNOH is required to register with the CQC and its current registration status is 'without conditions'.

RNOH was inspected by the CQC in May 2014, with subsequent inspection report published in August 2014. RNOH was one of the first specialist Trusts to be inspected under CQC's new inspection approach.

Overall, the Trust was rated as 'Requires improvement'. The ratings for each of the Trust's service areas are shown above.

In response to the CQC inspection report, the Trust had in place an action plan to address the conclusions reported by the CQC. RNOH has made good progress in implementing the actions to address these issues.

A programme of mock inspections and quality assurance visits took place during 2016 and 2017. Additionally, some services have undertaken peer reviews and benchmarking to assess and contextualise the quality and performance of their service.

A rolling action plan / areas of focus register have been created to run alongside the Trust's risk register. This action plan is multi-level, containing areas of focus from executive to ward levels. Issues identified through a variety of intelligence sources are logged on the action plan alongside the appropriate CQC domain and KLOE. This plan is discussed at divisional meetings to ensure all actionable issues are addressed.

APPENDIX 1

STATEMENTS FROM NHS ENGLAND SPECIALIST COMMISSIONERS AND HEALTHWATCH HARROW

The Quality Account has been developed by the Trust with input, involvement, and consultation from a range of stakeholders. This has included:

- Consultation on the Trust website, seeking views of proposed quality priorities
- Presentation of quality priorities with the RNOH Patient Group
- Discussion of our quality priorities with commissioners through the Clinical Quality
- Review Group
- Internal discussions of the Quality Account at the Clinical Quality and Governance
- Committee
- Presentation of draft and final Quality Account to Healthwatch Harrow
- Presentation of the Quality Account to Harrow Health and Social Care Scrutiny

Specialised Commissioning
London
NHS England
Skipton House
80 London Road
London
SE1 6LH

NHS England's response to
Royal National Orthopaedic Hospital NHS Trust
Quality Accounts 2017/18

NHS England would like to thank the Royal National Orthopaedic Hospital NHS Trust for the opportunity to review and provide a statement response to their 2017/18 Quality Accounts. From reviewing the Trust's Quality Accounts, we can confirm that as far as it can be ascertained it complies with the national requirements for such a report. We are satisfied with its clarity and accuracy (as far as it is based on the information available to NHS England).

Firstly, we congratulate the Trust on its achievements over the past year. In particular, for delivering the best improvement in referral to treatment performance in the UK that was acknowledged by the Secretary of State for Health. We also recognise the Trust's success in remaining on track with the planned construction of the new inpatient ward block and note the detailed narrative of the key quality priorities and challenges faced over the past 12 months. We would like to commend the Trust for its commitment to deliver clinical excellence for patients with initiatives such as the introduction of the Medical Emergency Team which allows for earlier intervention in patients whose health is deteriorating and the MEND initiative which improves post-operative outcomes. In addition, following on from the '*RNOH VAL-YOU Charter'* and 'I *deliver great care'* which started in 2016, we recognise that the Trust have advanced these schemes by offering their staff a host of additional benefits, all of which would have contributed to the positive staff experiences as reflected in the survey results. We are pleased to see the plans in place to further build on these achievements and the evident commitment of the Trust and its staff to high quality care for all patients.

Whilst we have acknowledged areas of achievements, we would welcome a strategy outlining how the Trust proposes to work with external providers to improve its 62-day cancer performance target. Trust and NHSE have agreed to work together to develop a more robust system for Serious Incident reporting and monitoring.

We support the priorities that have been identified for 2018/19 – particularly the Theatre Utilisation Project to improve theatre productivity and the range of metrics that will be employed to monitor the improved utilisation. Whilst we endorse the reducing length of stay project concerning hip and knee replacements, we would

encourage the Trust to expand this project to include some specialised service procedures. Finally, we strongly support the Trust's participation in Sustainability and Transformation Partnership (STP) wide programs such as the NCL Orthopaedic Services Review and hope that the Trust continues to play an integral role within the STP. We look forward to working closely with the Trust over the coming year to further improve the quality of local health services.

NHS England
London Region

Ms Vinice Thomas
Director of Nursing and Quality
Specialised Commissioning
On behalf of NHS England – London Region

Enterprise Wellness
Business of Health

healthwatch Harrow

07 June 2018

Muhammad Kashif
Quality Manager & Emergency Planning Lead
Royal National Orthopaedic Hospital NHS Trust,
Brockley Hill,
Stanmore,
Middlesex,
HA7 4LP

Dear Muhammad,

RNOH: Quality Accounts 2017/18

I am pleased to provide this statement on behalf of Enterprise Wellness, the Accountable body for the Healthwatch Harrow Service.

We note the considerable progress made in year on the quality of care, a great deal of which has been brought about by the positive experience that staff have reported - this is indeed critical to overall customer care and satisfaction.

We are pleased to note that RNOH had the best improvement in referral treatment performance in the UK. This too is a credit to all at RNOH.

We look forward to the completion of the New Inpatient Building in October 2018. This will not only enhance RNOH's reputation as the leading specialist Orthopaedic Hospital in the country, but also showcase the investment in equipment digital technology infrastructure.

We look forward to engaging with you over the coming year to see how Enterprise Wellness can play its part in promoting your future plans and aspirations.

Yours sincerely,

Ash Verma
Chair
Enterprise Wellness Ltd.
(Accountable body for Healthwatch Harrow)

Cllr Rekha Shah
Wealdstone Ward

Muhammad Kashif
Quality Manager & Emergency Planning Lead
The Royal National Orthopedic Hospital NHS Trust
Brockley Hill
Stanmore
HA7 4LP

29 June 2018

Dear Mr Kashif,

I confirm that the draft report on the Royal National Orthopaedic Hospital Draft Quality Accounts was circulated to members of the Council's Health and Social Care Scrutiny Sub-Committee; it was reviewed by members of the sub-committee to their satisfaction.

Yours sincerely,

Councillor Rekha Shah
Chair of the Health and Social Care Scrutiny Sub-Committee

APPENDIX 2

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNTS

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of the annual Quality Account (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 (as amended by the National Health Service (Quality Account) Amendment Regulations 2011).

The Quality Account presents a balanced picture of the Trust's performance over the period covered:

- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to
- appropriate scrutiny and review;
- The Quality Account has been prepared in accordance with Department of Health guidance
- The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

Professor Anthony Goldstone CBE
Chairman

Rob Hurd
Chief Executive Officer

Independent Practitioner's Limited Assurance Report to the Board of Directors of Royal National Orthopaedic Hospital NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Royal National Orthopaedic Hospital NHS Trust to perform an independent assurance engagement in respect of Royal National Orthopaedic Hospital NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the following indicators:

- Rate of clostridium difficile infections; and
- Percentage of patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from local Healthwatch organisations dated 7 June 2018;
- feedback from NHS England Specialised Commissioning;
- the local patient surveys dated June 2017 and January 2018;
- the 2017 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 25 May 2018; and
- the annual governance statement dated May 2018;

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

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

This report, including the conclusion, has been prepared solely for the Board of Directors of Royal National Orthopaedic Hospital NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Royal National Orthopaedic Hospital NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. 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;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower 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 that 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 Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Royal National Orthopaedic Hospital NHS Trust.

Our audit work on the financial statements of Royal National Orthopaedic Hospital NHS Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Royal National Orthopaedic Hospital NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Royal National Orthopaedic Hospital NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Royal National Orthopaedic Hospital NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Royal National Orthopaedic Hospital NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Royal National Orthopaedic Hospital NHS Trust and Royal National Orthopaedic Hospital NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants

30 Finsbury Square
London
EC2A 1AG

26 June 2018

GLOSSARY

AHP	Allied Healthcare Professionals
C. difficile	Clostridium difficile
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
DoLS	Deprivation of Liberties Safeguarding
EQ5D	A standardised measure of patient reported health outcome for hip and knee operations
FARs	Functional Assessment and Restoration
FFT	Friends and Family Test
GIRFT	Getting it Right First Time programme
HAPU	Hospital Acquired Pressure Ulcers
HES	Hospital Episode Statistics
IG	Information Governance
IOMS	Institute of Orthopaedic and Musculoskeletal Science
KPI	Key performance indicators
LCRN	Local Clinical Research Network
MCA	Mental Capacity Act
MRSA	Methicillin-resistant Staphylococcus aureus
NEWS	National Early Warning System
NHSI	NHS Improvement
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
PALS	Patient Advice Liaison Service
POD	Patient Outcomes Data
PROMs	Patient Reported Outcome Measures
RCA	Root Cause Analysis
RNOH	Royal National Orthopaedic Hospital NHS Trust
SHMI	Summary Hospital-level Mortality Indicator
SNCT	Safer Nursing Care Tool
TDA	NHS Trust Development Authority
UCL	University College London
UTI	Urinary Tract Infections
VTE	Venous Thromboembolism
WHO	World Health Organization

NHS
Royal National Orthopaedic Hospital
NHS Trust