2020-21

NHS

Royal National Orthopaedic Hospital

NHS Trust

ANNUAL REPORT

2020-21

www.rnoh.nhs.uk

ABOUT THIS DOCUMENT

The Annual Report comprises 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 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 explain 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, 2021. 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 **rnoh.communicationsdept@nhs.net**

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 159 of this annual report.

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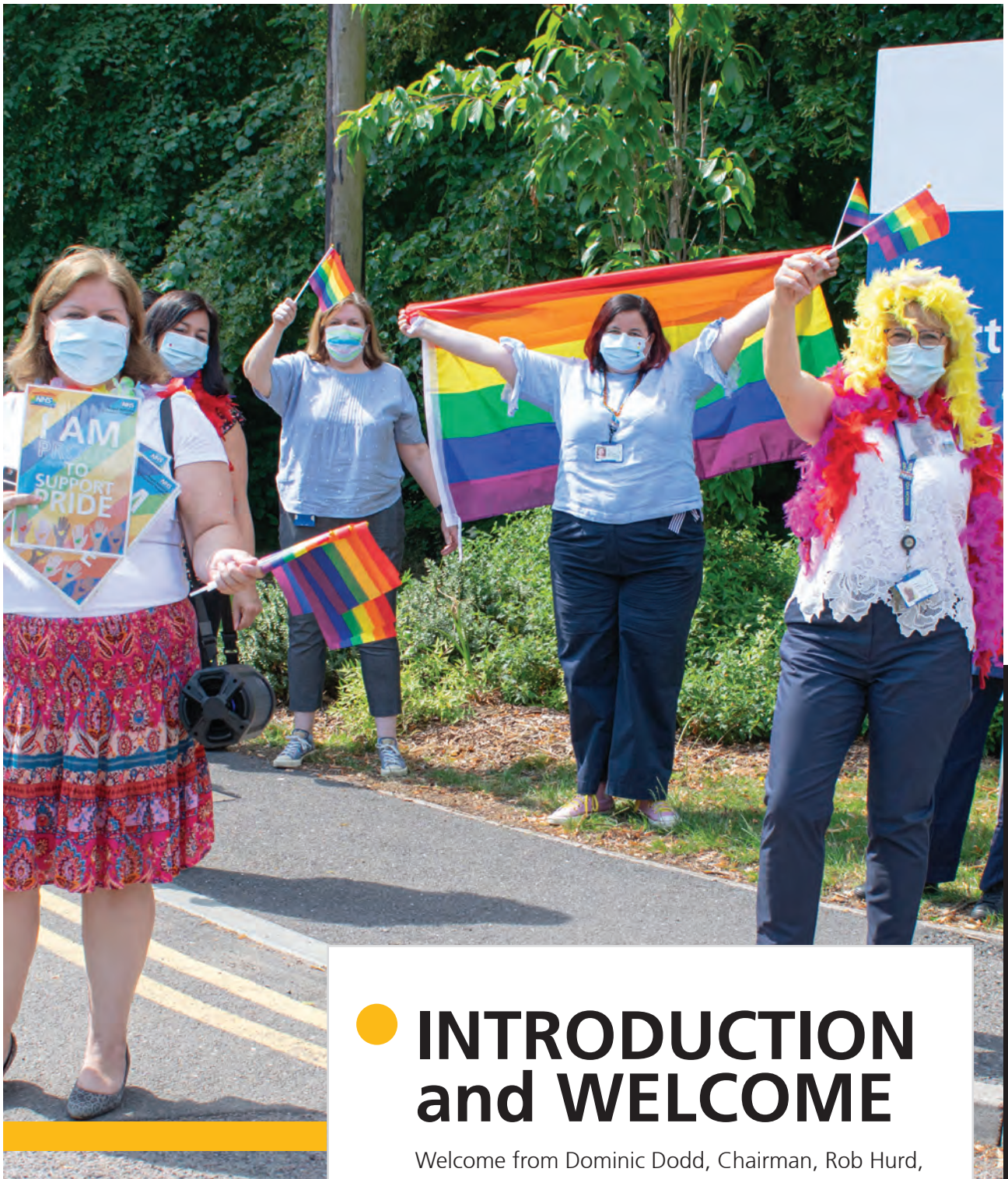


INTRODUCTION and WELCOME

Welcome from Dominic Dodd, Chairman, Rob Hurd, Accountable Officer and Professor Paul Fish Chief Executive and Chief Nursing Officer

WELCOME TO OUR 2020-2021 ROYAL NATIONAL ORTHOPAEDIC HOSPITAL (RNOH) ANNUAL REPORT

We are extremely proud of what we achieved at the RNOH during 2020-21. Coronavirus (COVID-19) had a significant impact on the NHS nationally. We have continued to operate throughout the year supporting orthopaedic and MSK (Musculoskeletal) care and have supported colleagues in North Central London (NCL) and the wider NHS during the pandemic. During the first wave, there was significant pressure on hospitals which had emergency departments to deal with COVID-19 patients and to maintain trauma surgery. After 30 years of not having undertaken this type of surgery on-site, a trauma service was established at the RNOH for North Central London and wider, to undertake emergency trauma surgery, treating patients with minor (ambulatory) trauma through to significant trauma. Critical care was also under significant pressure during the first wave and the RNOH deployed staff to both the Nightingale and also to partners in NCL to support critical care staffing there. The Trust transformed into a general acute hospital during the 2nd phase with a focus on continuing to provide elective MSK for RNOH patients and for the wider system. The Trust has now discharged all patients that were previously being treated for COVID-19 as part of its mutual aid response to support the system.

The flexibility, dedication and expertise of our staff during the second wave is something which each and everyone should be proud of. The response of our teams ensured that in the height of the second wave, when services across NCL were under extreme pressure, there was enough capacity to ensure that every patient received the care that they needed. We owe a special thank you to the teams who continued to add new and different processes into their routines and continued to put the needs of patients first during this challenging period in the NHS history. In support, the RNOH Charity launched a COVID-19 support fund to help the RNOH's frontline staff in any way that was possible, from providing meals, to purchasing essential equipment items, to supporting their mental health. The RNOH Charity also appealed for gifts-in-kind and our supporters did not let us down, donating a large number of clothes, numerous dried food items, drinks and toiletries. We also secured corporate support from a number of local and national businesses. We owe a huge debt of gratitude to our RNOH volunteers, the local community and partner organisations for their help and solidarity during the COVID-19 emergency.

There were a number of other significant events that marked 2020-21; the Trust worked with Middlesex University to develop a manufacturing process for the visors that were used as part of PPE and daily production reached 1,800 units. Large numbers of staff were identified who could work safely from their homes and there was significant work undertaken by the digital team to put the technology in place that would allow for this to happen. Many patients were consulted through virtual outpatient services with a target of moving OPD consultations to 80%, by either telephone or video. Led by our Chief Pharmacist, Ashik Shah, a vaccination programme to vaccinate staff at the RNOH was a huge success with rates for substantively employed staff reaching 84%. This was a huge team effort with around 60 colleagues from the clinical, administrative and RNOH volunteer teams contributing to the smooth running of the service. Almost every staff group was represented in the vaccine team, all volunteering to be part of the work.

The RNOH is part of the North London Partners Integrated Care System (ICS) which is a partnership of local authorities and health and care organisations from Barnet, Camden, Enfield, Haringey and Islington. We are working together to improve health and wellbeing outcomes for our population of 1.5 million people. Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. The ICS provides direction for existing delivery organisations and vehicles and is a way of partners working together to ensure that the whole system is working effectively to achieve our aims and ambitions. It takes a wide, strategic, and long-term view. Delivery is through the North Central London Provider Alliance. The purpose of which is to create a membership organisation where members work together to improve health value for the population we collectively serve; by improving the quality and reducing costs of health services above and beyond what each member organisation could achieve working on its own. The integration of services has been accelerated as a result of the need to collaborate in the response to COVID-19. This meant an increasingly closer working relationship with our colleagues in other NHS organisations, with opportunities to work together to co-deliver services, develop integrated pathways and undertake improvement as a system rather than at provider level. The aftermath of the response to COVID-19 will result in long-term changes to the way that

healthcare is delivered, not just at the RNOH but across the entire NHS.

The RNOH has established a clinical partnership with the Royal Free London Group to provide a vehicle for closer working in managing the wider MSK elective pathway in the North of NCL into the future. The Trust has an ambition to provide a greater leadership role across the pathway of musculoskeletal (MSK) care in North Central London and beyond. Our ambition includes developing new services for patients requiring first contact for an MSK condition, with therapies-led assessment and intervention, through to playing a leading role in the management of high volume, low complexity MSK surgery at Chase Farm Hospital alongside an expansion of our more specialist work at a regional and national level.

The Trust has also started hosting lists in paediatric orthopaedics and spinal surgery from the Royal Free Hospital (RFH) as the first stage of closer partnerships and system support. Surgeons from the RFH come to operate at the RNOH and the patient pathway includes preoperative assessment, critical care support and postoperative management. Out of hours cover is provided by RNOH surgical teams and a system of weekly review is being established. This closer working includes multidisciplinary team working and increased familiarity across clinical teams and is being led by clinicians from both units.

During the year, events were held to celebrate and support our Diversity, including Virtual Pride, Black Lives Matters day of solidarity and our annual Diversity Festival. As one of the many ongoing initiatives to raise awareness about inequality, the Trust and the Equality Achievement Network held a day of action in July 2020 in support of, and in solidarity with Black Lives Matter. There has been a real focus at the Trust on raising awareness in respect to diversity and inclusion and supporting staff to speak up and to live the Trust's values. The Trust proudly celebrated Pride at the end of June 2020 and even our road crossings are now a vibrant reminder of the inclusive organisation we are determined to be. We also marked Black History month for the first time, with a series of events to engage in the rich history and experiences of Black people. We also celebrated Eid-ul-Fitr and Diwali this year.

The Trust staff survey results for 2020 showed that the RNOH had the best staff engagement in the NHS, however it still has some way to go in respect of ensuring staff with protected characteristics benefit equally from a high-quality staff experience. The Trust remained static compared to the results in 2019 and so performed below the Acute Specialist Trust average for Equality and Diversity and Bullying and Harassment which draws national comparisons. The Trust was above the average on both of these factors when compared with all other London NHS Trusts.

September 2020 was truly a magical moment as Horatio's Garden team opened the gardens to show patients and staff this beautifully serene space just beyond the doors of the London Spinal Cord Injury Centre. Horatio's Garden London has been over two years in the making and the teams responsible for bringing the garden to life have worked tirelessly to ensure that they completed the build on time for patients and staff. Our thanks go out to garden designer Tom Stuart-Smith, architect Stephen Marshall, and to major contractors ARJ Construction for making this happen.

We are also immensely grateful for the support of our associated charities during the pandemic and the rest of the year. Their fundraising efforts during 2020/21 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: Radio Brockley, the Barbara Bus, ASPIRE, SCAT Bone Cancer Trust, the Disability Foundation and, of course, the RNOH Charity for their tireless fundraising.

The RNOH Charity continues to strengthen and support the people, research and infrastructure that make the RNOH one of the world's best orthopaedic hospitals. It donated £1.2m to the RNOH during the year. Contributions included the RNOH's first state-of-the-art SPECT-CT scanner (£667,984), continuation funding of the Volunteer Service team, the Buggy Service, Occupational Therapy Patient Equipment, Horatio's Garden, welcome packs for Australian nurses, Aspire gym membership, repairs and maintenance throughout the hospital site, including improving patient waiting areas and parent accommodation and the Staff Hardship Loans which were made available to all RNOH staff.

The COVID-19 outbreak put unprecedented pressure on the RNOH's clinical staff. For this reason, the RNOH Charity created a COVID-19 support fund to support staff and patients during the pandemic. The purpose of the fund was to help in any way possible - from providing meals, to purchasing essential equipment items, to supporting mental health in a time of crisis. The campaign was launched at the end of March 2020. In total £195,000 was raised towards the support fund. The RNOH Charity also appealed for gifts-in-kind from its supporters and were overwhelmed with a large number of clothes, dried food items, drinks and toiletries. The Charity also secured corporate support from local and national businesses.

Grants awarded by the Charity included a cardiology ultrasound machine, an RNOH Staff Wellbeing Lead offering mental health and emotional wellbeing support to all staff, listening events for staff to be held during 2021, a tumble dryer for the spinal cord injury centre, membership for spinal cord injury

centre staff of a national shared learning network set up by the Royal College of Psychiatrists in the wake of the pandemic to improve wellbeing and support teams to measure and make changes to enhance the workplace and sundry items to benefit patients, volunteers and staff including clothing and toiletries.

Grants awarded to research projects amounted to £215,890. 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.

Due to the pandemic, the RNOH Charity was not able to run its annual Buttercup Day this year. However, in October the Charity was delighted to launch a limited collection of beautiful, handcrafted porcelain buttercups to support staff and patients at the RNOH. The porcelain buttercups perfectly embody the hospital's message of optimism, hope and individuality. In a limited edition of 2,000, they are also a tribute to the many lives changed by the RNOH. Each is hand-finished, slip cast, shaped and painted by ceramic artist Clare Twomey. They can be purchased at www.thebuttercupcollection.co.uk.

The Trust delivered a financial surplus for 2020/21 however this was the result of the temporary financial framework in place. The impact of COVID-19 on the Trust's income, including the impact on private practice income alongside high unit costs relative to other Trusts indicate the need for a radically new approach to financial sustainability. Growth in both NHS and non-NHS income, productivity improvements and work, with system partners, to reduce the cost of overheads will all be required to improve this position.

We would like to take this opportunity to thank each and every one of our staff for their extraordinary contributions during this health emergency.

Dominic Dodd
Chairman

Rob Hurd
Accountable Officer

Professor Paul Fish
Chief Executive and
Chief Nursing Officer

PERFORMANCE REPORT

Overview

STATEMENT OF PURPOSE AND ACTIVITIES OF THE RNOH

This overview is a summary to provide the reader with information 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 realise this vision, we have an established track record of achieving excellent quality of patient experience and outcomes with over 66% of patients who completed the survey, indicating that they would recommend the Trust to friends and family who need similar treatment or care.

During 2020-21 the RNOH provided specialist orthopaedic care to 9,742 in-patients at the Stanmore site. Altogether, there were 124,173 outpatient attendances: 106,038 outpatient attendances at the Stanmore site, 17,752 outpatients attendances at the Bolsover street site and 383 at home or in another setting. 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 1,529 people with hundreds more employed by partners supporting its work. It provides services on two sites; the Stanmore Hospital site which is a 223 bed hospital with capacity for 16 intensive care patients and is set in 112 acres of land in the London Borough of Harrow and the Bolsover Street site which attends to outpatient cases only and is located in Central London.

The 30 clinical services provided by the RNOH are:

- Anaesthesia
- Cellular and molecular pathology
- Children and adolescents
- Chronic Pain Management
- Clinical Neurophysiology
- Foot, Ankle and Lower Limb
- Imaging Services
- Implant Science
- Integrated Back Unit
- Joint Cartilage Transplantation
- Joint Reconstruction: hip
- Joint Reconstruction: knee
- Limb reconstruction
- Neuromodulation
- Patient Outcome Data (POD)
- Peripheral Nerve Injury Unit
- Psychiatry and Psychology
- Pharmacy and medicines optimisation
- Private Care
- Prosthetic and Orthotics Rehabilitation Unit
- Rehabilitation Guidelines
- Rehabilitation and Therapy
- Rheumatology
- Safeguarding
- Sarcoma Unit
- Scoliosis
- Spinal Cord Injury Centre
- Spinal Surgical Unit
- Sport and Exercise Medicine
- Shoulder and Elbow unit

STATEMENT FROM THE CHIEF EXECUTIVE

Our people are at the core of our organisation and the many achievements that have been seen this year would not have been possible without their individual and collective effort. 2020/21 has seen a refocus of the organisation on well-being, mental health and equality, diversity and inclusion.

Our most recent staff survey showed the Trust had the best score for staff engagement of any NHS Trust in England. Staff rated the quality of care delivered to patients as the best for any specialist Trust in England, the 2nd best for all Trusts in England and the best in London. Staff also told us that both our health and well-being offer and their morale was the best of any Trust in London.

The Trust is rightly proud to have achieved these results, especially during our response to the pandemic, however we know that there is still more that we can do. We will have a relentless focus on equality, diversity and inclusion in 2021/22 and will strive to make the RNOH the best place to work in the NHS.

The Trust was ranked number one in the UK and 9th in the world in relation to MSK services. The Trust also made the top 50 in the overall global ranking of hospitals. This global top-ten ranking highlighted the crucial work the RNOH does in treating and supporting patients with some of the most complex and chronic musculoskeletal conditions, as well as vital research and development into future treatments and assistive technologies. It was also a recognition of the hard work that our staff do every day to help our patients.

The Trust is a member of the North Central London Integrated Care System and works with its partners to deliver the requirements set out in the NHS Long Term Plan. We have a collective commitment to deliver changes that will improve the health and wellbeing of patients and its residents. The purpose of any ICS is to create a collaborative process of local leadership in order to achieve the delivery of a more joined up system of health and care, centred around the residents and patients.

In October 2020, the Trust Board agreed to become a founding member of the NCL provider alliance. The alliance is likely to provide significant benefit to the RNOH in delivering the revised vision for the Trust

and helping to address some elements of financial sustainability. The purpose of the NCL Provider Alliance is to create a membership organisation where members work together to improve the health value for the population we collectively serve and by improving the quality and reducing costs of health services above and beyond what each member organisation could achieve working on its own. The focus will be on delivery.

Whilst at an early stage of development , the Trust has an ambition to take on a role within commissioning tertiary MSK services for London and, as part of a consortium of specialist providers, leading on this agenda nationally. Such a model would be a significant step towards strengthening the Trust vision for national partnerships and enhancing the Trust's role in national MSK leadership.

The first clinical partnership Trust Board of the RNOH/RFL clinical partnership was held in February 2021. The board agreed that the priority area for work was in building a model for high volume/low complexity MSK services in the North of NCL, at the Chase Farm site. A bi-lateral business case is in development for investment in the Chase Farm site to increase capacity for this model and further work will be undertaken over the course of the coming months to design the clinical, operational, financial and workforce models that are required to make this a success. In addition, a model of high street based, first contact MSK services is being developed. Led by therapists, as part of a multi-disciplinary team, these services will provide a holistic needs assessment and treatment for patients with early MSK ill-health and will provide an alternative pathway for some patients to surgical intervention. There are further opportunities to collaborate with RFL as part of the clinical partnership, such as working together to develop our digital aspirations.

The long term outlook for financial sustainability remains challenging due to the uncertainty around funding arrangements, the pressures facing the Trust and the NHS as a whole to deal with the long backlog of patients waiting more than 18 weeks for their treatment and the pressing need to deliver care more efficiently without a compromise on quality. The Trust strategy of growth and efficiency, achieved via a network of partnerships, is a confident response to these circumstances and provides the best opportunity for the Trust to achieve financial sustainability over the medium to long-term.

Another key risk to achieving further progress, remains National, Regional and local workforce pressures in relation to recruitment, retention and development of clinical professionals including nurses, doctors and allied health professionals. Significant progress has been made in reducing vacancies over the course of this last year as a result of implementing: Nursing Career clinics, Transfer-schemes, Rotational schemes, International Nurse Recruitment, Flexible working, Return to practice, Preceptorship and Experienced Nurses Retention initiatives. Going forward, opportunities to work collaboratively within our system and as part of the provider alliance are likely to strengthen these activities and further reduce this risk.

The social and financial impacts of the COVID-19 pandemic have had severe impacts on our communities within NCL and the Trust recognises its key role as an anchor institution. Work will be undertaken both independently and in partnership with other organisations to ensure that we make best use of our employment and training opportunities in support of our local community.

During the year, we were delighted to be shortlisted in the Workforce Team of the Year category in this year's Nursing Times Workforce Awards. As well as being the International Year of the Nurse and the Midwife, the 2020 awards ceremony ensured that the hard work and dedication of the nursing profession is recognised and celebrated following a difficult year.

During the year, the Trust received the first patient to benefit from the state-of-the-art SPECT-CT scanner. Particularly effective in the fight against cancer, the £670,000 machine combines the best aspects of two different types of scanning - SPECT (Single Photon Emission Computed Tomography) and CT (computerised tomography) scanning. As well as being much more convenient for patients, it provides doctors with instant and much more accurate images for diagnosis, to help them plan complex treatments.

At the end of the year, the Trust had discharged all patients who were being treated for COVID-19 as part of our mutual aid response to support the system. Elective services have now, after the period of staff rest, re-started and good progress is being made. It is clear that we must not only view recovery as a system issue with system-wide solutions, but that we should endeavour to provide leadership in the recovery of the MSK elective pathway. The Trust is working with system partners in managing the clinically urgent patients that require treatment.

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 six strategic aims and were delivered by our 2019-20 objectives which in turn informed us of what our strategic risks were.

The Trust Board agreed the following organisational objectives and strategic risks for 2020/21.

STRATEGIC AIM:	STRATEGIC RISKS:
ACHIEVE TOP DECILE PERFORMANCE IN OUTCOMES **CORPORATE OBJECTIVE:** Achieve top decile outcomes in MSK	**(a)** Absence of a single IT platform to collect outcomes data. **(b)** Variable outcome data collection at individual service level. **(c)** Limited use of standardised care pathways. **(d)** Inability to capture complexity data in a standardised way. **(e)** Inhouse/external solution is required in relation to the digital platform which will be determined by the Digital Strategy.
DEVELOP PARTNERSHIPS WITHIN NCL AND NATIONALLY TO FACILITATE LONG-TERM SUSTAINABILITY **CORPORATE OBJECTIVE:** **(a)** Clinical Partnerships **(b)** Lead MSK Provider **(c)** Provider Alliance **(d)** National MSK Leadership	**(a)** Failure to join the NCL Provider Alliance. **(b)** Failure to develop a clinical partnership model with Royal Free London Hospital Group. **(c)** Failure to develop and operationalise a model of MSK lead provider for the North of NCL. **(d)** Failure to achieve lead commissioner status for national specialist commissioning of MSK. **(e)** Failure to generate capital to build RNOH at Chase Farm Hospital site.
FINANCIAL SUSTAINABILITY **CORPORATE OBJECTIVE:** **(a)** Reference cost index of 110 **(b)** 15% turnover private practice **(c)** Clinical/corporate support services via provider alliance **(d)** MSK lead provider	**(a)** Failure to achieve efficiencies in corporate and clinical support services via the NCL provider alliance. **(b)** Failure to increase profit from private practice income. **(c)** Failure to improve operational efficiency and reduce cost base. **(d)** Failure to increase overall Trust turnover via NHS income growth strategy.

STRATEGIC AIM:	STRATEGIC RISKS:
BEST PATIENT AND STAFF EXPERIENCE **CORPORATE OBJECTIVE:** Best staff and patient experience in London	(a) Workforce supply and retention. (b) Failure to progress with EandD and BandH metrics as measured in the annual staff survey. (c) Failure to adequately support staff health and wellbeing during the COVID-19 response. (d) Financial constraints that impact on ability to support health and wellbeing. (e) Deterioration in access targets (RTT) leading to longer waits for treatment.
INFRASTRUCTURE - REDEVELOPMENT **CORPORATE OBJECTIVE:** Estate redevelopment - To enable and deliver the site redevelopment	Insufficient funding for redeveloping the site. The Trusts plans for redevelopment are on hold due to insufficient funding streams. NHSI have informed the Trust that Design, Build, Fund and Operate (DBFO) is no longer an acceptable contract for the procurement of new buildings. The RNOH has one of the highest backlog maintenance costs in the country.
INFRASTRUCTURE - ENABLE A DIGITAL FIRST ENVIRONMENT **CORPORATE OBJECTIVE:** Digital first enablement - Implement Digital Strategy	(a) Availability of investment in technology (both external funding and internal investment priority). (b) Availability of resources (technical resources and skills within the digital team). (c) Technological capability of wider RNOH workforce. (d) Engagement of the workforce to the digital strategy. (e) Technological capability of patients and other external stakeholders. (f) Possible change from current EPR strategy may delay implementation of the Digital Strategy.

PERFORMANCE SUMMARY

A. PATIENT SAFETY AND QUALITY

The RNOH remains committed to delivering the best quality of care and patient experience and working in an open and honest environment; this includes supporting staff to report incidents. Incident reporting is actively promoted through staff training and further embedded by the management of incident investigations.

Internal assurance is provided by the Trust's internal auditors who provided substantial assurance in-year on the Incident Reporting and Lessons learnt arrangements that includes a weekly Incident Review Group with oversight of the incident reporting and investigation activity Trust-wide. The group receives assurance from divisions and departments on the initial local review of all Incidents and discusses by exception in detail those incidents that may potentially meet the criteria for declaration as Serious Incident or Never Event.

A Safety Notes newsletter is disseminated Trust-wide to share key messages and learning from top recurring incidents discussed at the weekly meetings. The monthly Medicines Matters newsletter shares the key trends and lessons from Medication incidents. Serious incidents undergo a detailed investigation and a Clinician led root cause analysis, the results of which are shared with the patient and relatives. Learning from Serious incidents is shared through the Learning Brief Newsletter across the Trust. An externally facilitated workshop provided Root Cause Analysis training to senior clinical leaders and governance managers to support effective incident investigation within the Trust, including involvement of patients and their families in the investigation process.

Infection Control

The RNOH has a multidisciplinary Infection Prevention and Control (IPC) team comprising of specialists IPC nurses, a surgical site infection (SSI) surveillance nurse, a SSI coordinator/data analyst, an infection control doctor, antimicrobial pharmacist and bone infection nurse specialists. This report outlines achievements, good practices and key learnings based on post-infection investigations and root cause analysis from the financial year 2020-2021.

- The Trust continues to provide urgent and elective services to orthopaedic patients from all over the country throughout the pandemic by maintaining a COVID-19 protected 'Green Site' status by implementing updated local policies and protocols based on current national guidelines on COVID-19.
- The past year has seen the Trust transform as an orthopaedic trauma centre during the first wave of the pandemic and even to a COVID-19 step down hospital during the second wave to help relieve the burden from other Trust's in North Central London. The Trust also opened up to 10 beds in the intensive care unit for intubated COVID-19 patient to help neighbouring Trusts during this period.
- For over 10 continuous years, there hasn't been a Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia acquired within the Trust.
- For financial year 2020-21, there were 2 cases of Methicillin-Sensitive Staphylococcus Aureus (MSSA) acquired at the RNOH. Learning was identified from the post infection reviews where peripheral and central line care, wound care management and documentation, and post-operative care instructions were recognised as areas needing improvement.
- 7 gram-negative blood stream infections (GNBSI) were identified last year where sputum, wound and urine colonisation were mostly identified as the primary sources of the infections.
- There were 2 cases of hospital onset or healthcare associated Clostridiodes difficile (toxin positive) infections reported for the Trust in the year.
- Monthly hand hygiene, vascular access and environmental spot-check audits were undertaken by the network of Infection Prevention and Control Link Practitioners and Ward/Area Managers across the various clinical areas of the Trust. The spot checks identified that we needed more hand hygiene stations, accessibility to personal protective equipment (PPEs) and clinical waste bins. These were mitigated immediately by the Area Managers, Estates and Procurement.
- The IPC team led on implementing a 5-day Staphylococcus aureus decolonisation regimen for all surgical patients of the Trust composed of a chlorhexidine wash and nasal ointment which surgical patients use 2 days prior to surgery, on the day of surgery and followed-up with another 2 day course post-surgery as an attempt to lower rates of SSIs.

- Pre-assessment swabs and test are carried out for patient prior to attending RNOH to ensure the safety of all patients. These includes COVID-19, MRSA, CPE and other drug-resistant organisms as requested by the IPC team. A Patient Testing team was established to organise and to follow-up patient results prior to them being admitted to the Trust.
- SSI Surveillance is carried out by a specialist nurse and coordinator. We monitor hip, knee and spinal surgeries as per PHE mandatory orthopaedic categories in the national surveillance throughout the year. The team also monitor shoulder and elbow surgeries, and amputations which is internally reported to the Surgical Site Infection Prevention Group (SSIPG) and the Infection Prevention and Control Committee (IPCC).
- As part of SSI surveillance, patients are followed up through a post-discharge questionnaire supplemented with phone calls to robustly capture cases on top of monitoring re-admissions and wound management procedures.
- Seasonal flu vaccination uptake amongst RNOH patient facing staff was 62% compared to 71.5% the previous year. The general uptake of both clinical and non-clinical staff at 56%.
- The team delivers scheduled and ad hoc training on a range of topics. In addition to mandatory training sessions and regular medical inductions, the team also delivers bespoke sessions as part of the surgical ward study day series. The team also recorded a sessions used in virtual Joint School for all pre-admission Joint Reconstruction Unit patients, PPE donning and doffing training videos, and the use of the hood respirators.
- Throughout the year in this pandemic situation, the IPC multidisciplinary team managed to ran successful virtual campaigns for International Hand Hygiene Day, World Infection and Prevention Day, and World Antibiotic Awareness with a focus on nurse-led initiatives to promote IPC practices across the Trust.
- The team continue to conducted in-depth environmental cleaning audits of all inpatient areas grounded on national cleaning standards and best practice. The audit results were fed back to clinical areas and estates for action planning. The Trust has recently purchased an Adenosine Triphosphate (ATP) machine which is used as a rapid testing to monitor quality of cleaning. These audits are carried out regularly.
- The Trust recently purchased a hydrogen peroxide vapour (HPV) decontamination machine that is used as an adjunct to mechanical cleaning for deep or infection cleaning. ISS Global, who provides domestic services to the Trust also purchased an ultra-violet (UV) ray machine that is used in tandem with the HPV decontamination machine.
- The quarterly Infection Prevention and Control Committee and Surgical Site Infection groups continued. The IPCC agenda was revised and a new way of working introduced for the next financial year whereby divisions report into the Committee.

Complaints Handling Procedures and Principles of Remedy

Learning from patient and carer experience

The Trust is committed to engaging in a positive way with patients/carers and families and feedback is used to inform developments and improvements across the Trust's Services. Learning from patient and care experience is drawn from a range of sources. These include feedback from the Trust's Patient Advice and Liaison Service (PALS), information received through complaints, and comments from the Friends and Family Test (FFT).

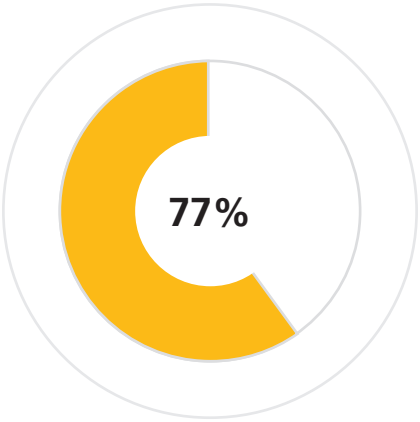
In collecting feedback, the aim is to ensure that there is an understanding of the whole patient's experience. There are different ways in which learning is disseminated and shared internally, for example with the relevant wards, through Trust safety huddles, clinical handover, team meetings, preceptorship, monthly Trust Quality report as well as the Trust Board, People Committee.

Patient Advice and Liaison Service (PALS)

The Trust PALS service is an integral part of the corporate quality team and acts as a single point for contact for members of the public who wish to raise complaints, concerns, and compliments or have a request for information. The service is responsible for coordinating the process and managing responses once the investigations and updates are received from relevant services.

The total number of PALS contacts is recorded at 938.

Year	2017/18	2018/19	2019/20	2020/21
Total number of PALS contacts	1,681	855	842	938



The Trust responded to and closed 724 of the 938 PALS enquires within 5 working days a performance figure of 77%

Complaints and Investigations

Complaints are a vital source of information from our patients, families and carers about the quality of our services and standards of our care. The Trust is committed to ensuring all complaints are addressed and improvements made to the service where required. The Complaints and PALS team continue to work collaboratively with the divisions in the Trust and external organisations to ensure a seamless complaints management process.

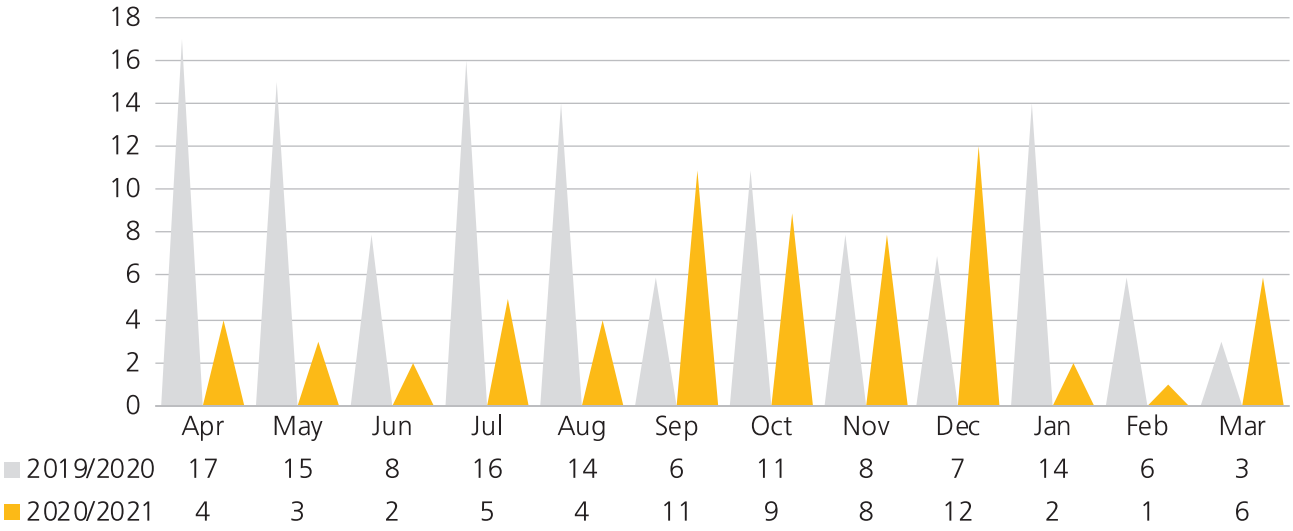
The percentage of complaints acknowledged within 2 working days has improved from last year and all complaints were acknowledged within 2 days, 100% of the time.

Performance 1 April 2020 – 31 March 2021

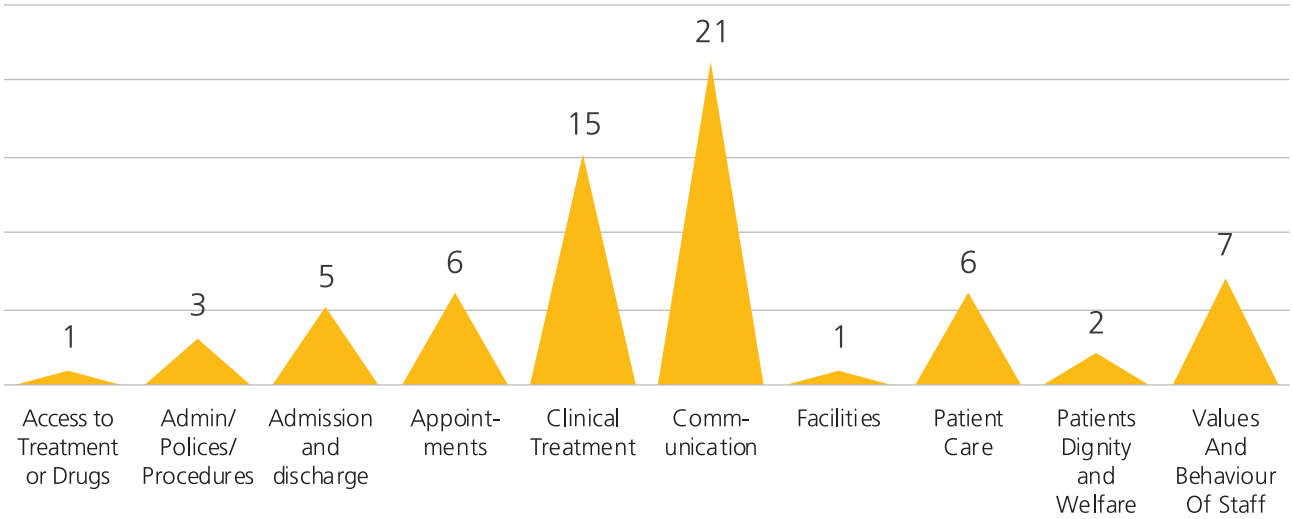
	Total for 2020-21
No of complaints received	938
% responded to within time	78%
% of complaints acknowledged within 2 working days	100%

Between the 1 April 2020 and 31 March 2021 the Trust received 67 Complaints compared to 125 complaints in 2019/20. This equates to an average of 6 complaints per month. The reduction in complaints was largely due to the effects of COVID-19. The top three themes for the year were communication, clinical treatment followed by values and behaviour. Communication remains the most reported complaint category although a majority of complaints have more than one theme in each complaint. Each theme is further analysed to support identification of improvement areas and support learning.

Complaints Comparison Graph



Categories of complaints




NHS
Royal National
Orthopaedic Hospital
NHS Trust
Volunteer with us
Funded by
The RNOH Charity
Telephone:
0208 909 5394
Email:
volunteering@rnoh.nhs.uk

Parliamentary and Health Service Ombudsman (PHSO)

Complainants who are dissatisfied with the Trust response have a right to ask that the PHSO reconsider their complaint. This year one complainant requested a review of their case. The Trust have no other cases with the PHSO.

Key improvements during 2020/21

- Redesign of the Patient information leaflet on 'how to raise a concern/complaint'.
- New and improved Patient Experience intranet page with access to up-to-date information and resources.
- Updated Complaints Policy.
- Automated weekly PALS and Complaints reports to divisions to standardise reporting and prompts Trust-wide.
- Introduction of the QR codes and SMS messaging to obtain FFT feedback.

Friends and Family Test (FFT)

NHS England carried out a project to improve some areas of the way FFT works across the country with ambition of making FFT a more effective tool for gathering patient's feedback to help drive improvement.

The changes announced mean that providers now have to use the new mandatory question 'Overall how was your experience of our service' with answers ranging from Very good, Good, Neither good nor Poor, Poor, Don't Know. This is followed up with 2 questions 'Please tell us why you gave your answer ' and 'Please tell us anything that we could have done better'.

The changes were due to come into force in April 2020, however, because of the COVID-19 pandemic there has been delays implementing the guidance until January 2021.

Patient Safety

The RNOH remains committed to delivering the best quality of care and patient experience and working in an open and honest environment; this includes supporting staff to report incidents. Incident reporting is actively promoted through staff training and further embedded by the management of incident investigations.

Internal assurance is provided by the Trust's internal auditors who provided substantial assurance in-year on the Incident Reporting and Lessons learnt arrangements that includes a weekly Incident Review Group with oversight of the incident reporting and investigation activity Trust-wide. The group receives assurance from divisions and departments on the initial local review of all Incidents and discusses by exception in detail those incidents that may potentially meet the criteria for declaration as Serious Incident or Never Event.

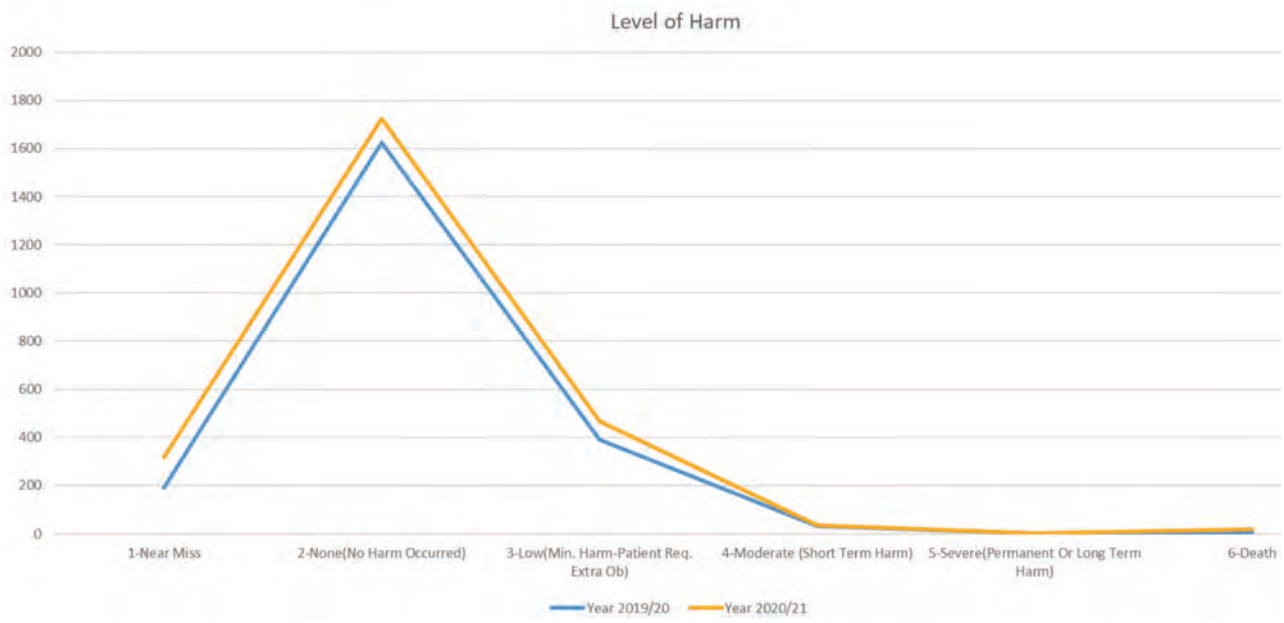
A Safety Notes newsletter is disseminated Trust-wide to share key messages and learning from top recurring incidents discussed at the weekly meetings. The monthly Medicines Matters newsletter shares the key trends and lessons from Medication incidents. Serious incidents undergo a detailed investigation and a Clinician led root cause analysis, the results of which are shared with the patient and relatives. Learning from Serious incidents is shared through the Learning Brief Newsletter across the Trust. An externally facilitated workshop provided Root Cause Analysis training to senior clinical leaders and governance managers to support effective incident investigation within the Trust, including involvement of patients and their families in the investigation process.

Incident Reporting

Our data demonstrates the Trust generally has a good reporting culture and reports all types of incidents with varying degrees of harm including no harm and low-harm incidents.

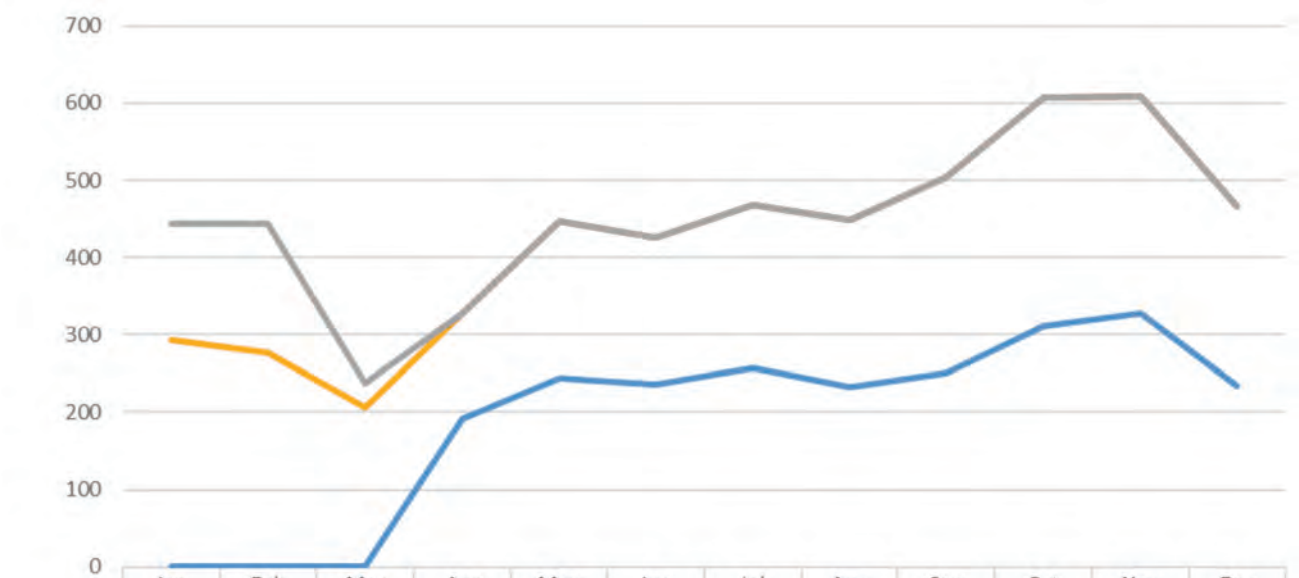
Incidents by Level of Harm

Harm levels in the last two years displayed below shows no significant change in trend despite a slight drop in the reporting activity overall attributed to the COVID-19 pandemic.

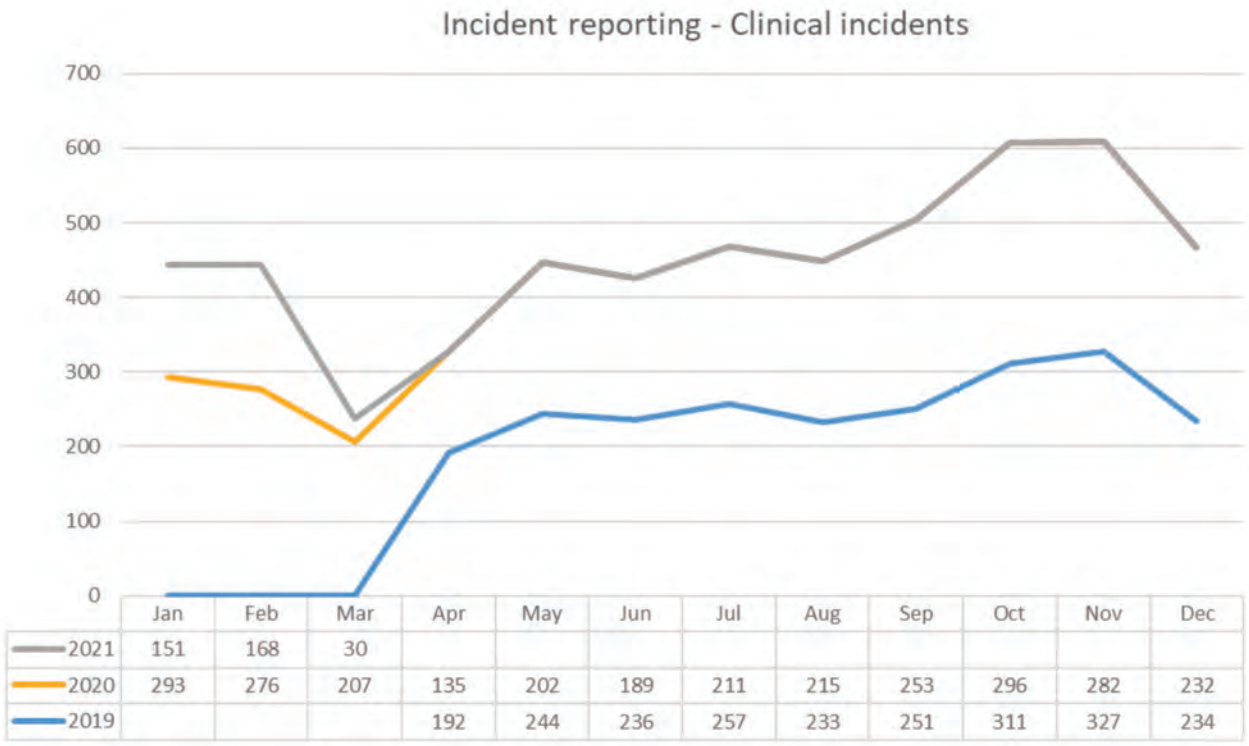


Mortality

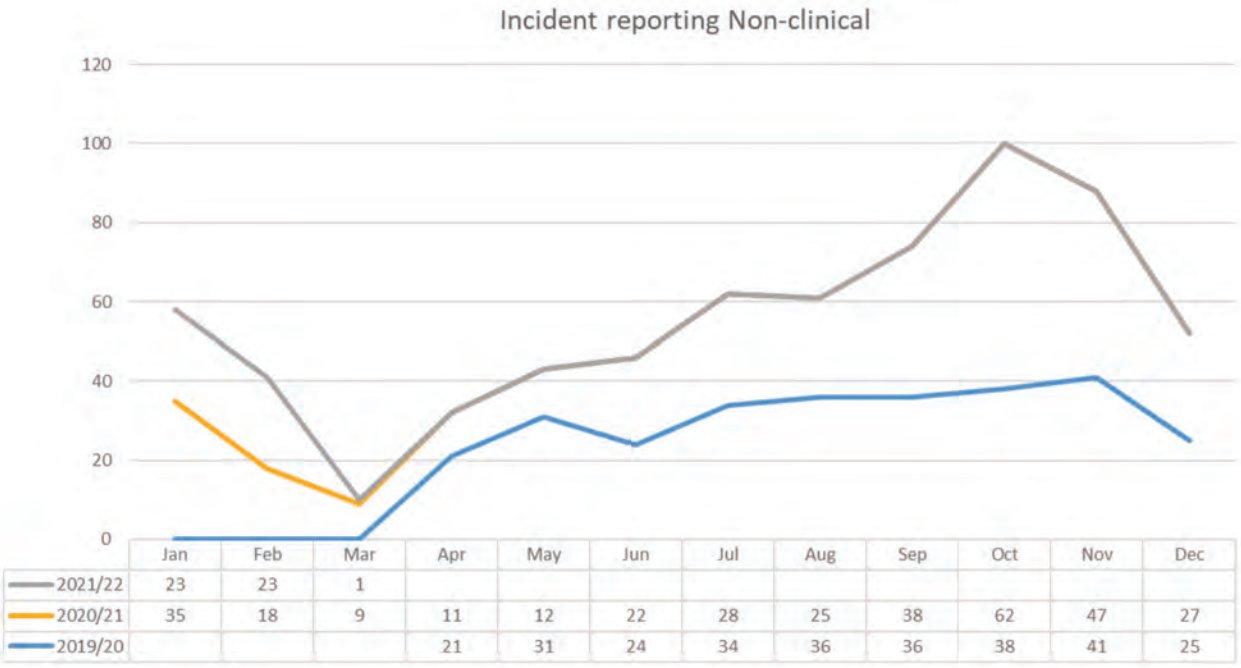
There has been a general increase to 34 (6 in 2019/20) in the number of deaths". The Trust Learning from Deaths process reviews every death and any concerns of sub-optimal care are escalated through the Patient Safety governance process to identify learning and take necessary action to mitigate the risk of reoccurrence. Of the 34 deaths during 2020/21, over 60% of patients died with a confirmed COVID-19 positive test. All deaths were reviewed via the Learning from Deaths process and any concerns of sub-optimal care were escalated through the Patient Safety governance process to identify learning. During 2020/21, only one case was escalated for further investigation as a root cause analysis (RCA) which found no concerns with the patient treatment and care at the RNOH.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	151	168	30									
2020	293	276	207	135	202	189	211	215	253	296	282	232
2019				192	244	236	257	233	251	311	327	234



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	151	168	30									
2020	293	276	207	135	202	189	211	215	253	296	282	232
2019				192	244	236	257	233	251	311	327	234

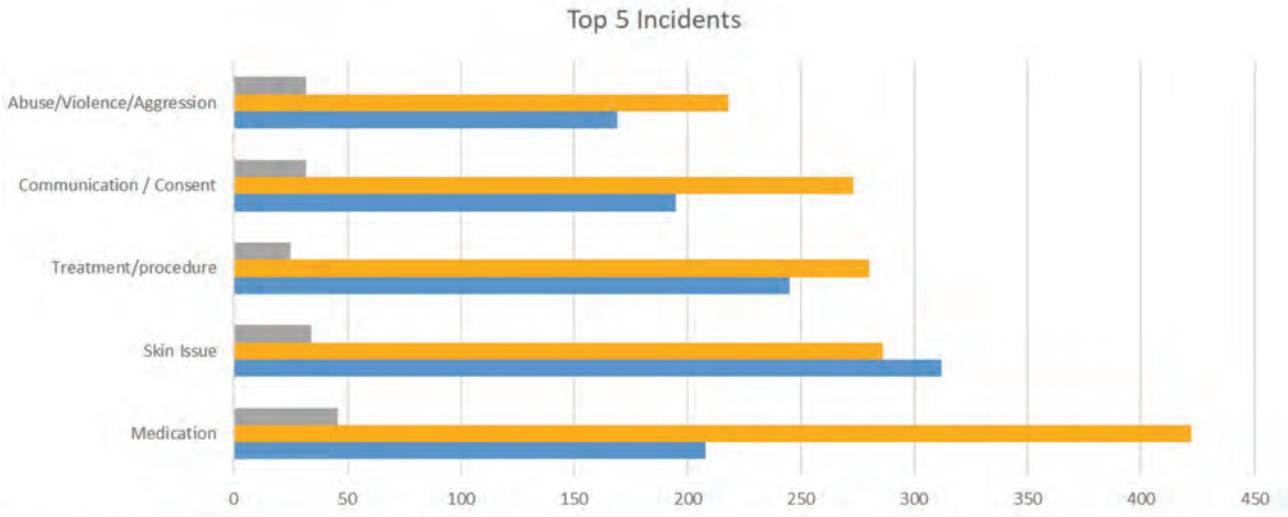


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021/22	23	23	1									
2020/21	35	18	9	11	12	22	28	25	38	62	47	27
2019/20				21	31	24	34	36	36	38	41	25

Top 5 Incidents

Data from the last two financial years indicate that our most frequently reported incidents related to:

- Medication.
- Communication / Consent.
- Allegation / Abuse / Aggression related incidents.
- Skin Issues.
- Treatment / Procedure.



	Medication	Skin Issue	Treatment/procedure	Communication / Consent	Abuse/Violence/Aggression
2021/22	46	34	25	32	32
2020/21	422	286	280	273	218
2019/20	208	312	245	195	169

The Trust has increased incident reporting levels demonstrating a more robust reporting culture. With the introduction of the ePMA (electronic Prescribing and Medicines Administration) system which is currently being built, the bulk of most medication incidents will be traceable which means higher volume reporting will be achievable in the future. Processes, policies, and training (medicines safety teaching sessions, Ward Safety Huddles/ teaching etc.) ensure that staff are competent to carry out their duties. Between January 2020 - December 2020, 90.64% of medication incidents caused no harm to patients which compared well to our peers/nationally with data captured on the NHS Model Hospital Dashboard. The Trust has an appointed Medicines Safety Officer (MSO) who is a core member of the Trust Incident Review Group and has oversight of all medication incidents. There is also a robust process in place to routinely audit practice against Patient Safety Alerts and National Patient Safety Alerts. The Trust also has links with the NCL partners for pan-London medicines safety strategies and initiatives. There are also a number of quality initiatives led by the Pharmacy team that enhance the detection of errors before harm is caused such as the Medication Safety Dashboard and monthly Medicines Matter newsletter covering key learnings and all topics involving medication safety that is disseminated across the Trust.

Approximately 9% of patients who do suffer harm from medication incidents, the Trust performs a deep dive (e.g. 72hr reports, RCA concise/comprehensive investigations) to see what the root cause was, what the contributory factors were, and what learning and recommendations need to be put in place to mitigate this from happening again. The learning is shared through various forums such as the weekly Incident Review Group attended by divisional representatives, monthly Pharmacy department meeting, feedback at bi-monthly Clinical Pharmacist meetings and at the bi-monthly Medicines Safety Committee.

Key achievements in 2020/21

- The Reconfiguration/ Remapping project on Ulysses Incidents Module with the aim to improve the way data is captured on incidents presenting an intuitive approach to categorising the types of incidents reported that in turn allows a systematic way of classifying these into themes to capture high quality data.
- The launch of the Action Planning function on the Incidents Module to fully utilise the system as a central repository for capturing learning, actions and evidence of implemented change.
- The upgrade of the Risk Management System offering advanced features for trend analysis and Dashboards.

- A Trust-wide training programme roll-out including refresher training for all staff on the system requirements of reporting as well as training to further enhance the Trust's reporting culture.
- The launch of Learning Brief Newsletter with the aim to improve our approach to sharing the learning from key incidents discussed at the Trust's Incident Review Group. The newsletter focuses on key investigations and learning that can be disseminated across all staff levels and aims to encourage discussions and reinforce the key learning from Trust's Patient Safety incidents.
- A week-long quality and safety event promoting learning and participation in Safety and Quality activities across the Trust.

The Trust is committed to:

- Enabling effective decision making; strategically and operationally, by working collaboratively with staff to develop, safeguard and embed robust systems, frameworks and processes that facilitate the delivery of safe, effective, caring and responsive services to our patients and their carers' in practice.
- Equipping staff to assess, manage and mitigate risks, enthusing a culture of high-quality incident reporting and investigating that generates intelligence to aid in the delivery of continuous learning and quality improvement.
- Working effectively together as a team working in partnership and seamlessly with staff across the divisions and the Trust Board, to bring to life the well-led framework that will provide assurance to our Board, Commissioners and Regulators.

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 endeavours 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)

Early March 2020, the NHS declared a Level 4 National Incident in response to the COVID-19 pandemic. Since then, the Trust, along with the rest of the NHS and the wider system have been making significant changes at pace to ensure that risks which may threaten our business continuity are actively identify and plans put in place to mitigate such issues as they arise. Over the last few years, the Trust has been successful in embedding a robust, evidence based and tested EPRR practice across its services. This has undoubtedly contributed to our successful response to the COVID-19 pandemic. We continue to develop and monitor our plans and policies for responding to internal and external major incidents and business continuity issues for the safety of our patients, staff and those in neighbouring Trusts.

The Trust participated in the NHS England and NHS Improvement (London) EPRR Annual Assurance Process and Winter Planning for 2020/21. The assurance process this year was a less granular process compared to previous years due to the ongoing pandemic, seasonal pressures and operational demand to reorganise services. The annual assurance process therefore focused on providing evidence for the following three areas:

1. Progress made by organisations that were reported as partially or non-compliant in the 2019/20 process.
2. The process of capturing and embedding the learning from the first wave of the COVID-19 pandemic.
3. Inclusion of progress and learning in winter planning preparations.

- The Trust achieved FULL compliance level during the EPRR 2019-20 assurance assessment. The Trust has continued to maintain and improve the EPRR processes, policies and continue to share the learning throughout the organisation.
- The Trust organised the RNOH COVID-19 response debrief immediately after the first wave. This exercise reflected on the lived experiences of well over 100 members of staff from across the organisation and at different levels of the response. A number of learning points applicable to EPRR were captured and shared with the wider organisation during the engagement with the Gold and Silver command structure. The EPRR policies and processes are being updated with the learning from the pandemic.
- The Trust submitted a comprehensive winter plan taking into account the learning from the first wave of the pandemic and the role the Trust would take within North Central London (NCL) as a COVID-19 protected/green, elective site. The Flu vaccination program to protect staff, patients and visitors and the cold weather plans were reviewed and operationalised during September 2020.

B. REFERRAL TO TREATMENT (RTT)

The 'incomplete waiting time standard' states that the time waited must be 18 weeks or less for at least 92% of patients on incomplete pathways, i.e. those patients not yet treated. This standard was initially superseded by the 2018/19 Refreshing NHS Plans guidance and then, more recently by the 2020/21 NHS Operational Planning and Contracting guidance which stated that the overall RTT waiting list size should be no higher in January 2021 than it was in January 2020 and, where possible, it should be reduced. The guidance also stated that, nationally, the number of patients waiting 52 weeks or more should be eradicated. Whilst formally the operational requirement for elective care now focuses on the overall size of the waiting list, performance data for the 'incomplete pathways' is still collected nationally.

To ensure resources could be focused on the response to Coronavirus, Trusts were asked on two occasions (for a number of months at a time) to pause almost all elective activity. The RNOH continued to provide services for a small number of very urgent pathways (including cancer and spinal cord injuries) but cancelled all other non-priority operations. In the first wave, this allowed the RNOH to become the hub for Trauma patients for North Central London, as Trusts were unable to manage these patients locally due their own redirected focus on treating COVID-19 patients. During the December - February wave, the RNOH converted a number of theatres into additional critical care beds for COVID-19 patients and also took patients with improving COVID-19 symptoms from other hospitals in NCL, allowing them capacity to manage more acutely unwell patients. The pausing of elective activity across these waves meant that the number of elective patients RNOH treated dropped significantly, resulting in fewer closed RTT pathways. This reduced activity meant that fewer patients were treated, leading to an increase in waiting times.

In response to the pandemic, the Royal College of Surgeons introduced a clinical prioritisation criteria that could be used for patients to assess the timeframe that surgery should take place within for each patient. Priority 1 and 2 (P1/P2) stated that patients must receive treatment within 72 hours and 4 weeks, respectively. During the elective recovery phases of the year, which took place after the COVID-19 peaks in Spring and Winter 2020, the focus was treating P1 and P2 patients as they clinically required treatment most urgently. To enable this, the Trust adapted the normal theatre template and reallocated theatre sessions to teams in proportion to the number of clinically urgent P1 and P2 patients. This focus meant that less urgent patients continued to wait for treatment, increasing the number of patients waiting over a year for treatment. Prior to the pandemic, the RNOH rarely had any patients waiting more than 52 weeks RTT, but as a result of the significantly reduced elective activity the RNOH was able to deliver during the two main COVID-19 peaks and the focus on clinically urgent P1 and P2 cases, the RNOH had 409 patients over 52 weeks at the end of March 2021.

The RNOH has provided support to other Trusts within the sector, offering capacity to the Royal Free London to operate on 70 paediatric orthopaedic and spinal patients (figures until end of January 2021) to ensure the equity of access across North Central London. It should be noted that these cases delivered on behalf of RFL meant that we were unable to utilise the capacity for patients referred to the RNOH, further impacting the Trust's waiting list. The RNOH is continuing to work with other Trusts in North Central London to identify areas where mutual aid is required and the Trust will continue to offer capacity to Trusts for orthopaedic cases to ensure access is equitable across the sector.

The RNOH had a waiting list of 6,554 RTT patients in January 2020 so this was the benchmark for 2020/21. The Trust achieved the target of reducing the waiting list size by January 2021, as the waiting list was 5,584, a reduction of 14.8% from the January 2020 position. Whilst reduced activity would normally cause a growth in the waiting list, this was more than offset by the drop in referrals received during the year which has been attributed to COVID-19 and fewer patients visiting their GP for non-urgent conditions.
Whilst RTT performance across the whole of the NHS notably dropped during 20/21 as a result of COVID-19, the RNOH performed well when comparing specialty performance for Trauma and Orthopaedics. The RNOH, with a performance of 66.0%, significantly outperformed England (51.3%) and London (53.9%). (March 2021 figures – latest figures available nationally at the time of writing).

C. NEVER EVENTS

Never Events are serious, largely preventable, safety incidents. During the last year there were no Never Events and two Serious Incidents reported on the Strategic Executive Information System (StEIS).

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. Further detail is available in the Governance Statement on page 104.

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 104.

1. Achieve top decile performance in outcomes.
2. Develop partnerships within NCL and nationally to facilitate long-term sustainability.
3. Financial Sustainability.
4. Best Patient and Staff Experience.
5. Infrastructure.
6. Infrastructure - Enable a digital first environment.
7. Coronavirus.

PERFORMANCE REPORT

Performance Analysis

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 2020/21, 73 key indicators were monitored covering:

- Clinical Quality.
- Access to Services.
- Workforce.
- Digital Services.
- Research and Innovation.
- Estates.
- Finance.

The process of agreeing which key performance indicators, which targets to measure and their methods of measurement, is undertaken prior to the commencement of every 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 2020-21, the Trust reviewed the indicators and agreed those which measure the Trust's performance most effectively, and are 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.

PERFORMANCE DURING 2020/21

	Target	2019-20	2020-21
Outpatient Attendances	-	136,227	123,083
Inpatient Admissions	-	15,841	9,742
Dementia Screening	>=90.0%	47.1%	7.3%
Mortality Numbers	-	6	34
Number of formal complaints received	-	126	67
Number of PALS Contacts	-	708	939
Friends and Family Inpatients % of patients responded	>=70%	44.2%	17.1%
Friends and Family Inpatients % unlikely/likely to Recommend Hospital	-	0.8%/95.4%	2.9%/94.6%
Mixed Sex Accommodation Breaches	-	118	4
Diagnostic Waits Compliance	>=99.0%	99.3%	73.3%
Referral to Treatment Open Pathways	>=92.0%	87.98%	71.3%
Cancer 2 Week Wait	>=93.0%	96.1%	99%
Cancer 31 day first treatment	>=96.0%	97.2%	99.1%
Cancer 31 day subsequent treat	>=94.0%	96.7%	96.7%
Cancer 62 day standard treatment	>=85.0%	80.5%	88.5%
Operations cancelled not operated within 28 days (Breaches of the standard)	-	19	32
Reportable DoH Last Minute Cancelled Operations	-	2.5%	1.4%
Trust Staff Turnover Rate (%)	<=13%	7.32%	8.94%
Trust Staff Sickness Absence (%)	<=3%	3.02%	3.26%
Staff Engagement (annual figure)	-	7.6	7.6
Finance and Use of Resources ratings	>3.0	3.0	3.0
Staff who would recommend Hospital as a place to receive care	-	84.2%	89.4%
Clinical System Availability	>= 99.009/C	99.9%	99.9%
Paediatric Referral to Treatment Open Pathways	>= 92.00%	95.08%	71.3%
SUS Data Quality - Data Validity Summary	-	97.6%	95.6%

PERFORMANCE ANALYSIS

REFERRAL TO TREATMENT AND CANCER PERFORMANCE

The formal national target to measure Trust performance on elective waiting times changed in 2018/19. It has previously been measured by the Referral to Treatment Target (RTT) which states that the time waited must be 18 weeks or less for at least 92% of patients on 'incomplete pathways', i.e. those patients not yet treated. In the 2018/19 Refreshing NHS Plans guidance, the new target focused on the overall RTT waiting list size. The target for 20/21 was that the waiting list should be no higher in January 2021 than it was in January 2020 and, where possible, it should be reduced. The guidance also stated that, nationally, the number of patients waiting 52 weeks or more should be eradicated. Whilst formally the operational requirement for elective care now focuses on the overall size of the waiting list, performance data for the 'incomplete pathways' is still collected nationally.

Whilst RNOH has seen a drop in RTT performance due to challenges experienced due to the COVID-19 pandemic, it has maintained a performance that is higher than both the London and England average, as well as outperforming The Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry.

The Trust's cancer waiting time performance remained strong during 2020/21 despite the COVID-19 pandemic. RNOH continued to deliver services for urgent cancer patients throughout the pandemic, designating cancer services as one of the Trust's protected pathways which would be prioritised for access of outpatient clinics, diagnostics and theatre access. This commitment of maintaining cancer services to our patients allowed this clinically urgent patient group to receive diagnosis and treatment, throughout the peaks of the pandemic.

The Trust has achieved the two week wait target for first consultation following urgent GP referral every month from May 2019. The Trust achieved compliance with the 31 day standard from diagnosis to first treatment in all but one month and the Trust achieved the 31 day standard for subsequent treatment every

month apart from two (figures until December 2020). The 62 day wait from referral to treatment cancer standard remains the most challenging target to achieve, as the number of patients diagnosed with a malignancy and treated by the Trust is usually very small (between three and nine patients per month from 200+ referrals per month for suspected cancer); a single accountable breach for a patient who receives treatment after day 62 can cause the Trust to fail this standard in a given month. The year to date performance (April 2020 - December 2020) exceeds the 85% target with a performance of 88.5%, with the target met in all but one month.

The proportion of confirmed sarcomas remains static, but prior to the pandemic, the referrals received were increasing by approximately 10-15% year on year. 2WW referrals were at 66.5% of 2019-20 levels when comparing the first three quarters of that year with the same period in 2020-21. Reassuringly, despite the reduction in referrals, the number of patients receiving a first definitive treatment for cancer increased by 11.9% when comparing 2019-20 with 2020-21. This could be considered indicative that patients with cancer are still being referred in for their symptoms and that the referral gap seen is likely to be patients that would have cancer ruled out once investigated by the Trust.

Every cancer waiting time breach is reviewed to understand bottlenecks in the pathway to develop internal processes to improve patient care and access. The Trust also continues to work closely with external partners to minimise waiting times. One stop clinics were trialled during 2019/20 to complete the initial patient consultation and diagnostics with the intention of reducing the overall length of the patient pathway and to reduce the number of times the patient needs to travel to the hospital. Growth in this area has been limited as a result of the COVID-19 pandemic but the Trust intends to increase the number of patients being cared for through the one stop clinics during 2021/22.

SICKNESS ABSENCE

The Trust sickness absence rate for 2020/21 was 3.51%, slightly above the Trust target of 3%.
All managers have access to sickness absence data on the Workforce Dashboard and the Trust balanced scorecard is discussed at the People Committee and Partnership Committee and is circulated to Trust Board.

Absence rates have been closely monitored at Divisional Performance Review meetings and daily operational meetings to monitor any immediate impact of on patient care during the COVID-19 pandemic.

The reported absence rate includes COVID-19 related absences where the individual has COVID-19 symptoms and has been unable to work including working from home.

RETENTION RATE

The Trust retention rate for 2020/2021 was 91.09%, above Trust target of 88.5%. The retention rate indicates the number of staff who have remained working within the organisation in the reference period. This figure excludes those who have retired, those on fixed term contracts that come to an end and employee transfers through TUPE processes.

The Trust has seen a very positive retention rate during 2020/2021, remaining above the target of 88.5% every month for the past year.

Staff retention figures are reported and monitored on a monthly basis by Divisional Performance review meetings and through the Trust's monthly balanced scorecard, as well as receiving greater scrutiny at the People Committee, through specific papers reviewing turnover analysis and trends.

The staff group with the highest turnover in 2020/2021 was the 'add Prof Scientific and Technical' group and in particular the areas of Pharmacy and TSSU. Where reasons for leaving were provided, 'voluntary resignation – relocation' was the main reason given by those leaving the Trust.

SAFE STAFFING NURSING

The RNOH utilises the SAFECARE APP from Allocate to monitor safe staffing levels daily (per shift) the APP utilises the Safer Nursing care tool (SNCT) which is the only NICE approved tool and is based on the assessment of patient acuity and dependency. A Bi-monthly safe staffing report is submitted to the board highlighting any safe staffing shortfalls and action taken to mitigate risk. In addition to this a detailed report using the SNCT methodology and professional judgment is presented to the Board annually to provide ward to board assurance. During the first and second wave of COVID-19, Nursing staffing was continually monitored to ensure the safest care possible was delivered. A team of ten was developed that ensured a multi professional response during the challenging periods.

FINANCIAL PERFORMANCE

ANNUAL REPORT STATEMENT

The 2020/21 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, this has been signed by the Chief Executive and is included in the Annual Accounts.

2020/21 FINANCIAL PERFORMANCE

The Trust reported an adjusted surplus of £1.846m for the financial year ended 31st March 2021, after adjusting for donated asset transactions and impairments. Prior to these adjustments, a headline surplus of £2.271m was recorded for the financial year.

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

	2020/21 Plan	2020/21 Actual	Actual Variance
Tota Income*	162,536	179,604	17,068
Total Operating Costs**	(163,427)	(168,700)	(5,273)
EBITDA	**(891)**	**10,904**	**11,795**
RETAINED (DEFICIT)/SURPLUS FOR THE YEAR	(8,357)	2,271	10,628
Adjusted retained (deficit)/surplus	**(828)**	**1,846**	**2,684**
Cash at end of period	13,044	38,693	25,649
Capital Expenditure	8,662	10,333	1,671
I&E cost improvement programme (CIP)	1,219	681	(538)

*Ttoal income excludes donations

**Total operating costs exclude depreciation and impairments

In a normal financial year, NHS Improvement requires each Trust to develop an annual plan that identifies the Trust's objectives and financial plans for the coming year. Due to the pandemic financial planning was paused for 2020/21 and revised financial arrangements were in place throughout the Financial Year. Trusts were largely funded by Commissioner Blocks, Central Reimbursement and 'Top Up' payments, with breakeven for the first half of that year and small deficit target for the second half of the year.

The 2020/21 favourable variance to plan was largely driven by non NHS income, central funding associated with non NHS income lost, offset by CIP non delivery.

Capital expenditure amounted to £10.3m in 2020/21. The principal reasons for the higher than planned capital expenditure relate to greater donated asset acquisitions and additional specific capital schemes funded by the DHSC. Expenditure on donated capital asset acquisitions is excluded from the calculation of the charge against the Capital Resource Limit (CRL). The CRL establishes a cap on capital expenditure excluding donated asset acquisitions and is set by DHSC. The charge against the CRL was less than the CRL and the capital resource financial duty was therefore achieved. Capital expenditure at category level is shown in the 'Capital Investment' section below.

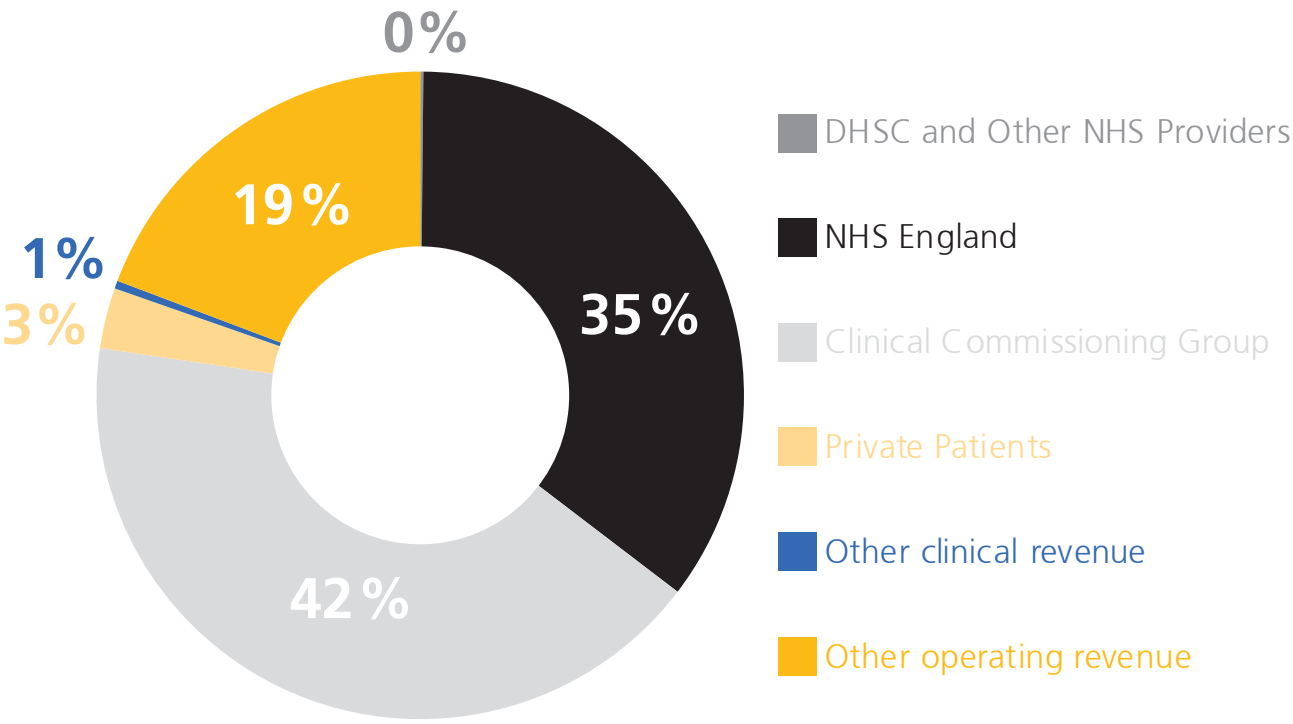
Delivery of cost improvement plans for the year was adverse to plan – with savings of £0.681m recorded against a plan of £1.219m. The Trust achieved its External Financing Limit, which is the centrally set cash target for the organisation, and the Capital Resource Limit, which sets out the quantum of capital expenditure.

INCOME AND EXPENDITURE ANALYSIS

Income

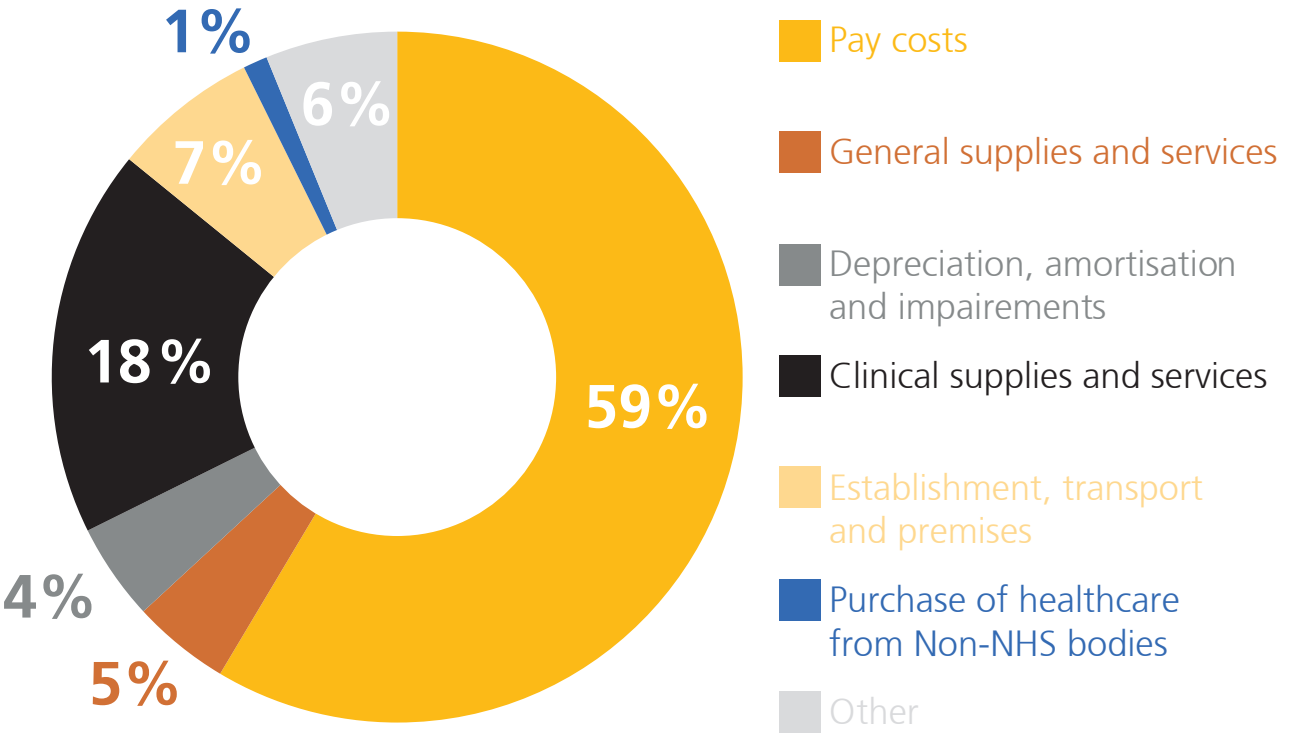
Income of £182.1 million was recorded by the Trust in 2020/21. Clinical income from Clinical Commissioning Groups was the highest proportion, accounting for £76.4 million or 42% of the total income of the Trust, with the purchase of healthcare services by NHS England also being a highly significant item (£64.1 million or 35%). The remaining material items were comprised of Private Patient income (£5.5 million or 3% of income). Other operating revenue (£35m or 19% of income) includes education, training and research (£3.5m), reimbursement and top up funding (£19.8m) and charitable, capital grants and donations (£4.6m).

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



Operating Expenses

Total operating expenses for 2020/21 were £176.7 million, and are set out in the chart below:



Expenditure on pay costs (excludes staff charged to capital schemes)

The Trust spent £103.5 million on staff pay costs during 2020/21, and within this amount £8.3 million was spent on bank (£5.5m) and agency staff (£2.8m), 8% of the total pay cost.

Expenditure on other costs

The Trust's non-pay operating expenses of £73.2 million were due to the costs of clinical supplies (£32.1 million – 44% of non-pay expenditure), utilisation of healthcare capacity outside of the Trust (£2 million – 3% of non-pay expenditure), and general supplies and services (£8.1 million – 11% of non-pay expenditure) required to maintain the operational services of the Trust. The residual costs were incurred on establishment, transport and premises costs (£12.1 million – 16% of non-pay expenditure), depreciation, amortisation and impairments (£8 million – 11% of non-pay expenditure), and other expenditure (£10.9 million – 15% of non-pay expenditure).

Capital Investment

Capital expenditure during 2020/21 was £10.3 million. An analysis by category is provided below.

	£'m
Estate - Major Developments, Backlog and Business as Usual	2.1
Spect CT	0.8
Medical Device Replacement and Other medical equipment	1.8
Digital	2.9
Projects related to the COVID pandemic	1.1
Horatio's Garden	1.7
	10.3

The Trust achieved its capital allocation or Capital Resource Limit by £0.662 million in 2020/21.

Estate valuation

During 2020/21, 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 2021 based on a detailed on-site inspection. In accordance with International Accounting Standard 16, assets are required to be carried at Fair Value. Buildings have been valued at depreciated replacement cost. The valuation of hospital land assumes a continuation of existing use. A modern equivalent asset basis has been applied to the valuation of land and buildings.

Future financial plans

As a result of the COVID-19 pandemic the NHS financial regime has changed. With the exception of capital planning, national planning is currently being undertaken for the first six months of the 2021/22 financial year only. The current financial framework is system based; commissioner block payments, system level COVID-19 payments and top up payments will be in place. A new incentive payment has also been introduced linked to Elective Recovery. In addition the North Central London ICS is one of the chosen systems in the Accelerator programme; as such providers within the patch will be working towards delivering activity over and above the 2019/20 levels in a bit to recover elective waiting times and deal with the back log of patients that have accrued as a result of the pandemic. Additional funding, has been made available via this programme to pay for the costs associated with achieving the levels of activity.

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

Financial Summary (£'000)	Plan 2021/22
RETAINED SURPLUS M1-6	521
Adjusted retained surplus M1-6	**638**
Cash at end of period	34,825
Capital Expenditure	20,772
I&E cost improvement programme (CIP)	2,921

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 35 to the Accounts, with a summary provided below:

	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	23,220	99,489	25,014	99,415
Total non-NHS trade invoices paid within target	18,164	76,988	20,848	77,514
Percentage of non-NHS trade invoices paid within target	78.2%	77.4%	83.3%	78.0%
NHS Payables				
Total NHS trade invoices paid in the year	838	10,427	1,136	12,583
Total NHS trade invoices paid within target	605	6,827	733	8,586
Percentage of NHS trade invoices paid within target	72.2%	65.5%	64.5%	68.2%

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

Treatment of pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. This is described in Note 1.7 and Note 8 in the Annual Accounts and further details on pension entitlements of Directors are given in the Remuneration Report.

During 2020/21 there were no early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of the ill-health retirement in 2019/20 is £178k. The cost of ill-health retirements are borne by the NHS Business Services Authority - Pensions Division.

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.

The Trust has contracted an external firm, RSM Risk Assurance Services, 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.

In April 2020 the National Audit Office introduced a new Code of Audit Practice which comes into effect from audit year 2020/21. The Code introduced a revised approach to the audit of Value For Money. The Code requires auditors to consider whether the body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. The Code requires that where auditors identify significant weaknesses in arrangements they should make recommendations setting out the actions that should be taken by the body. Under the Code the auditor issues an Annual Auditor's Report which will

include the Value For Money assessment. The Auditor's Annual Report for 2020/21 is required to be issued no later than 20th September 2021. The Code requires that auditors structure the value for money commentary under three specified criteria:

- Improving economy, efficiency and effectiveness.
- Financial sustainability.
- Governance.

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, and
- 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 commentary on whether the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This commentary covers financial sustainability, governance and improving economy, efficiency and effectiveness. There is also the requirement to make a recommendation where significant weaknesses are identified.

The Trust has a breakeven duty to ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings chargeable to the revenue account. The phrase 'taking one financial year with another' has been interpreted by the Department of Health and Social Care and HM Treasury as meaning that the duty is met if income equals or exceeds expenditure over a 3-year period or exceptionally a 5-year rolling period with the agreement of NHS Improvement. External audit are to issue a S30 (a) and (b) referral to the Secretary of State detailing the Trust's cumulative deficit and outlining that the Trust had not achieved the breakeven duty for the period up to 31st March 2021.

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 audit of the 2020/21 Quality Account is not required and has not been commissioned.

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 two-year term commencing April 2017 with a further one year extension commencing in April 2019. A further two-year extension was agreed with Grant Thornton commencing April 2020.

The cost of the statutory audit services work performed by Grant Thornton in 2020/21 was £78,000 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 Surendran Chellappah chairs this Committee. Dr Jane Collins and Mrs Doris Olulode also serve as Non-Executive Director members of the Audit Committee.

DIGITAL SERVICES

2020/2021 was the second year of delivery for our Digital strategy which sets out the roadmap to ensure that the RNOH is at the forefront in use of modern and innovative Digital solutions to support the Trust's vision and strategic aims.

Despite the COVID-19 pandemic we have delivered a significant proportion of the agreed the Year 2 programme of work.

- We have maintained our protection from cyber-attacks with the investment in technology and provision of staff training to protect the Trust. The Digital Team have also been successful in two bids for competitive national funding to enhance the Trust's cyber security defences. More than 99.7% of Trust PCs are now running Windows 10 with Advanced Threat Protection (ATP).
- Maintaining a modern, robust and resilient Digital services and infrastructure to deliver a high quality service with 99% availability of systems and networks with excellent customer satisfaction scores.
- The IT infrastructure continues to be strengthened with a programme of replacement of older technology and adding resilience and high availability to vital digital services. This is exemplified by the replacement of fibre optic cables, storage arrays and core/edge networking switches this year.
- The programme of coding validation has been further enhanced 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.
- We continue to work to identify, test, pilot and if appropriate, implement innovative digital technologies to help our clinical staff and patients.
- Continued our journey to build modern and easy to use Apps to give clinicians access to key information whilst managing the inpatient's pathway from referral to discharge by a delivering further 4 apps.

Other key achievements and areas of developments include:

- Digital have been a key part of the pandemic effort. Technology was quickly mobilised to enable a massive increase in home working. This included significant changes and expansion of the infrastructure, procurement and provision of home working equipment, and a roll out virtual collaboration tools for staff and patients.
- We have procured and begun the implementation of Microsoft 365. This not only provides modern office tools to enable our staff to work seamlessly from anywhere and across many devices, but it also is a foundation which will be used to transform the operational and administrative functions.
- As the Trust responded to the system's urgent need for help, the RNOH transformed the types of clinical services delivered several times during the year. Digital was one of many facilitators to enable this.
- Launch of an exciting secure data platform for research. This will enable our clinicians to safely and securely collaborate in national and international research projects.

SUSTAINABILITY REPORT

CARBON EMISSIONS

Targets

The Trust has set carbon dioxide equivalent emission targets to match the NHS targets 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 England). The basis for these targets is an expected improvement in energy efficiency in the new buildings and facilities that have recently been constructed and closure of energy inefficient older buildings.

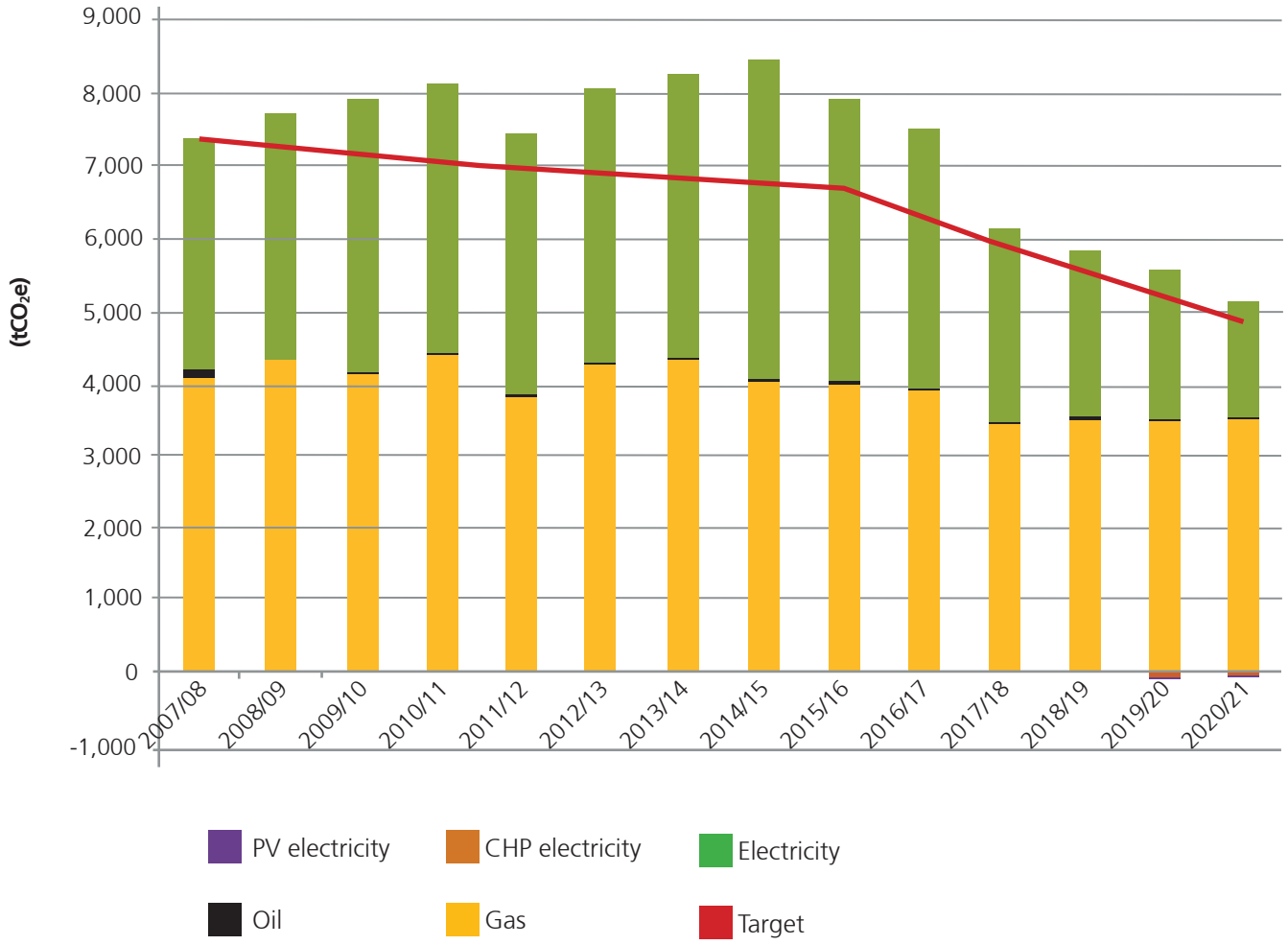
Energy (scope 1 and 2 emissions)

In 2018 the Trust completed the construction of a new ward block which incorporates a combined heat and power (CHP) plant and photovoltaic (PV) solar panels, which are now generating electricity and providing heat for the new ward block. 2020/21 was the second full year of operation of the CHP plant and PV panels. The electricity generated by these facilities has been included in the figures 1 and 2 below and shown as negative carbon dioxide equivalent emissions, as it reduced the carbon emissions that would have been produced from national grid electricity. The gas consumed by the CHP has been included in the gas related emissions. It should also be noted that at the time of reporting, data for February and March 2021 was not available so we have used 12 months data covering the period February 2020 to January 2021.

The Trust spent £1,521,767 on energy in 2020/21, a decrease of 0.7% in energy spend compared with last year. Electricity consumption has decreased by about 6.0% whilst gas consumption increased by 1.1% compared with last year and hence the reduction in cost is due to a reduction in electricity use. The CHP plant was not operational in the period April 2020 to June 2020 and part of July 2020 causing a 37.4% reduction in electricity generation compared with the previous year. The CHP was not operational due to an inability to obtain parts and contractor issues during the COVID-19 pandemic. The reduction in electricity consumption was caused by the closure of Bolsover Street and Aspire for the period April 2020 to June 2020 due to the COVID-19 pandemic.

The Trust has set a carbon reduction target of a 34% reduction in carbon emissions by 2020/21 compared with the 2007/8 baseline. Energy is a significant contributor to the Trust's carbon footprint (carbon dioxide equivalent emissions – CO2e) and the change in energy carbon emissions since 2007/8 is shown in the figure 1 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).

Figure 1 Carbon dioxide equivalent emissions from energy use



The carbon emissions associated with electricity production from the CHP plant and solar PV panels have been included as negative values to represent a saving in carbon emissions but the quantities are small and only just visible on the chart.

In absolute terms, the Trust has not met its carbon emission target but the trend over the last four years is downward with emissions reaching 30.2% below the 2007/8 emissions by 2020 compared with the 34% carbon reduction target. The reduction in energy carbon emissions in 2020/21 is largely due to the reduction in carbon conversion factor for UK electricity by 8.8% compared with 2019/20 as, nationally, coal generation has decreased significantly and gas and renewables electricity generation increased.

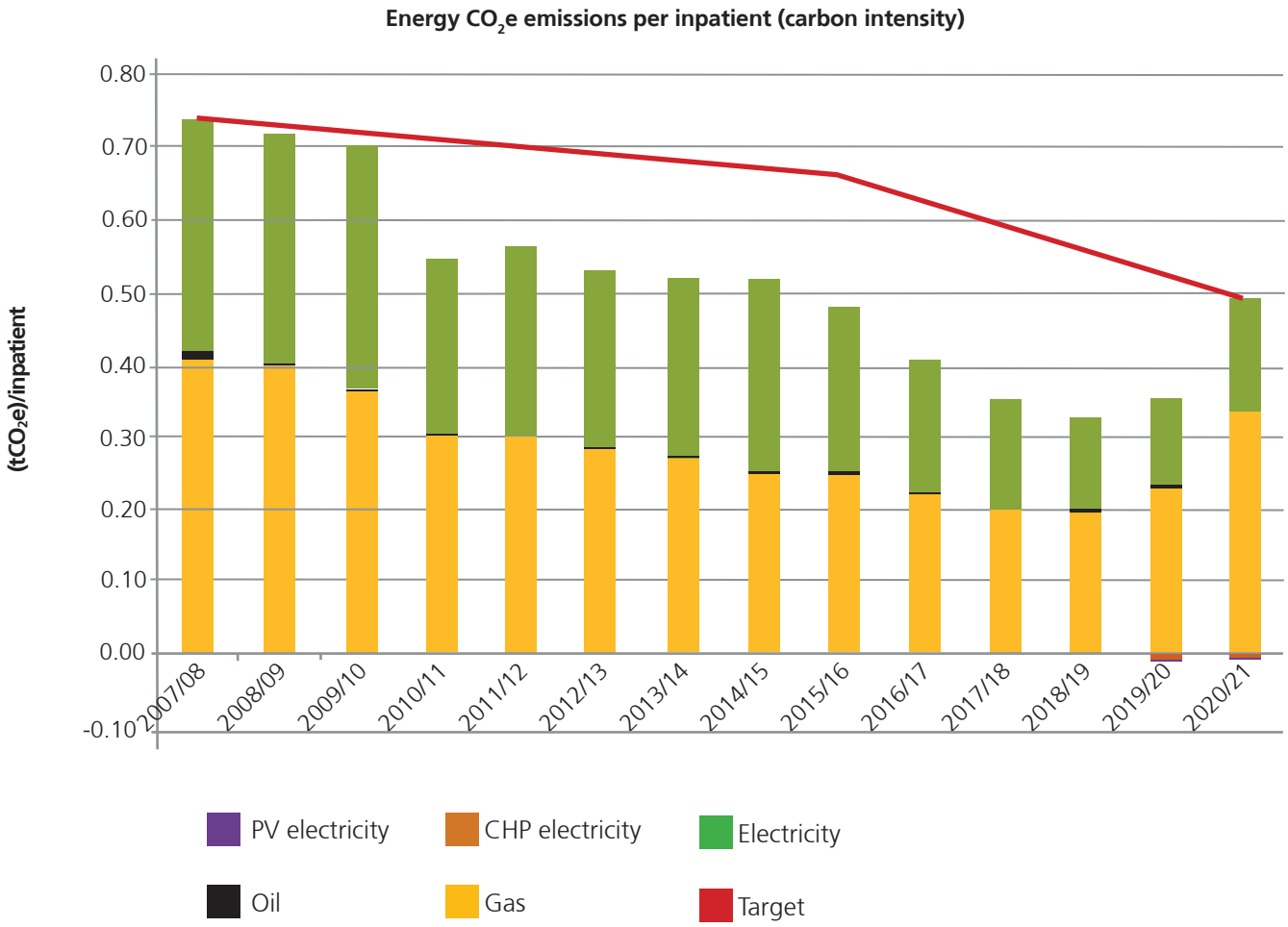
Energy carbon intensity

Figure 2 below compares the energy related carbon emissions for each in-patient (annual carbon intensity) against the target emissions per in-patient (target carbon intensity) for the period 2007/8 to 2020/21, and shows that annual carbon intensity has increased above the target in 2020/21. In-patient numbers have been chosen, rather than outpatient 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.

In 2020/21, the Trust has seen a 33.5% decline in inpatient numbers and an 8.7% decline in outpatient numbers compared with last year due to COVID-19. This will have the effect of increasing the carbon intensity as buildings still need to be heated when only part full.

The Trust has made a number of changes to reduce its energy carbon emissions through the construction of more energy efficient building and the installation of a CHP and solar panels to reduce electricity consumption. 2020/21 has been an unprecedented year due to COVID-19 which has resulted in the reduction of inpatient and outpatient numbers and a marked change in carbon intensity.

Figure 2 Carbon dioxide equivalent emissions from energy use per inpatient



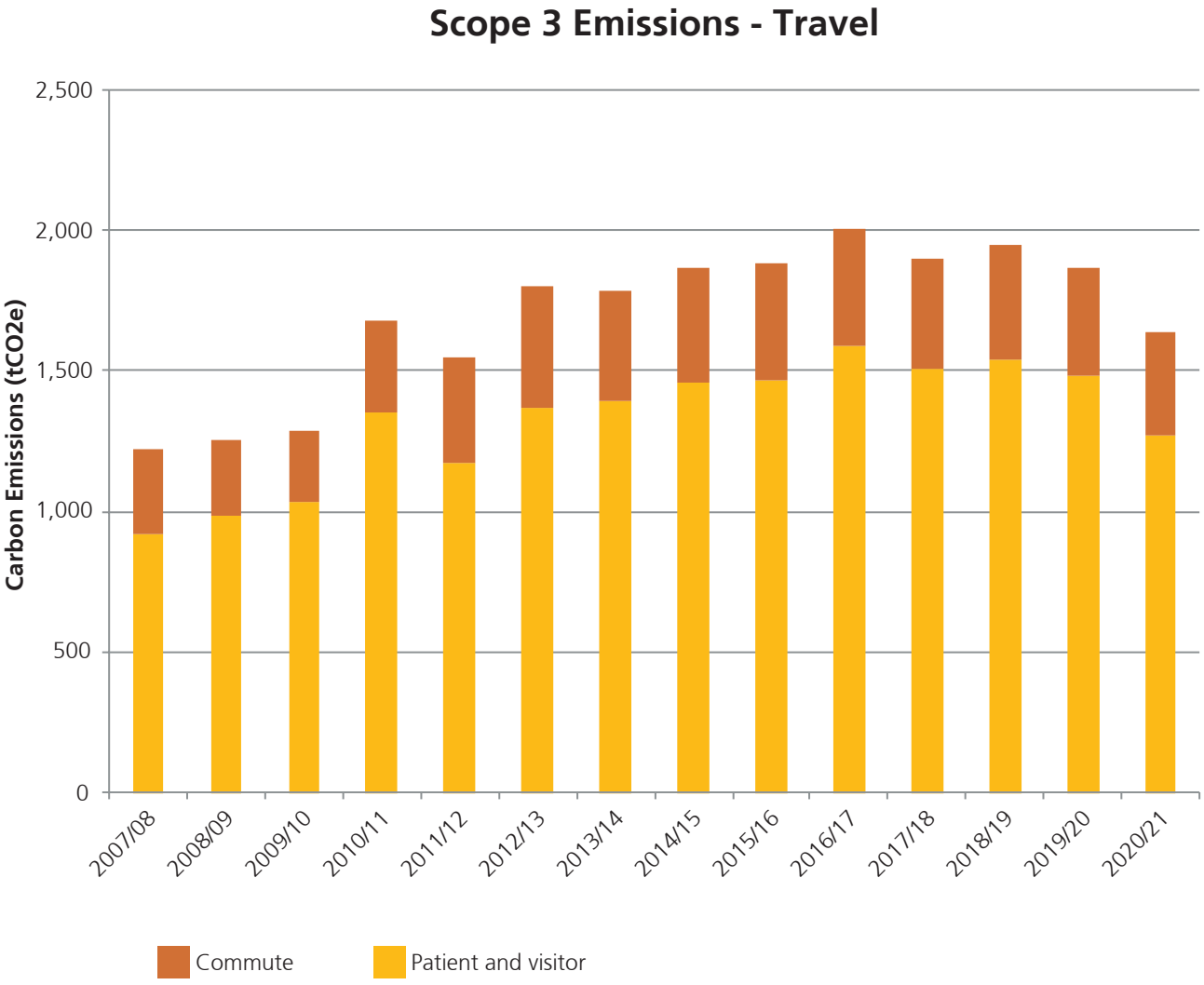
Scope 3 emissions

Scope 3 emissions are indirect emissions caused by activities not under the control of the Trust. 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. However, although these activities are not under the control of the Trust, reducing the quantities used or produced of these contributors to scope 3 emissions, will reduce emissions. These elements of the footprint are shown in the figures 3, 4 and 6 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 (in-patients and outpatients), as advised by the NHS Sustainable Development Unit. Travel emission calculations for staff commuting is based on the average miles travelled per year commuting by road (NTS 0409b), and number of full-time equivalent staff. Emissions are presented below and reflect a general increase in number of patient contacts and staff over the years. However, the indications are that, more recently, the number of inpatient and outpatient numbers are beginning to level off and in fact in 2020/21 the patient numbers fell due to COVID-19 thus reducing the travel carbon emissions.

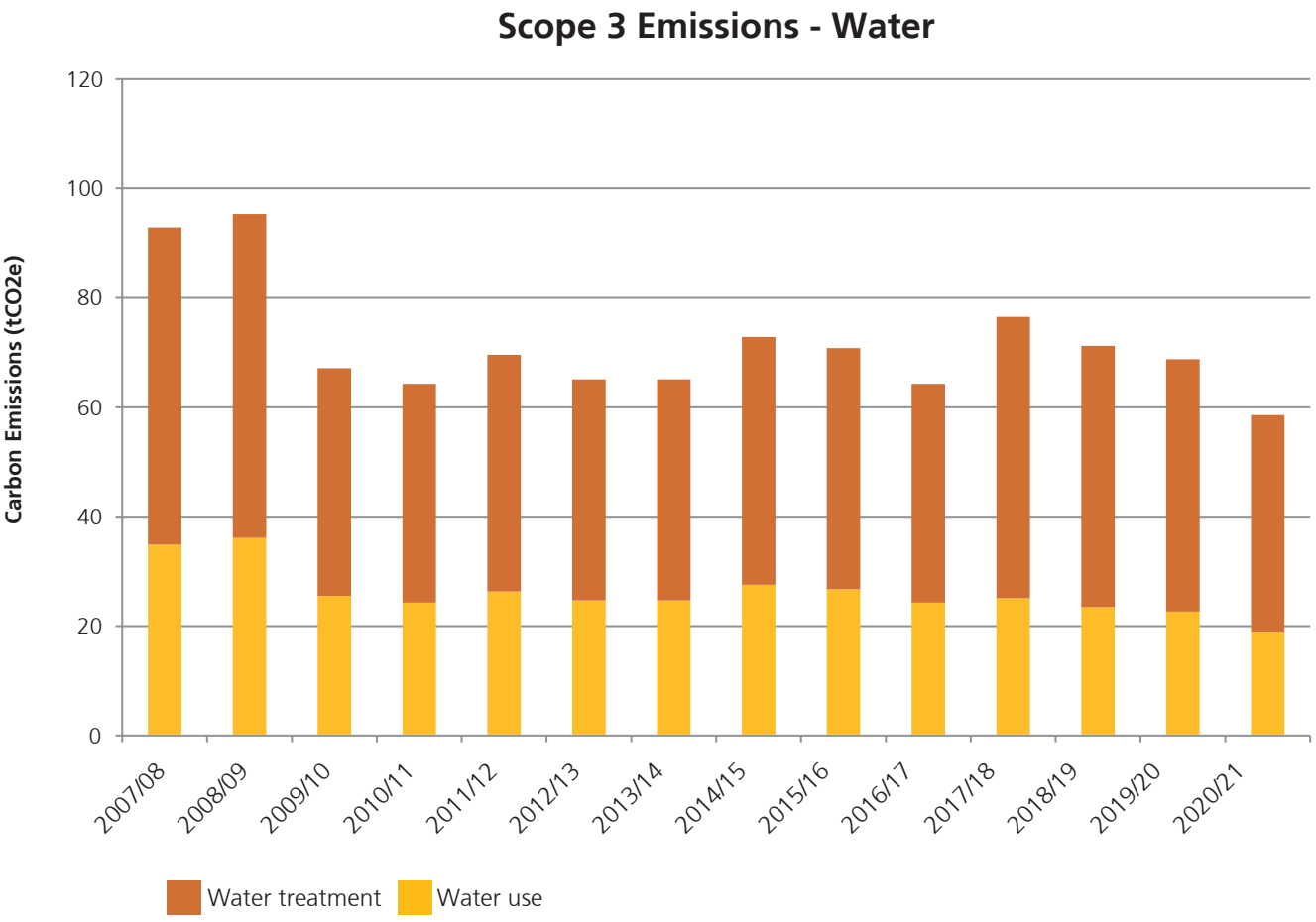
Figure 3 Scope 3 emissions attributable to commuting and patient and visitor journeys



Use of natural resources

The cost of water and sewage was £125,666 in 2020/21, an increase of 1.0% on the previous year, even though water consumption and sewage volumes fell by 14.9% this year compared with 2019/20. The increased costs arise from an increase in the unit charge rate for both potable water and sewage services. Figure 4 below shows the contribution to scope 3 carbon emissions from water consumption.

Figure 4 Scope 3 emissions attributable to water consumption and sewage treatment



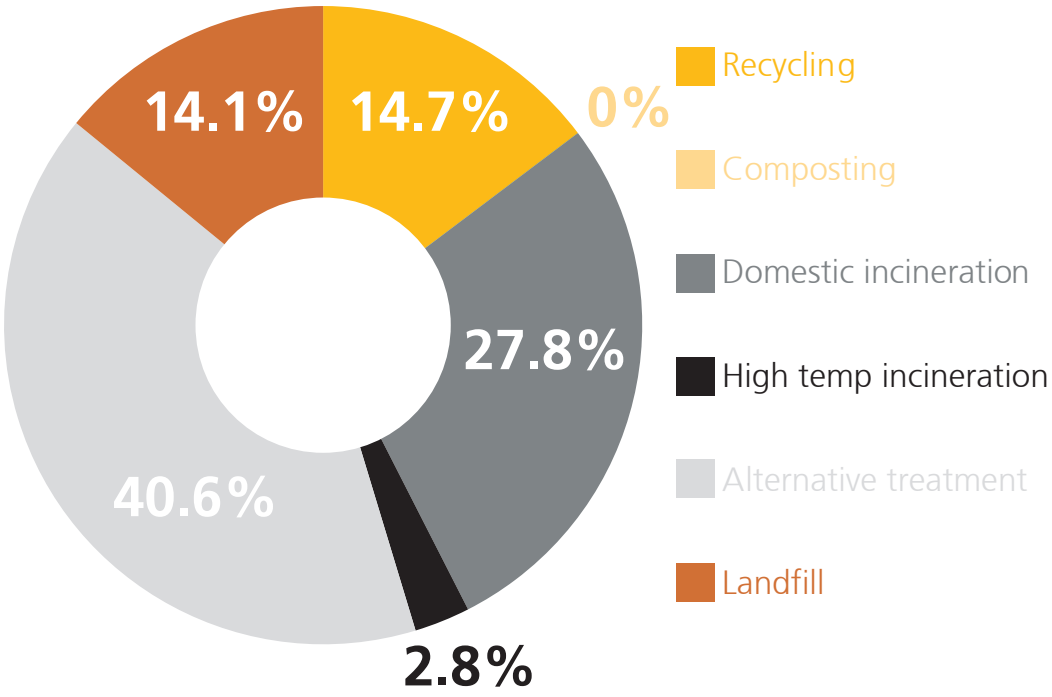
The carbon conversion factor is higher for sewage treatment compared with water supply thus giving higher emissions associated with sewage treatment.

Waste generation

The cost of waste management in 2020/21 was £161,705 an increase of 17.7% compared with 2018/19 (the cost data for 2019/20 provided by the Trust was twice that expected and has not been used). Although the overall volume of waste decreased by 10.9% there was an increase in the quantity of waste sent to landfill (50.7%) and alternative treatment (48.3%) and a decrease in the quantity recycled (50.7%).

Most domestic waste (65.4%) is sent for incineration. About 3% of waste is clinical waste, sent for high temperature incineration and the remainder (41%) is sent for alternative treatment. The proportion of waste recycled is 14.7% compared with 14.1% sent for landfill as shown in figure 5 below.

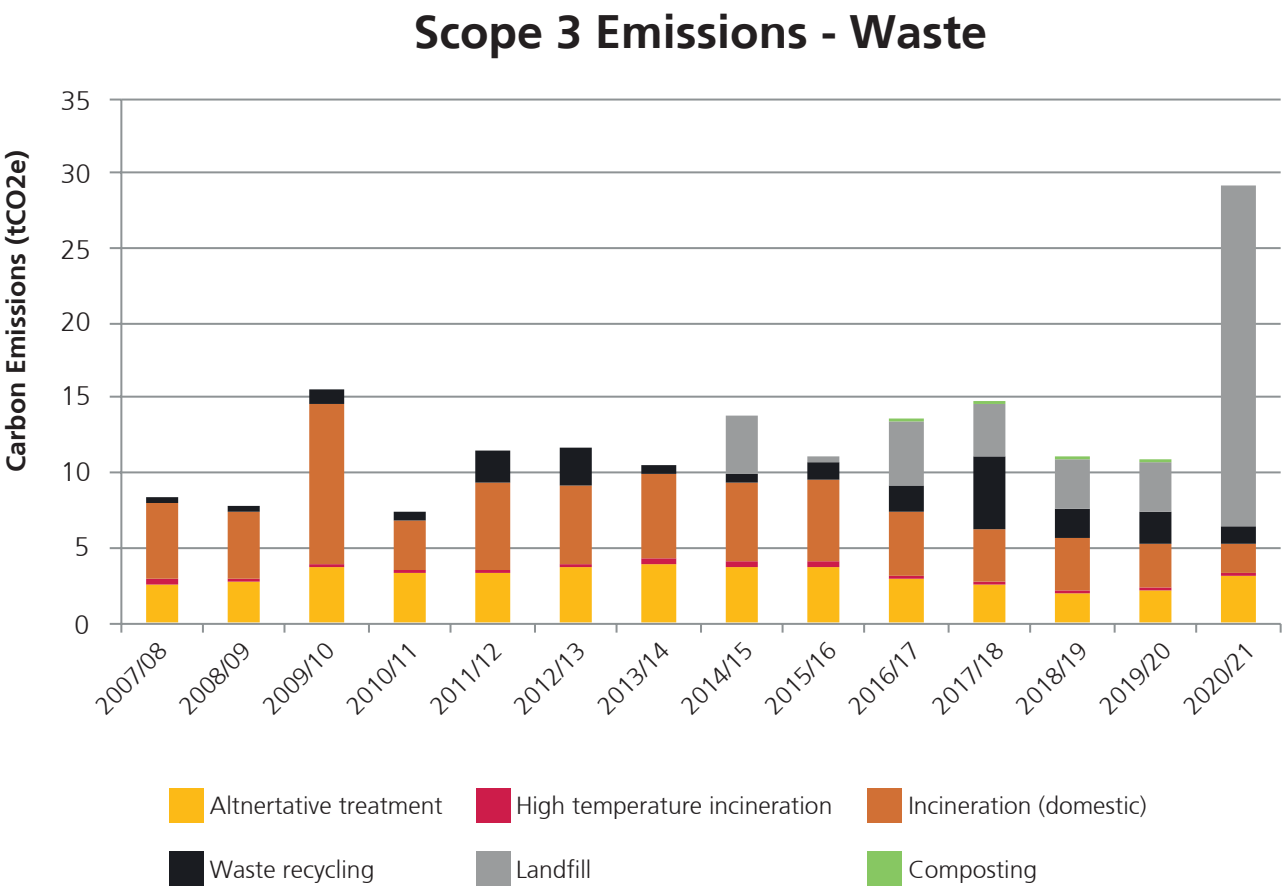
Figure 5 Proportion of waste disposed by disposal route



The total amount of waste generated has decreased by 10.9% this year compared with 2019/20. The current level of waste recycling is lower than previous years due to the impact of COVID-19 as some of the waste destined for recycling had to be changed to general waste due to the risk of contamination. Figure 6 below shows the contribution to scope 3 carbon emissions from waste and shows the marked increase in emissions associated with landfill due to a more than four-fold increase in the CO2e conversion factor for landfill from 2019 to 2020. The conversion factor includes collection, transportation and landfill

emissions.

Figure 6 Scope 3 emissions attributable to waste disposal and recycling



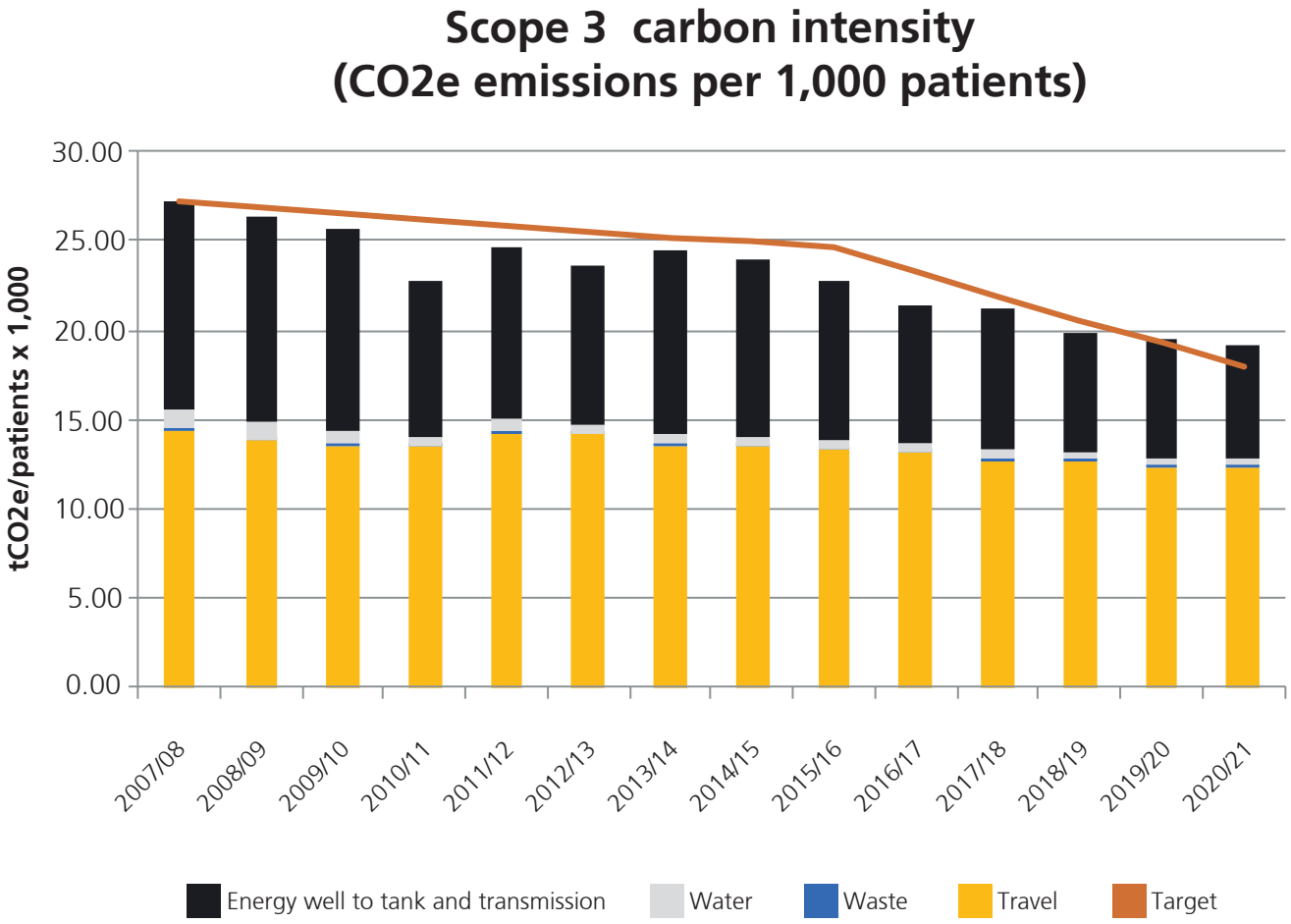
Scope 3 Carbon intensity

The scope 3 carbon emissions produced by the Trust will increase with the number of patient contacts. Figure 7 below therefore shows the scope 3 carbon emissions for every 1,000 patients and the contribution from travel, water, waste and energy well to tank and transmission. The latter accounts for extraction, refining and transportation of primary fuels before their use in the generation of electricity and the transportation of raw fuel sources to an organisation's site, prior to combustion.

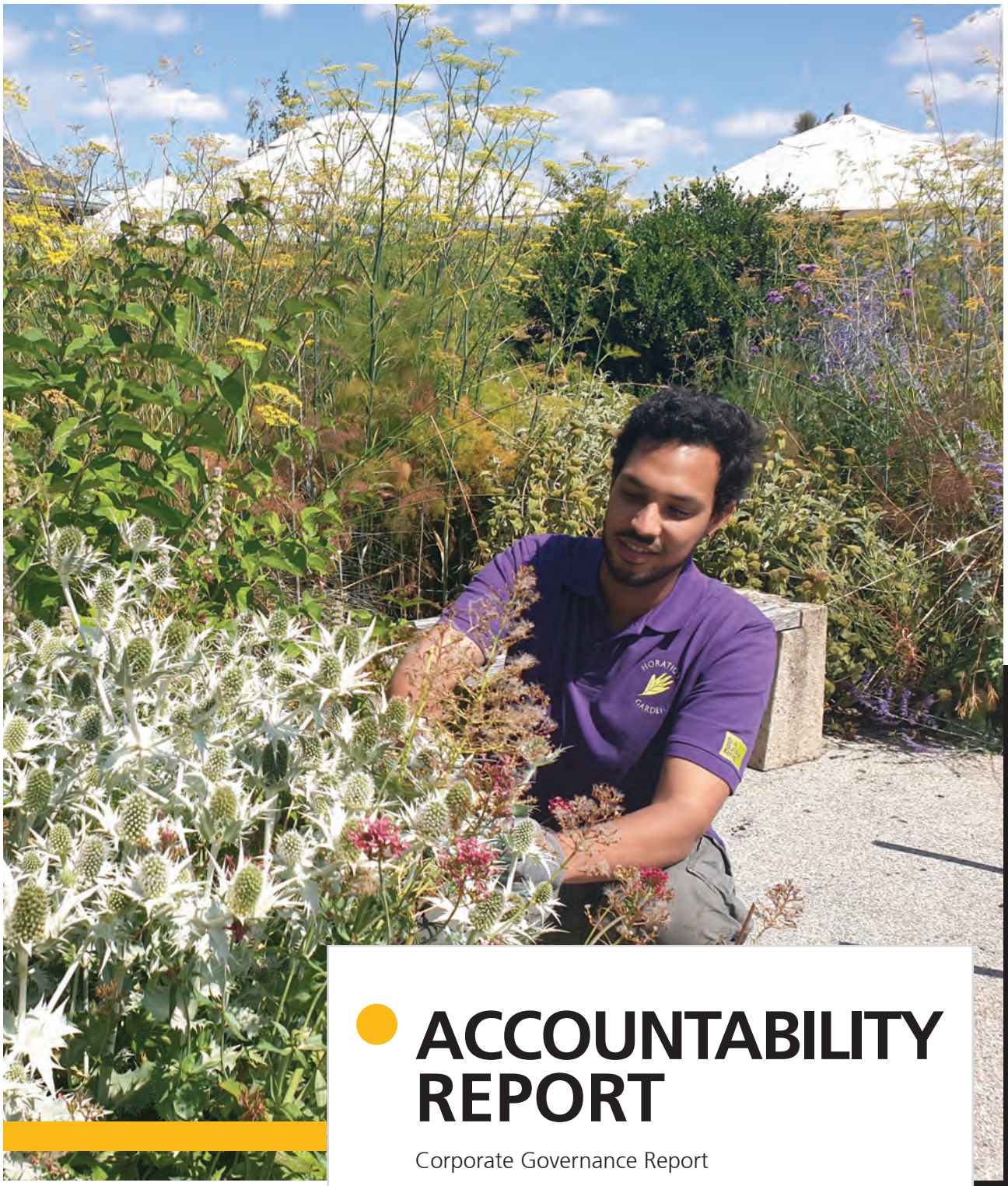
The carbon intensity has been determined from the actual attendance numbers for outpatients rather than appointments booked. This is shown against the target of 10% reduction in emissions by 2015/16 and then a 34% reduction in emissions by 2020/21 with 2007/8 as the baseline year. The scope 3 carbon intensity in 2019/20 (19.6) and 2020/21 (19.2) are just above the carbon intensity target (19.3 and 18.0) with the main contribution from travel. This indicates that reducing emissions from travel should be the Trust's focus for reducing scope 3 emissions for the future. The carbon intensity level for 2020/21 will not have been affected by the reduction in patient numbers as this would also have reduced water, waste and travel emissions.

The scope 3 carbon intensity has reduced by 2.0% in 2020/21 compared with 2019/20, assisted by the reduction in energy well-to-tank and transmission carbon conversion factors for electricity generation, transmission and distribution due to the change in UK electricity generation fuel mix and reduction in coal generation.

Figure 7 Scope 3 carbon intensity per 1,000 patients



Professor Paul Fish
Chief Executive and
Chief Nursing Officer



ACCOUNTABILITY REPORT

Corporate Governance Report

DIRECTORS' REPORT

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 the RNOH.

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 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 Director, 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 the 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 necessary steps to ensure that they are aware of any relevant audit information and to establish that the auditors are also aware.

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

RNOH TRUST BOARD MEMBERS

DOMINIC DODD

CHAIR

Voting member
In post since: November 2019

Trust Roles:

Chair: Trust Board, Finance and Compliance Committee and Remuneration Committee

Member: Clinical Standards and Innovation Committee and People Committee

Experience:

Dominic was Managing Partner of Marakon Associates, a strategy consulting firm, where he worked for 15 years advising chief executives of publicly-traded companies in the UK, Europe, the US and Asia.

Since leaving Marakon he has worked as a chair, non executive director and advisor in the private, public and charity sectors, specialising in growth, turnaround and governance, mainly in healthcare and financial services.

Dominic was appointed chair of the Trust from November 2019. He is also chair of The Royal Free London NHS Foundation Trust.

Elsewhere in the NHS, Dominic is a member of the national chairs' advisory group for NHS England, NHS Improvement and the Care Quality Commission, a director of UCL Partners and a Trustee of the health and social care think tank The King's Fund.

PROFESSOR PAUL FISH

INTERIM CHIEF EXECUTIVE AND CHIEF NURSE

Voting member

In post since: February 2015 (In post as Interim Chief Executive since May 2020)

Trust Roles:

Interim Chief Executive

Chair of the Executive Committee

Member: Audit Committee, Trust Board, Clinical Standards and Innovation Committee, People Committee and Finance and Compliance Committee and Executive Committee

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, 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.

ROB HURD

ACCOUNTABLE OFFICER

Voting member
In post since: Accountable Officer - May 2020
Chief Executive - August 2008 to April 2020

Trust Roles:

RNOH Accountable Officer

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 more than 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 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 and is Joint Senior Responsible Officer for this National Programme. GIRFT also has academic validation as a formal NIHR CLAHRC evaluation project and publication in BMC Health Services Research (and highly commended HSJ Award). He is also the provider Chief Executive sponsor of the North London Partners in Health and Care Adult Elective Orthopaedics Services review and the NHS Management Member of the National Joint Registry Steering Committee – a national audit programme commissioned by NHS England.

Rob is on the Board for the National Orthopaedic Alliance as a Senior Responsible Officer. The National Orthopaedic Alliance is a collaboration of major specialist orthopaedic centres, which has a membership of 12 specialist orthopaedic units from across the UK. Rob is also 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).

DR JANE COLLINS

VICE CHAIR

Voting member

In post since: February 2020

Trust Roles:

Chair: Clinical Standards and Innovation Committee

Member: Audit Committee and Remuneration Committee

Experience:

Jane started her career as a consultant paediatric neurologist at Guy's Hospital. She was appointed chief executive of both Great Ormond Street Hospital for Children and the Great Ormond Street Hospital Children's Charity in 2001. From 2012 until 2019 she was chief executive of Marie Curie. She chaired the London Clinical Senate Council between 2013 and 2018.

She is an honorary fellow of UCL and the UCL Institute of Child Health, a Trustee of The King's Fund and vice chair of University College Hospitals NHS Foundation Trust.

DORIS OLULODE

NON-EXECUTIVE DIRECTOR

Voting member
In post since: February 2020

Trust Roles:

Chair: People Committee

Member: Trust Board, Clinical Standards and Innovation Committee, Audit Committee and Remuneration Committee

Experience:

Doris has extensive human resources experience gained in a career at Ford Motor Company. Latterly, she was Ford's HR Director for Europe, the Middle East and Africa. Doris also led the African Ancestry Network at Ford and was named by Autocar as one of the top 100 most influential women in the Auto industry.

Doris holds non-executive directorships at the Royal Free London NHS Foundation Trust, the Chartered Institute of Legal Executives, Clarion Housing and the University of East London. She is also a Lay Member to HM Courts and Tribunals Service and freelances as an HR Consultant.

DR GABRIELLE SILVER

NON-EXECUTIVE DIRECTOR

Non-Voting member
In post since: November 2015

Trust Roles:

Member: Trust Board, Remuneration Committee, Clinical Standards and Innovation Committee and People Committee.

Experience:

Dr Gabrielle Silver joined CHS Healthcare as the chief executive in January 2019. CHS Healthcare is the leading provider of hospital discharge services and Continuing Healthcare in the UK.

A qualified doctor who practiced as an anaesthetist, Dr Silver brings extensive experience of leading healthcare businesses on a national and global level.

Dr Silver qualified and practised as a doctor in London before moving her focus to the life sciences sector, taking new therapies through development to market in the fields of neuroscience, psychiatry and pain management. She has held strategic leadership positions in global companies including Eisai, Bristol-Myers Squibb, GE Healthcare and Brunswick, where she co-led the global healthcare practice.

Dr Silver's recent positions have been operationally focused, as Speciality Operations Director for McKesson UK, combined with the role of General Manager for LloydsPharmacy Clinical Homecare. She also serves as the Senior Independent Director at Opiant Pharmaceuticals, a NASDAQ listed biopharmaceutical company, focused on developing drugs for addiction disorders.

SURENDRAN CHELLAPPAH

NON-EXECUTIVE DIRECTOR

Voting member
In post since: March 2020

Trust Roles:

Chair: Audit Committee

Member: Trust Board, Remuneration Committee and Finance and Compliance Committee

Experience:

Surendran is Global Head of Risk and European Chief Operating Officer and Chief Financial Officer of the financial services firm Sanford C. Bernstein. He was formerly European Chief Financial Officer for Instinet. He has many years of experience of leading on finance, operations and technology and of chairing risk oversight committees.

Outside of financial services, he has worked with Pilotlight, an award-winning charity to match skilled business leaders with charities and social enterprises across the UK.

He has an MBA from Henley Management College, is a Fellow of the Chartered Association of Certified Accountants and a Fellow of the Chartered Institute for Securities and Investment.

PROFESSOR REBECCA SHIPLEY

NON-EXECUTIVE DIRECTOR

Voting member
In post since: June 2020

Trust Roles:

Trust Board, Clinical Standards and Innovation Committee and Remuneration Committee

Experience:

Currently, Vice Dean (Health) in the UCL Faculty of Engineering Sciences, and also Director of the UCL Institute of Healthcare Engineering, which coordinates interdisciplinary research, innovation and education activities within healthcare engineering across UCL Engineering, the UCL School of Life and Medical Sciences, and the hospitals within the UCL Partners academic health system.

Her research interests lie in mathematical and computational modelling in medicine and biology, including cancer, tissue engineering and human physiology, and with a particular emphasis on multidisciplinary approaches which integrate data from biological experiments, imaging and clinical sources. She co-founded the UCL Centre for Nerve Engineering, which brings together physical, engineering, life and clinical scientists to tackle nerve injury repair, and includes extensive collaboration with the RNOH.

DR LILA DINNER

CHIEF MEDICAL OFFICER

Voting member
In post since: October 2019

Trust Roles:

Co-Chair: Clinical Standards and Innovation Committee

Member: Trust Board, Executive Committee and People Committee

Experience:

Lila joined the RNOH as Medical Director in October 2019, having been a Consultant Anaesthetist at the Royal Free Hospital London since 2001. She continues to work as a Consultant Neuroanaesthetist at the National Hospital for Neurology and Neurosurgery, UCLH part time.

She has taken on a number of leadership roles during this time including Divisional Director of Surgery and Associated Services, Royal Free Hospital London (2017-19), Chair of the Clinical Pathways Group in Surgery (2017-19), Lead Regional Advisor for the Royal College of Anaesthetists (2015-17) sitting on the editorial board for the Bulletin of the College as well as the Professional Standards and Revalidation Committees, NHS England Appraiser (2016-), Head of the Central London School of Anaesthetics (2013-17), Chair of the Training Programme Management Committee, UCLP (2013-17) and Executive Board Member of the London Academy of Anaesthesia, Health Education England (2010-17).

CAROLINE OWUSU-BENNOAH

CHIEF FINANCIAL OFFICER

Voting member
In post since: March 2020

Trust Roles:

Member: Trust Board, Finance and Compliance Committee and Executive Committee

Attendance at the following Trust Board Committee: Audit Committee

Experience:

Caroline started her career in the NHS on the NHS National Graduate Management Training Programme where she had exposure in working in the various sectors of the NHS including Mental Health, Primary Care and an Acute Hospital.

Following the Graduate scheme, Caroline went on to work for Barking Havering and Redbridge University Hospitals Trust where she undertook various roles including being the Associate Director of Finance for Strategy, Planning and Service Line reporting.

Caroline then took a role with Lewisham and Greenwich NHS Trust in July 2015 where she worked until March 2020, undertaking various roles including the Deputy Director of Finance role.

She's currently a member of the London Regional Talent and Diversity Board, which promotes talent and Diversity within the finance community in London.

Qualifications include BSc Administration (Banking and Finance), CIMA qualified (Chartered Institute of Management Accountants)

LUCY DAVIES

CHIEF OPERATING OFFICER AND DIRECTOR OF STRATEGY AND IMPROVEMENT

Voting member
In post since: May 2015

Trust Roles:

Executive Director for Operational Performance

Member: Trust Board, Clinical Standards and Innovation Committee, People Committee, Finance and Compliance Committee and Executive 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, 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.

PROFESSOR JOHN SKINNER

DIRECTOR OF RESEARCH AND INNOVATION CENTRE

Non-Voting member
In post since: January 2017

Trust Roles:

Member: Trust Board, Clinical Standards and Innovation Committee

Attendance at the following: 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 SAROJ PATEL

CHIEF DIGITAL AND INNOVATION OFFICER

Non-Voting member
In post since: March 2005

Trust Roles:

Member: Trust Board, Clinical Standards and Innovation Committee and Executive Committee

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 IMandT.

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, FACILITIES AND REDEVELOPMENT

Non-Voting member
In post since: November 2003

Trust Roles:

Member: Trust Board, Finance and Compliance Committee and Executive 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.

LAURA BEVAN

CHIEF PEOPLE OFFICER

Non-Voting member
In post since: January 2020

Trust Roles:

Member: Trust Board, Executive Committee, People Committee, Finance and Compliance Committee.
Attendance at the following: Remuneration Committee

Experience:

Laura started her HR career running the graduate recruitment programme for an international management consultancy firm.

Laura joined the NHS in 2002 as an HR Advisor at West Hertfordshire Hospitals NHS Trust, where she subsequently took on the role of Senior HR Manager and then Associate HR Director. Laura became Deputy HR Director for West Hertfordshire Hospitals NHS Trust in 2014 and was responsible for the effective running of all operational HR services in the Trust. In this post, Laura delivered a significant HR transformation programme, supporting the Trust to dramatically reduce its vacancy rate for nurses and move to become a top quartile Trust for staff experience, resulting in the Trust being awarded Best UK Employer by Nursing Times in 2019.

In January 2020, Laura joined the RNOH as the Director of Workforce and Organisational Development. Laura holds a BA honours degree in English Literature from York University and is a qualified member of the CIPD (Chartered Institute of Personnel and Development).

JOHN DOYLE

DIRECTOR OF ALLIED HEALTH PROFESSIONALS

Non-Voting member
In post since: July 2019

Trust Roles:

Trust Board, Clinical Standards and Innovation Committee, People Committee and Executive Committee

Experience:

John joined the RNOH as Director of Allied Health in July 2019. John trained as a Physiotherapist at the University of Southampton before later completing his Master's degree in Physiotherapy at Kings College London. John has worked in leadership roles in both the NHS and Independent sector. He has previously worked in clinical roles as St Georges Hospital, Imperial College NHS Trust, Ashford and St Peters NHS Trust and Frimley Park Foundation Trust. John is also a Trustee of the Chartered Society of Physiotherapy Charitable Trust.

DARYL LUTCHMAYA

DEPUTY DIRECTOR OF CORPORATE AFFAIRS (TRUST SECRETARY)

Non-Voting member
In post since: November 2015

Trust Roles:

Attendance at the following: Trust Board, Clinical Standards and Innovation Committee, Audit Committee, and Executive Committee

Senior Information Risk Owner

Experience:

Daryl's career experience has 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 Chartered Secretary (ICSA), Fellow of the Association of Chartered Certified Accountants (FCCA) and member of the Institute of Risk Management (MIRM).

TRUST BOARD MEMBERS WHO RETIRED DURING THE YEAR

PROFESSOR DAVID ISENBERG

NON-EXECUTIVE DIRECTOR

Voting member
In post since: June 2011

Trust Roles:

Member: Trust Board, Remuneration Committee and Clinical Standards and Innovation Committee

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, Remuneration Committee, Finance and Compliance Committee and People Committee

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 has included 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.

KATHERINE MURPHY

ASSOCIATE NON-EXECUTIVE DIRECTOR

Non-Voting member
In post since: September 2017

Trust Roles:

Member: Trust Board, Remuneration Committee and People 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 Patient Association; 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.

MARK BRAMWELL

ASSOCIATE NON-EXECUTIVE DIRECTOR

Non-Voting member
In post since: July 2018

Trust Roles:

Member: Trust Board, Remuneration Committee and Clinical Standards and Innovation Committee

Experience:

Currently in the position(s) of CIO and Director of Professional Services for Said Business School - University of Oxford.

Previous Chairman of the Corporate IT Forum and Non-Executive Director positions for Circle Care and Support and CPM/Stipenda.

Experienced and skilled in IT Strategy, Technology Transformation, Digital Strategy, Change Management and Team Building.

Proven track record and experienced in successfully creating, delivering and managing complex change programmes in IT.

Experienced in the pro-active strategic, commercial and supplier performance management of external solution vendors and experienced and influential in building professional business and customer relationships at all levels.

RNOH TRUST BOARD MEMBERS' DECLARATIONS OF INTERESTS

Mr Dominic Dodd	Non-Executive Director (Chair)	UCL Health Alliance (NCL Provider Alliance)	Non-Executive Director (Chair)
Mr Dominic Dodd	Non-Executive Director (Chair)	Skin Analytics	Non-Executive Director (Chair)
Mr Dominic Dodd [1]	Non-Executive Director (Chair)	Royal Free London NHS Foundation Trust	Non-Executive Director (Chair)
Mr Dominic Dodd [2]	Non-Executive Director (Chair)	UCL Partners	Director
Mr Dominic Dodd	Non-Executive Director (Chair)	Wildwood Square Ltd	Director
Mr Dominic Dodd	Non-Executive Director (Chair)	KEHF Ltd (wholly owned trading subsidiary of The King's Fund)	Director
Mr Dominic Dodd	Non-Executive Director (Chair)	The King's Fund	Trustee
Mr Dominic Dodd	Non-Executive Director (Chair)	NHSI London	Advisor
Dr Jane Collins	Non-Executive Director (Vice Chair)	UCL and the UCL Institute of Child Health	Honorary Fellow
Dr Jane Collins	Non-Executive Director (Vice Chair)	University College Hospitals NHS Foundation Trust	Non-Executive Director (Vice Chair)
Dr Jane Collins	Non-Executive Director (Vice Chair)	The King's Fund	Trustee
Mr Surendran Chellappah	Non-Executive Director	Sanford C. Bernstein Limited	Director
Mr Surendran Chellappah	Non-Executive Director	Autonomous Research LLP	Partner
Mr Surendran Chellappah	Non-Executive Director	Sanford C. Bernstein (Ireland) Limited	Director
Mr Surendran Chellappah	Non-Executive Director	Sanford C. Bernstein (Autonomous UK) 1 Limited	Director
Professor David Isenberg [3]	Non-Executive Director	Versus Arthritis	Executive Board Member
Mrs Doris Olulode	Non-Executive Director	Clarion Housing Group	
	Non-Executive Director		
Mrs Doris Olulode	Non-Executive Director	Royal Free London NHS Foundation Trust	Non-Executive Director
Mrs Doris Olulode	Non-Executive Director	Chartered Institute of Legal Executives	Non-Executive Director
Mrs Doris Olulode	Non-Executive Director	HM Courts and Tribunals Service	Lay Member
Mrs Doris Olulode	Non-Executive Director	University of East London Higher Education Corporation	Independent Governor
Professor Rebecca Shipley [4]	Non-Executive Director	International Medical Education Trust 2000 (IMET2000)	Member of the Board of Trustees
Professor Rebecca Shipley [4]	Non-Executive Director	EPSRC EP/T017791/1 CHIMERA: Collaborative Healthcare Innovation through Mathematics, Engineering and AI (£1.1M) (PI)	Research award
Professor Rebecca Shipley [4]	Non-Executive Director	EPSRC EP/R004463/1 Mathematical Modelling Led Design of Tissue-Engineered Constructs: A New Paradigm for Peripheral Nerve Repair (Nerve Design) (£1.1M) (PI)	Research award
Professor Rebecca Shipley [4]	Non-Executive Director	Rosetrees Trust – UCL Institute of Healthcare Engineering Research Awards (£250K) (PI)	Research award
Professor Rebecca Shipley [4]	Non-Executive Director	Royal Academy of Engineering Ingenious Award: Tomorrow's Home (£30K) (PI)	Research award
Professor Rebecca Shipley [4]	Non-Executive Director	Cancer Research UK – EPSRC Multidisciplinary Award. Understanding and Improving the Delivery of Nanoparticles to Tumours (£500K) (Co-PI)	Research award

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Dr Gabrielle Silver [5]	Non-Executive Director	CHS Healthcare (part of Acacium Group [healthcare staffing provider]	Chief Executive Officer
Dr Gabrielle Silver [5]	Non-Executive Director	Opiant [US biopharmaceutical business focusing on drugs for addiction]	Non-Executive Director
Dr Gabrielle Silver [5]	Non-Executive Director	CHS Healthcare / Acacium Group	Share ownership
Mr Robin Whitby [6]	Non-Executive Director	Robin Whitby Consulting Limited	Controlling share in business seeking to do business with NHS organisations other than the RNOH
Mr Robin Whitby [6]	Non-Executive Director	Whipps Cross Hospital Redevelopment (Barts Health NHS Trust)	Interim Hospital Design and Development Director
Mr Mark Bramwell [7]	Associate Non-Executive Director	Buckingham Palace's IT Advisory Group	Non-Executive Director
Mr Mark Bramwell [7]	Associate Non-Executive Director	Construct Education	Senior Advisor
Mr Mark Bramwell [7]	Associate Non-Executive Director	Corporate IT Forum Membership Council	Senior Advisor
Ms Katherine Murphy [8]	Associate Non-Executive Director	NIL	NIL
Mrs Laura Bevan	Board Level Director	NIL	NIL
Ms Lucy Davies	Board Level Director	NIL	NIL
Mr John Doyle	Board Level Director	'The OT Practice'	Wife appointed as a director of 'The OT Practice' (an independent company that may provide services to the NHS and local authorities) from June 2021.
Mr John Doyle	Board Level Director	Chartered Society of Physiotherapy Charitable Trust	Trustee
Dr Lila Dinner	Board Level Director	NHSE/I London Elective Surgery Recovery and Transformation Programme	Clinical Director, Anaesthetics
Dr Lila Dinner	Board Level Director	Healthcare Management Trust	Trustee
Dr Lila Dinner	Board Level Director	Medical Advisory Group for NHS Professionals	Member
Professor Paul Fish	Board Level Director	London Southbank University	Visiting Professor
Mr Rob Hurd	Board Level Director	NHS Improvement Getting it Right First Time Programme	Joint Senior Responsible Officer
Mr Rob Hurd	Board Level Director	NHS North London Partners Sustainability and Transformation Programme Adult Elective Orthopaedic Services Review	Joint Senior Responsible Officer
Mr Rob Hurd	Board Level Director	National Joint Registry Steering Committee	NHS Management Member
Mr Mark Masters	Board Level Director	NIL	NIL
Ms Caroline Owusu-Bennoah	Board Level Director	Point of Care Foundation	Trustee
Dr Saroj Patel	Board Level Director	Aspire	Chair of the Trustee Board
Professor John Skinner	Board Level Director	Medacta	Lecture and demonstration of Total Knee Replacement Surgery in a Cadaver Lab
Mr Daryl Lutchmaya	Trust Secretary	NIL	NIL

[1] Mr Dominic Dodd's appointment as Non-Executive Director (Chair), Royal Free London NHS Foundation Trust ceased on 31 March 2021.
[2] Mr Dominic Dodd's appointment as Director, UCL Partners ceased on 31 March 2021.
[3] Professor David Isenberg's appointment as Non-Executive Director ceased on 15 June 2020.
[4] Professor Rebecca Shipley's appointment as Non-Executive Director commenced on 16 June 2020.
[5] Dr Gabrielle Silver appointment as Non-Executive Director commenced on 19 June 2020.
[6] Mr Robin Whitby's appointment as Non-Executive Director ceased on 18 June 2020.
[7] Mr Mark Bramwell's appointment as Associate Non-Executive Director ceased on 31 December 2020.
[8] Ms Katherine Murphy's appointment as Associate Non-Executive Director ceased on 24 March 2021.

PERSONAL DATA INCIDENTS REPORTED TO THE INFORMATION COMMISSIONERS OFFICE

An organisation must notify a breach of personal data within 72 hours. If the breach is likely to result in a high risk to the rights and freedoms of individuals, organisations must also inform individuals concerned without undue delay. Breaches that also fulfil the criteria of a NIS notifiable incident will be forwarded to the Department of Health and Social Care where the Secretary of State is the competent authority for the implementation of the NIS directive in the health and social care sector. The Information Commissioner remains the national regulatory authority for the NIS directive.

During 2020/21, the Trust had no reportable incidents assessed against the breach assessment grading.

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.

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:

- As a Director, they have taken all of the necessary steps to ensure awareness of any relevant audit information; and to establish that the auditor is also aware of that relevant audit information;
- So far as they are aware, there is no relevant audit information which has not been brought to the attention of the auditor.

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, other items of comprehensive income 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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

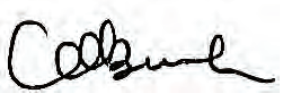
The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They 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 belief they have complied with the above requirements in preparing the accounts.

The Directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board

Professor Paul Fish
Chief Executive and
Chief Nursing Officer



Caroline Owusu-Bennoah
Chief Finance Officer

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, other items of comprehensive income and cash flows for the year.

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

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

Professor Paul Fish
Chief Executive and
Chief Nursing Officer

GOVERNANCE STATEMENT 2020 – 2021

A. INTRODUCTION

This Governance Statement describes the 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 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 responsibility for maintaining a sound system of internal control that supports the achievement of the 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 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:

- The RNOH contributing massively to the local NHS system through temporarily establishing a local trauma centre, ITU transfer teams, a COVID-19 patient hub and staffing and service mutual aid (e.g. in spinal surgery and orthopaedic paediatrics services) in response to various phases of the pandemic
- Meetings between the RNOH and NHSE with NHSI and CCG/ICS representatives in attendance, known as the Clinical Quality Review meeting;
- Regular meetings with the RNOH Patient Group, Healthwatch, Clinical Commissioning groups, NCL Integrated Care System and the Local Authority Health and Social Care Scrutiny Committee;
- During the year, the RNOH has continued to support the development of stronger working relationships and productive partnership between the local North London Partners Integrated Care System, The Royal Free NHS Foundation Trust, 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 local orthopaedic networks specialised paediatric orthopaedics, orthopaedic cancer services, other small scale specialised services, orthopaedic coding, commissioning and specialised prosthesis procurement;
- The RNOH CEO and Executive Directors have participated and contributed to the local Integrated Care System response to the pandemic. The RNOH CEO is appointed to the North Central London Provider Alliance and is a member of the ICS "Gold"/System Recovery Executive, the NCL system lead for Infection Prevention and Control and lead CEO for Sustainability. The RNOH COO is the ICS Executive lead for mutual aid. The RNOH CMO is London clinical lead for Anaesthetics.
- 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 continued to be jointly hosted by NHSI and the RNOH during 2020/21. This is a national programme supported by NHSI 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. The RNOH Accountable Officer is appointed 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. The Accountable Officer 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;
- The RNOH is a leader of the National Orthopaedic Alliance (NOA), which has been successful in achieving national vanguard status under the NHS England national New Models of Care programme – the NOA work consistently with other orthopaedic centres and the national GIRFT Programme with the stated aim of enhancing quality and reducing complications. This is a vital project for implementing shared learning in improving orthopaedic care.

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 Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

D. GOVERNANCE FRAMEWORK

The Trust Board

The Trust is a statutory body that was formed on 1st April 1991 under the 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.
- Chief Medical Officer.
- Chief Finance Officer.
- Chief Nurse.
- Chief Operating Officer.

During the year, there were a number of Non-Executive Director retirements from the Board and in their places, new Non-Executive Director appointments made. Professor David Isenberg, Mr Robin Whitby, Ms Katherine Murphy and Mr Mark Bramwell completed their Non-Executive Director terms.

During the year, two Non-Executive Director appointments were made. Professor Rebecca Shipley and Dr Gabrielle Silver (formerly an Associate Non-Executive Director) were appointed.

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 convened in public 10 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, either 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 bi-monthly 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.

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


Santa
Baby

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Name	Title	30 APR	28 MAY	25 JUN	23 JUL	28 AUG	18 SEP	30 OCT	27 NOV	28 DEC	28 JAN	25 FEB	25 MAR	Attendance Record
Mr Dominic Dodd	Chairman	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Professor Paul Fish	Interim Chief Executive and Chief Nurse	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Dr Jane Collins	Vice Chair / Non-Executive Director	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Mr Rob Hurd	Accountable Officer	A	A	A	A		A	✓	A	✓		✓	A	3/10
Mrs Doris Olulode	Non-Executive Director	✓	✓	✓	A		A	✓	✓	✓		✓	✓	8/10
Mr Surendran Chellappah	Non-Executive Director	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Dr Gabrielle Silver	Non-Executive Director	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Professor Rebbeca Shipley	Non-Executive Director (from June 2020)			✓	✓		✓	✓	✓	✓		✓	✓	8/8
Professor David Isenberg	Non-Executive Director	✓	✓											2/2
Mr Robin Whitby	Non-Executive Director	✓	✓											2/2
Mrs Katherine Murphy	Associate Non-Executive Director	✓	✓	✓	✓		✓	✓	✓	✓		✓	A	9/10
Mr Mark Bramwell	Associate Non-Executive Director	✓	✓	✓	✓		✓	✓	✓	✓				8/8
Dr Lila Dinner	Chief Medical Officer	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Mrs Caroline Owusu-Bennoah	Chief Finance Officer	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Ms Lucy Davies	Chief Operating Officer and Director of Strategy and Improvement	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Dr Saroj Patel	Chief Digital and Innovation Officer	✓	✓	✓	A		✓	✓	✓	✓		✓	✓	9/10
Mr Mark Masters	Director of Estates and Facilities	✓	✓	✓	✓		A	✓	✓	A		✓	✓	8/10
Mrs Laura Bevan	Chief People Officer	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10
Professor John Skinner	Director of Research and Innovation Centre	✓	✓	✓	✓		✓	✓	✓	A		✓	✓	9/10
Mr John Doyle	Director of Allied Health Professionals (From July 2019)	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	9/10
Mr Daryl Lutchmaya	Deputy Director of Corporate Governance (Trust Secretary)	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	10/10

A Board meeting is not held in August

Board meeting was cancelled due to COVID-19

Board Committees

During the year, Board Committees convened virtually as required. Membership of the Board Committees were as follows:

- Audit Committee: Membership - Mr Surendran Chellappah (Chair), Dr Jane Collins and Mrs Doris Olulode.
- Auditor Panel: Membership - Mr Surendran Chellappah (Chair), Dr Jane Collins and Mrs Doris Olulode.
- Remuneration Committee: Membership - Mr Dominic Dodd (Chair), Mr Surendran Chellappah, Dr Jane Collins, Mrs Doris Olulode, Professor Rebecca Shipley and Dr Gabrielle Silver.
- Clinical Standards and Innovation Committee: Membership – Dr Jane Collins (Chair), Mr Dominic Dodd, Professor Rebecca Shipley, Mrs Doris Olulode, Dr Gabrielle Silver, Ms Lucy Davies, Dr Lila Dinner, Mr John Doyle, Professor Paul Fish, Dr Saroj Patel and Professor John Skinner.
- People Committee: Membership – Mrs Doris Olulode (Chair), Mr Dominic Dodd, Dr Gabrielle Silver, Mrs Laura Bevan, Ms Lucy Davies, Dr Lila Dinner, and Professor Paul Fish.
- Finance and Compliance Committee: Membership - Mr Dominic Dodd (Chair), Mr Surendran Chellappah, Mrs Caroline Owusu-Bennoah, Mrs Laura Bevan, Professor Paul Fish and Ms Lucy Davies.
- Executive Committee: Membership - Professor Paul Fish (Chair), Mrs Laura Bevan, Ms Lucy Davies, Dr Lila Dinner, Mr John Doyle, Mr Mark Masters, Mrs Caroline Owusu-Bennoah, Dr Saroj Patel and Professor John Skinner.

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 /or minutes.

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

April 2020 - March 2021	Number of meetings held
Audit Committee	4
Remuneration Committee	2
Clinical Standards and Innovation Committee	4
Finance and Compliance Committee	10
People Committee	2
Executive Committee	51

All the meetings of the 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 Skills and Experience

Progressive sharing of Non-Executive Directors' experiences from other Trusts was taken advantage of through the recruitment of Mr Dominic Dodd, Mrs Doris Olulode and Dr Jane Collins, all of whom hold Non-Executive Directorships with other Trusts.

Dominic Dodd was appointed Chair of the Trust from November 2019. He is also the former Chair of The Royal Free London NHS Foundation Trust. Elsewhere in the NHS, Dominic is the Chair of the UCL Health Alliance (NCL Provider Alliance), a Trustee of The King's Fund and Advisor to NHSI London.

Dr Jane Collins started her career as a consultant paediatric neurologist at Guy's Hospital. She was appointed Chief Executive of both Great Ormond Street Hospital for Children and the Great Ormond Street Hospital Children's Charity in 2001. From 2012 until 2019, she was Chief Executive of Marie Curie. She chaired the London Clinical Senate Council between 2013 and 2018. She is an honorary fellow of UCL and the UCL Institute of Child Health, a Trustee of The King's Fund and Vice Chair of University College Hospitals NHS Foundation Trust.

Doris Olulode holds Non-Executive Directorships at Cambridge University Hospitals NHS Foundation Trust, Royal Free London NHS Foundation Trust and the Chartered Institute of Legal Executives. She is also a Lay Member to HM Courts and Tribunals Service and an Independent Governor of University of East London Higher Education Corporation.

Surendran Chellappah is Global Head of Risk and European Chief Operating Officer and Chief Financial Officer of the financial services firm Sanford C. Bernstein.

Professor Rebecca Shipley is Vice Dean (Health) in the UCL Faculty of Engineering Sciences, and also Director of the UCL Institute of Healthcare Engineering, which coordinates interdisciplinary research, innovation and education activities within healthcare engineering across UCL Engineering, the UCL School of Life and Medical Sciences, and the hospitals within the UCL Partners academic health system. She is also a Member of the Board of Trustees of the International Medical Education Trust 2000.

A key element of effective Board working is the ability to self-assess leadership impact and identify areas of continuous Board development. Whilst there is a regulatory requirement to undertake such an assessment (NHSI provides a template for Well-Led reviews, based on the CQC's eight Key Lines of

Enquiry (KLOE's)), the more significant driver is the positive impact on patient care and staff experience that having a continually developing Board in place provides for the organisation.

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. During the current year, the Board commenced the Well Led review and the process will be completed during 2022.

Audit Committee

- The Committee is chaired by a Non-Executive Director who is a finance professional and two other 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.
- The Audit Committee's remit includes reviewing the Annual Financial Statements and Annual Governance Statement. It reviews and plans the work of the External Auditor, Grant Thornton, agrees the annual workplan and reviews the clinical and non-clinical internal controls of the Trust through scrutiny of reports from the Trust's Internal Auditor, RSM. Additionally, it agrees the annual workplan and reviews the work and reports of the Trust's Local Counter Fraud resource, which is provided by RSM. It also monitors the process of implementation of management actions arising from Internal Audit Reports
- The Audit Committee receives and reviews the Trust Board Assurance Framework documents and the underlying risk processes and requests further work to ensure that the Trust's risk reporting systems are fit for purpose. It reviews the Trust's constitutional documents for Board approval and reviews tender waivers, losses and special payments.

Remuneration Committee

- The Remuneration Committee is chaired by the Chair of the Trust Board and includes 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, cars, season ticket loans, arrangements for termination of employment and other contractual terms.

Clinical Standards and Innovation Committee

- The Clinical Standards and Innovation Committee is chaired by a Non-Executive Director and includes five other Non-Executive Directors and meets quarterly.
- The Clinical Standards and Innovation Committee is responsible for providing the Trust Board with assurance that the Trust is reducing unwarranted variation in clinical practice, developing and applying the latest clinical innovations successfully, reviewing systems of clinical governance in relation to patient safety, leading on clinical quality improvement, securing assurance in respect of the Trust's clinical performance through its clinical audit programme, overseeing the Trust's research productivity and educational effectiveness and seeking to support improvements in the quality of clinical data and use of dashboards for patient safety, clinical effectiveness and related compliance; particularly in meeting the Trust's priorities for clinical outcomes.
- The Clinical Standards and Innovation Committee monitors the extent to which the Trust meets the requirements of commissioners and external regulators and ensures that the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

People Committee

- The People Committee is chaired by a Non-Executive Director and includes four other Non-Executive Directors and meets quarterly.
- The purpose of the Committee is to provide the Board with assurance that the Trust is working to deliver a high quality experience for patients and staff. For staff this includes the recruitment, development and retention of staff, deploying effective workforce planning and performance management approaches and organisational development in support of providing the best staff experience. For patients this includes the communication and engagement with patients, carers and volunteers to ensure patients of the Trust receive the highest standards of care.
- The People Committee monitors and evaluates the Trust's compliance with the Public Sector Equality Duty, Workforce Race Equality Scheme, Workforce Disability Equality Scheme and Gender Pay Gap.
- The Committee also monitors and seeks assurance on risks registered in relation to patient and staff experience and ensure that high level risks and impacts to the achievement of Trust objectives and

organisation performance in relation to patient, carer, staff and volunteer experience are captured on the risk register and that appropriate mitigations are in place.

Finance and Compliance Committee

- The Finance and Compliance Committee is chaired by a Non-Executive Director and includes one other Non-Executive Director and meets monthly.
- The Finance and Compliance Committee's overall role is to review the financial performance of the Trust and its operational units including delivery of financial sustainability plans, the capital plan and cost improvement/savings plan.
- The Committee provides assurance to the Trust Board about the Trust's operational and financial performance and the delivery of the Trust's financial strategy and underpinning financial plans and targets.
- Assurance is also provided to the Trust Board that the Trust is compliant with the regulatory framework in terms of statutory and regulatory submissions, with NHS constitutional standards and contract requirements and has oversight of the CQC action plan and progress against environmental sustainability initiatives.

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 Chief Finance Officer and as per the Scheme of Delegation. The Committee has continued to work extensively on developing the RNOH's strategy and the associated workstreams that will deliver on its strategic aims and organisational objectives.

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 the RNOH and this is described above in the Clinical Standards and Innovation Committee.

The Clinical Quality Review Meeting provides assurance to external stakeholders including Commissioners, NHSI and NHSE. The Chief Nurse, Chief Medical Officer and the Deputy Director of Quality are members of the Group.

Other mechanisms to ensure quality within the Trust include;

- Having a Chief Nurse 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 and Staff Safety; Patient Experience and 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.

The key areas of focus for clinical audit during 2020/21 have included: WHO Safety Checklist; Combined Nursing Documentation Audit; Hand Hygiene Audit; Vascular Access Audit; Environmental Spot Check Audit; Controlled Drugs Audit; Medicines Reconciliation Audit; Antimicrobial Prescribing Audit; Countersignature of Notes Audit and Medical Record Keeping Audit.

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 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 Clinical Standards and Innovation 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 based on the Executive Directors' knowledge of their own directorate risks and those from the Trust Risk Register.

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A summary of the Trust's strategic risks as contained in the BAF as at March 2021 are as follows:

Corporate Objectives	Strategic Risk	Inherent Risk	Current Risk March 2021	Target Risk	Strength of Controls	Strength of Assurance
Achieve top decile performance in outcomes	(a) Absence of a single IT platform to collect outcomes data. (b) Variable outcome data collection at individual service level. (c) Limited use of standardised care pathways. (d) Inability to capture complexity data in a standardised way. (e) Inhouse/external solution is required in relation to the digital platform which will be determined by the Digital Strategy.	25	20	10		
Develop partnerships within NCL and nationally to facilitate long-term sustainability	a) Failure to join the NCL Provider Alliance. (b) Failure to develop a clinical partnership model with Royal Free London Hospital Group. (c) Failure to develop and operationalise a model of MSK lead provider for the North of NCL. (d) Failure to achieve lead commissioner status for national specialist commissioning of MSK (e) Failure to generate capital to build RNOH at Chase Farm Hospital site.	12	12	4		
Financial sustainability	(a) Failure to achieve efficiencies in corporate and clinical support services via the NCL provider alliance. (b) Failure to increase profit from private practice income. (c) Failure to improve operational efficiency and reduce cost base. (d) Failure to increase overall Trust turnover via NHS income growth strategy.	20	20	15		
Best Patient and Staff Experience	a) Workforce supply and retention. (b) Failure to progress with EandD and BandH metrics as measured in the annual staff survey. (c) Failure to adequately support staff health and wellbeing during the COVID-19 response. (d) Financial constraints that impact on ability to support health and wellbeing. (e) Deterioration in access targets (RTT) leading to longer waits for treatment.	16	16	8		
Infrastructure – Redevelopment	Insufficient funding for redeveloping the site. The Trusts plans for redevelopment are on hold due to insufficient funding streams. NHSI have informed the Trust that Design, Build, Fund and Operate (DBFO) is no longer an acceptable contract for the procurement of new buildings. The RNOH has one of the highest backlog maintenance costs in the country.	25	20	10		
Infrastructure – Enable a digital first environment	(a) Availability of investment in technology (both external funding and internal investment priority). (b) Availability of resources (technical resources and skills within the digital team). (c) Technological capability of wider RNOH workforce. (d) Engagement of the workforce to the digital strategy. (e) Technological capability of patients and other external stakeholders. (f) Possible change from current EPR strategy may delay implementation of the Digital Strategy.	15	15	10		


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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.

As at March 2021, there were 26 risks on the Trust's risk register with a residual score of 15 and above. 9 of these were at the strategic level and 17 at local level. Some of these risks related to:

- Achievement of the RTT 18 week target.
- Inadequate supply of Personal Protective Equipment (PPE).
- Service capacity reduction during COVID-19.
- Recruitment, retention and development of nurses and the high levels of vacancies.
- Failure to increase income from non-NHS sources.
- Older buildings on site are constructed with asbestos.
- The Trust is highly dependant on a small number of staff in the Finance department.
- Risk that the Trust's IT systems and/or infrastructure would be compromised by Cyber-attacks in the form of malware, ransomware, viruses, denial of service or other attack either random or targeted.

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

Incident Reporting

The Trust process for reporting incidents is through the Safeguard reporting system which is monitored by the Patient Safety Team. When an incident is reported, it is Trust policy that the incidents are reviewed by managers within divisions and corporate departments on a daily and/or ongoing basis. These incidents are also reviewed on a weekly basis at the Incident Reporting Group (IRG) to discuss any concerns, review grading and decide which incidents meet the external serious incident criteria for external notification.

The Patient Safety Team works alongside the services to support with root causes analysis investigations. Learning themes are shared at the Quality Improvement and Lessons Learned Meeting (QUILL) and action and assurance on implementation are followed up with divisions.

Never Events are serious, largely preventable, safety incidents. During the last year, there were no Never Events and two Serious Incidents reported on the Strategic Executive Information System (StEIS).

The Data Security Protection (DSP) Toolkit forms part of a framework for assuring that the Trust is implementing the ten data security standards and meeting its statutory obligations on data protection and data security in line with the General Data Protection Regulation (GDPR). The DSP Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health guidance. All organisations that have access to NHS patient information must provide assurances that they are practising good information governance and use the Data Security and Protection Toolkit to evidence this by the publication of annual assessments. The Toolkit provides a mechanism for organisations to demonstrate that they can be Trusted to maintain the confidentiality and security of personal information. This in turn increases public confidence that 'the NHS' and its partners can be Trusted with personal data. The Trust has completed and published DSP assessment for 2019/2020 in demonstrating satisfactory compliance to provide services to patients.

THE RISK AND CONTROL FRAMEWORK

The Board Assurance Framework is the management tool used for identifying and for managing in year risks based upon the annual objectives of each Trust Strategic Objective which are shown on pages 18 and/or page 120 of this Annual Report. Future risks are identified as and when the next set of annual objectives are agreed by the Executive Team in pursuance of the Trust's Strategic Objectives.

The CQC Fundamental standards are integral to everything we do and reviewed through quality and performance metrics that are reported via the Trust's balanced scorecard and at key Trust governance Committees. Exception areas are reviewed and acted upon with assurance sought and/or provided through Trust committees. Each division also has a CQC action plan that is reviewed and exceptions areas addressed.

The Quality team (Nursing, Quality and 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 (via Ulysses the online incident management portal), 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 divisional/departmental 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 as stipulated in 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.
- Risk register reviews take place at a series of local and Trust-wide meetings, including Divisional Performance Reviews, Operational and Scrutiny level groups such as the Risk Management Group and Executive Leadership Team meetings Board committees including the Clinical Standards and Innovation Committee and at the Executive Committee meetings.
- 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. The 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 Clinical Standards and Innovation Committee assist the Board in identifying whether risk processes are adequate, and in overseeing the required improvements.
- There is a dedicated Quality Team which works with the Clinical, Operational and Corporate teams to manage amongst Patient and Staff Safety; Patient Experience and Involvement and Clinical Effectiveness the Risk management systems and processes within the Trust.

The Trust continues to work to support better risk oversight and to ensure that there is seamless alignment and escalation of risk from ward to Board.

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 Chief Nurse and Deputy Director of Quality has delegated authority for the clinical and operational risk management framework including its training.

The Risk Management Policy 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 to 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 assessment and information on aspects of internal control such as clinical and non-clinical risk, and health and safety. 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 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.

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 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 Clinical Standards and Innovation 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 Clinical Standards and Innovation 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. The Head of Internal Audit opinion for 2020/21 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. Based on the work Internal Audit undertook on the Trust's system of internal control, it did not consider there to be any issues that the Trust should include within its Annual Governance Statement. The Head of Internal Audit opinion for 2020/21 was based on the rating of 'Reasonable Assurance' on the following audits that were undertaken:

- Remote Working and Operational Resilience.
- Risk Management.
- Payroll.
- Incidents and Lessons Learnt.
- Stock Control.
- Health and Safety.

There was also one 'Partial Assurance' relating to Recruitment and Retention and two 'Advisory reports' in relation to Financial Governance and to the Data Security and Protection Toolkit.

Reasonable assurances were given where enhancements are required and in each of these cases management actions have been agreed, the implementation of which will improve the control environment.

The Head of Internal Audit opinion was also based on a partial assurance opinion in relation to Recruitment and Retention. Internal Audit found that the Trust did not have a strategy in place which detailed values and benefits, and evidence based initiatives. Negative comments had been provided within local induction feedback forms, and therefore there was an opportunity to assess the quality of the induction and share best practice. There was generally a low uptake of exit interview forms, however the form could be further enhanced by splitting out the areas by topic and also using the data gathered to undertake trend analysis. Furthermore, there were inconsistent personal development forms in use and there were opportunities to develop a formal career framework.

Action plans have been agreed with management for all internal audit reports. Progress of implementing management actions is also monitored by the Audit Committee.

The Department for Health and Social Care has determined that the breakeven duty is met if expenditure is covered by income over a three year period, i.e. a Trust is not compliant if the Trust has a cumulative adjusted deficit for 3 consecutive years. The Trust had a cumulative adjusted deficit in 2017/18, 2018/19 and 2019/20 and remains non-compliant with this duty in 2020/21.

The Trust has a breakeven duty to ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings chargeable to the revenue account. The phrase 'taking one financial year with another' has been interpreted by the Department of Health and Social Care and HM Treasury as meaning that the duty is met if income equals or exceeds expenditure over a 3-year period or exceptionally a 5-year rolling period with the agreement of NHS Improvement. External audit are to issue a S30 (a) and (b) referral to the Secretary of State detailing the Trust's cumulative deficit and outlining that the Trust had not achieved the breakeven duty for the period up to 31st March 2021.

The Audit Committee gains assurance from management in relation to fraud as follows:

a) The Trust has assessed the risk of material misstatement in the financial statements due to fraud as follows:

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. 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.

No significant areas of concern have been brought to the attention of the Audit Committee which would lead to a material misstatement in the financial statements.

b) The Trust has the following processes in place to identify and respond to risks of fraud:

Proactive and reactive fraud prevention and investigation is undertaken by the Trust's Local Counter Fraud Service provider, RSM. This includes a slot on the induction programme for new staff, bespoke training sessions in key risk areas, and a visible presence within the Trust through both physical presence and articles in the Trust newsletter.

Further assurance is provided by fraud and bribery risk assessments, local proactive exercises in known and high risk areas, participating in the National Fraud Initiative and the internal audit review of financial systems, which includes testing the design, efficacy and compliance with controls which are intended to prevent fraud. Internal control weaknesses and control breaches identified by RSM are reported to management and the Audit Committee and tracked via the management action tracker. Internal audit also test if recommendations arising from each audit have been implemented, and report their findings to management and to 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 work plan and investigations. Regular

liaison meetings with senior staff is undertaken and evidenced in the form of agendas and minutes. The LCFS work plan presented to the Audit Committee includes an analysis of fraud risks, a local review of fraud risks and the intended time of delivery.

c) In the event that 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 Counter Fraud Authority and fraud alerts with emerging risks received from other LCFS' are, where relevant, disseminated to the organisation's relevant contact/ department in order to highlight, prevent and detect potential areas of weakness. These are followed up periodically to ensure measures remain effective to combat the threat.

The LCFS produces an annual work plan each year, which reflects relevant fraud risks. These risks are assessed and monitored throughout the year and an overall position is provided at year end within the LCFS Annual Report. This report includes details and actions submitted to NHS Counter Fraud Authority as part of the self-review toolkit, against the Standards for Providers, which is approved by the Chief Financial Officer and Audit Chair and is taken to the Audit Committee.

Local proactive exercises are undertaken during the year, based on these risks. The proposed exercises are captured within the LCFS work plan, and for 2020/21 covered conflicts of interest. A planned review of procurement risk to be conducted centrally by the NHS CFA has been postponed due to the pandemic. In addition, limited gap testing will be conducted before the end of the year in relation to pre-employment checks. Areas of coverage for 2021/22 are currently in discussion with the Chief Financial Officer and are based on the Trust's fraud risk profile.

d) Internal controls, including segregation of duties, are in place and are operating effectively.

e) The risks and the mitigating actions which have been identified by internal audit have been agreed by the Executive to ensure that adequate controls are implemented. The Audit Committee gains assurance that these actions are implemented through the internal audit update presented to each Audit Committee.

f) The risk of management over-ride of controls is not considered to be significant. Apart from

the internal control reviews undertaken by internal audit, the Executive provides monthly reports on the achievement of financial targets to the Finance and Compliance Committee. The Finance and Compliance Committee consists of three Non-Executive Directors and has the Interim Chief Executive and Chief Nurse, Chief Financial Officer, Chief Operating Officer, Chief People Officer and the Director of Estates and Facilities in attendance. Management reports on the achievement of key financial targets are scrutinised and challenged effectively by the members of the Committee.

g) It is considered that there are no areas which have significant risk of misreporting. This view reflects the reports received from Grant Thornton on the outcome of testing undertaken during the interim statutory audit.

h) The Audit Committee exercises oversight over management's processes for identifying and responding to risks of fraud to identify and respond to the risks of fraud in the organisation as follows:

The Trust's LCFS, provided by RSM UK, works closely with the Trust's Executive, particularly with the Finance, HR and Governance teams. The LCFS agrees management actions with the Executive to mitigate fraud risks which they have identified. The LCFS produces reports for each Audit Committee on the work undertaken in the areas of fraud awareness, deterrence, detection, governance and investigations undertaken. The members of the Audit Committee seek assurance from both the LCFS and the Executive at Audit Committee meetings. The LCFS produces an annual work plan for the forthcoming year, which reflects fraud risks, which is taken to the Audit Committee for approval. The Audit Committee reports on its considerations to the Trust Board.

i) 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.

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 LCFS liaison meetings the Chief Financial Officer, Audit Committee Chair 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.

j) The Trust communicates and encourages ethical behaviour of its staff and contractors. The Trust has a range of policies and procedures to help prevent, deter and detect fraud.

k) The following policies are in place and are available to all staff via the Trust's intranet. Members of staff and off-payroll contractors are required to adhere to these policies:

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

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

- Metropolitan Police Service.
- HR.
- Communications Department.
- Risk Management.
- Payroll.
- Local Security Management Service.
- Freedom to Speak Up Guardian.

All new employees at the Trust have received a virtual or video presentation on counter-fraud and anti-bribery as part of the Trust's induction programme. This is presented by the LCFS and effectiveness is measured. Bespoke training and awareness sessions have also been provided to other Trust departments as well as a focus during November's fraud awareness month.

l) The LCFS distributes quarterly fraud newsletters to all staff via communications. The newsletters are designed to bring recent cases or emerging scams to the attention of staff members to help recognise the signs of fraud in the NHS. Other awareness platforms are used and in all LCFS messages there is detail to ensure staff are informed of the various reporting lines. Effectiveness of the awareness platforms utilised is measured.

m) The Trust adopts the NHS standard contract for all suppliers which include a range of terms and conditions requiring ethical behaviour by suppliers, covering, for example, fraud, conflicts of interest and compliance with equality legislation.

n) Staff are encouraged to report their concerns about fraud. The Anti-Fraud and Anti-Bribery Policy requires that any reasonable suspicion of fraud should be reported to the LCFS or Chief Financial Officer.

Fraud awareness material is made available on the Trust 's intranet page and on noticeboards around the Trust, which details the appropriate reporting lines staff should take when reporting any concerns. The reporting lines are also stipulated within Trust policies. Moreover, new starters and key staff groups receive counter fraud training from the LCFS in which the reporting lines are also explained. The LCFS has in place protocols for joint working with key personnel again advocating the reporting procedures, such as the Freedom to Speak Up Guardian (FTSUG). The Trust also promotes the Whistleblowing Policy (Making a Disclosure in the Public Interest) which aims to encourage and protect employees when making referrals.

Staff in higher risk positions are required to make a COI declaration as part of the annual exercise, relevant staff are required to undertake a DBS check and senior managers/board members are subject to the 'fit and proper persons' test.

The LCFS presentations, which form part of the induction process for new members of staff, encourage members of staff to report any concerns about fraud via the various reporting lines.

The LCFS has regular meetings to discuss fraud activity and risk with the departments most likely to be affected (Finance and HR). The LCFS also reports quarterly to the Chief Financial Officer and attends Audit Committee meetings to provide updates against the counter fraud work plan.

o) There have not been any reported instances from the LCFS or internal audit to the Audit Committee of specific related party transactions or related party relationships during 2020/21 which could give rise to the significant risk of fraud.

p) Three referrals have been received by the LCFS since April 2020, noted within the Audit Committee papers and reported to the NHS CFA. None of these referrals have led to a significant financial loss to the Trust.

q) The Trust has the following arrangements in place to prevent and detect non-compliance with laws and regulations and enables management to gain assurance:

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.

r) 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. Board papers bear a declaration that legal advice has been sought where appropriate. A report of all losses and special payments is presented to every Audit Committee.

The Trust's advisors, in particular its internal auditors, advise the Executive and the Audit Committee of new legal requirements with which the Trust must comply.

s) The following arrangements are in place to identify, evaluate and account for litigation or claims:

Reports are received at every Audit Committee setting out losses and special payments. The Trust's management also receive letters from the Trust's legal advisors in April 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 June 2021 Audit Committee at which the draft 2020/21 financial statements are considered. Reports are received at every Audit Committee setting out losses and special payments.

t) The Trust is not aware of any potential litigation claim, for example one that would be uninsured, that would have a material impact on the Trust's 2020/21 financial statements.

u) The development of COVID-19 required the Trust to adapt rapidly to the changing situation. The underlying principles of decision making during this period was to protect pathways for patients where there was a risk to life or serious morbidity, identify ways that the Trust could support the wider system, in particular partner hospitals with Emergency Departments under pressure from COVID-19 admissions and to protect staff and to focus on their welfare.

Critical protected pathways; cancer pathways (sarcoma, myeloma and metastatic spinal cord compression), spinal cord injuries and severe bone infection were maintained during COVID-19. Additionally, significant pressure for those hospitals with emergency departments dealing with COVID-19 was to maintain trauma surgery. Part way through April 2020, the RNOH had established a trauma service.

Critical care was under significant pressure as a result of COVID-19. As a result of this the RNOH deployed staff to both the Nightingale and also to partners in NCL to support critical care staffing there. In addition to staffing critical care units, the RNOH provided anaesthetist and critical care nurses to staff critical care transfer teams, which provided essential additional capacity for movement of patients between hospital sites within NCL and also from NCL to the Nightingale.

As the pandemic developed, the RNOH developed and delivered training programmes for social care relating to infection control and to PPE. The Trust also worked with Middlesex University which developed a manufacturing process for the visors that were being used as part of PPE. Further work was undertaken to develop gowns. The equipment was moved into the NHS supply chain for use across the system.

Looking after our staff was a priority since the start of the pandemic. From the beginning, large numbers of staff were identified that could safely work from home and there was significant work undertaken by the digital team to put the technology in place that would allow for this. A number of interventions were put in place to support staff during this time.

Much of the normal governance that was in place in the NHS was paused as a result of COVID-19. A small number of key governance processes were maintained, but with re-designed processes to ensure that clinicians could concentrate their time on the care of their patients. The Trust continued to report and review clinical incidents, review deaths, respond to patient complaints and document key Trust risks associated with COVID-19. As of April 2021, as COVID-19 moved into a steady state, governance processes were being re-started in a revised format to ensure that there was adequate oversight. These included oversight by Divisional performance reviews and the Clinical Standards and Innovation Committee. Board meetings and Board Committees have met virtually during the pandemic.

Much of the structure of NHS financial control was revised as a result of COVID-19. The Trust was aware of the potential risk of fraud and of the importance of safeguarding public funds appropriately.

Authorisation of spend was in line with the existing delegation levels for the period of the incident. Where capital purchases were required, this was undertaken via a virtual CAPSAG meeting and then given final authorisation provided by either the Chief Finance Officer or Deputy Chief Executive.

Comprehensive records of decisions, matched with spend and tracking of assets ensured that there was a clear narrative of how money was spent over this period. A challenge of spend to date was undertaken every fortnight at the Executive Committee and the overall financial governance process was presented at both the Audit and Finance and Compliance Committees.

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.

Professor Paul Fish
Chief Executive and
Chief Nursing Officer

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 any good corporate governance guidance issued by NHS Improvement, to be brought to the attention of the Board in a timely manner. The Trust's Standing Orders have been reviewed 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. A Board Matrix is in place to assist with Board succession planning, and the Remuneration Committee meets to discuss Executive Directors' performance. Board members comply with the annual Fit and Proper Person Test. The Board Committee Structure has been updated 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 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 Clinical Innovation and Standards Committee and/or substantive items being presented to it. The Clinical Innovation and Standards Committee is a Board Committee which meets quarterly to consider and to oversee quality issues. It also receives a quarterly Integrated Quality Report. There is an established governance framework below the level of the Clinical Innovation and Standards Committee which considers clinical and quality. 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.

The Board is satisfied that the RNOH applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS and in compliance with the NHS Provider Licence. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation have been reviewed. The Board Committee Structure has also evolved to reflect the needs of the organisation and Committees' Terms of References have been updated.

The Board had significant oversight over the Trust's performance during the year. It convened regular Board and Committee meetings which undertook reviews of planned work and included regular oversight of performance information, financial information and the BAF. It was also assured that the Trust had safe and effective systems through robust external and internal audit processes which confirmed that there were not any material concerns about key internal controls and processes.

CARE QUALITY COMMISSION

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

SINGLE OPERATING FRAMEWORK 2020/21

The RNOH remains in segment 2 of the NHSI's Single Oversight Framework. 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 Trust Development Authority (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.

NHS England and NHS Improvement have prepared proposals for a new approach to NHS system oversight. The proposed approach aligns with the vision set out for Integrated Care Systems (ICS) in Integrating Care and in the Government's White Paper, Integration and Innovation: working together to improve health and social care for all.

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 to ensure that resources have been used economically, efficiently and effectively. The Trust Board, Clinical Standards and Innovation Committee and Executive Committee scrutinise quality dashboards regularly; workforce metrics are reviewed in detail by the Board, People Committee and by the Executive Committee; and financial performance is considered by the Board, the Finance and Compliance Committee and by the Executive Committee. 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. Alongside the above, there are a number of processes used by the Trust to deliver economy, efficiency and effectiveness of the use of resources. These include:

- Use of Standing Financial Instructions;
- Regular, systematic and risk based Internal Audit;
- Detailed bottom-up process for budget setting and
- Business cases; and
- Financial and efficiency benchmarking at Trust level against other specialist NHS Trusts.

The Trust is able to demonstrate that it has used resources economically, efficiently and effectively within the constraints of the global pandemic. During 2020/21, the financial regime was such that one cannot effectively come to the conclusion that the Trust over achieved its financial target despite having a favourable outturn to plan. This is mainly driven by how the NHS was funded in the 2020/21 financial year; Organisations were funded at 2019/20 levels of income and a top up given to support Infection Prevention and Control, COVID-19 requirements as well as a top up for non-achievement of Private patient income. As a result of the pandemic, the Trust struggled to achieve its efficiency target as the focus of the organisation was supporting the wider NHS in the fight against COVID-19. The Trust met its agency cap, spending £1.7m less on agency than the ceiling set by NHS Improvement, against a backdrop of national recruitment and retention challenges.

DATA QUALITY AND GOVERNANCE

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. 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 team 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 daily 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 Divisional Managers also use the validation spreadsheet to undertake and to record outcomes for their quality assurance checks each week.

The Trust has produced a detailed suite of standard operating procedures for scheduling and validation processes. These are available on the Trust intranet for all staff and are used as a supplementary tool, in addition to departmental training.

All mandated data submissions completed by the Information Team are listed within a collections timetable and are supported by written work instructions which include a validation/sign-off protocol. The data required for routine submissions has been developed into reports available within the Trust's business intelligence reporting tool which are refreshed daily or at the required frequency for any given submission. Exceptionally where the data required for a submission is not available on an electronic system this will be submitted to the Information team by email. Submissions are routinely signed off at Executive or Deputy level prior to external submission.

The Trust Balanced Scorecard encompasses key indicators used by the Trust Board and it's Committees to monitor performance. The Scorecard brings together information that was previously provided in numerous reports and in a variety of formats 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 well managed.

All indicators have a Data Owner at Executive Board level. The process of agreeing indicators, targets and methods of measurement is carried out prior to the commencement of each new financial year and once agreed by the data owners is approved by the Executive Committee and by the Board.
Some indicators relate to measures that are national standards and have agreed targets, for other indicators the target is set internally based on historical performance with some improvement factored in. Each month the indicators must be approved by the relevant Data Owner providing ownership at Executive level of the Balanced Scorecard. The scorecard data is used at Trust Board and meetings of the Board's Committees information is reported consistently.

The Balanced Scorecard which is received and considered at the Executive Committee, other relevant Board Committees and at the Board, contains a data quality assurance RAG rating in order to indicate the level of accuracy and completeness of the data and is completed by the data owner:

- Green: Assurance in data quality and completeness.
- Amber: Gaps identified in data quality and completeness.
- Red: Significant gaps identified in data quality and completeness.

The quality of the data contained and presented in reports is assessed and validated by the relevant owner of the data. Performance information is reviewed by each relevant Executive Director for their respective areas and is reported to the Trust Board. Other reports containing data which are received by the Board have been considered by a previous relevant Board Committee where scrutiny and challenge will have taken place and / or directly from a relevant directorate where internal data validation and checks have been undertaken.

The Board Assurance Framework is updated by the relevant Executive Director and discussed at the Executive Committee. The relevant strategic risks are also considered at their respective Board Committees and updates made to them. The Board receives the most up to date version at its meetings.
The Trust undertakes various data quality audits to validate the quality of the information the core audits include but not limited to; clinical records audit; corporate records audit; NHS number audit and clinical coding audit. The business intelligence reporting/information portal (Insight) provides information dashboards where data sets can be reviewed to identify errors and omissions for correction.

VALUE FOR MONEY OPINION

In April 2020, the National Audit Office introduced a new Code of Audit Practice which comes into effect from audit year 2020/21. The Code introduced a revised approach to the audit of Value For Money. The Code requires auditors to consider whether the body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. The Code requires that where auditors identify significant weaknesses in arrangements they should make recommendations setting out the actions that should be taken by the body. Under the Code the auditor issues an Annual Auditor's Report which will include the Value For Money assessment. The Auditor's Annual Report for 2020/21 is required to be issued no later than 20th September 2021. The Code requires that auditors structure the value for money commentary under three specified criteria:

- Improving economy, efficiency and effectiveness.
- Financial sustainability.
- Governance.

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.

The 2019/20 data can be found at: https://www.rnoh.nhs.uk/about-us/corporate-information

At the time of publishing this Annual Report, the 2020/21 data was not available, however, it would be uploaded to the RNOH website by 31st July 2021.

FRAUD DETERRENT

The 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 a team of accredited Local Counter Fraud Specialists (LCFS) in place.

The Trust does not tolerate fraud, bribery or corruption anywhere in the organisation and our intention is to eliminate these 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 our 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.
Fraud risk assessment is an ongoing process which is based on a continuous cycle of review and assessment. New risks are identified, the inherent risk position scored, the controls and assurances already in place at the Trust assessed and any new measures to further reduce the remaining level of fraud risk are noted along with a target risk score. This process allows for the incorporation of new risks when they are identified as well as updating scores and progress on actions on known risks.

The Trust's counter fraud team have an active program of awareness and training for Trust staff which aims to ensure all staff are aware of the risk of fraud and are encouraged to report any suspicions as they arise. Staff, contractors and the public are able to report their concerns directly to the counter fraud team, or through National reporting routes hosted by the NHS Counter Fraud Authority.

The Trust is committed to taking all necessary steps to counter fraud and corruption and is reviewing its approach to meet the new Government Functional Standards which have been adapted for the NHS by the NHS Counter Fraud Authority into 13 NHS Requirements.

The Trust will take all necessary steps to counter fraud and corruption in accordance with the Trust's anti-fraud and anti-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. In 2020/21, the Counter fraud team have received three allegations of suspected fraud, bribery or corruption. These were investigated and appropriate action taken to prevent any loss or recurrence.

REGISTER OF INTERESTS

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. This can be found at: Declarations of Interest, Gifts and Hospitality

The Trust has a Declaration of Interest Policy that complies with 'Managing Conflicts of Interests in the NHS' guidance.

Declarations by decision-making staff are made:

- On appointment with the organisation. It must be noted that this includes any material roles outside of the RNOH such as Non-Executive Directorships and as consultants;
- When a relevant member of staff moves to a new role or their responsibilities change significantly;
- At the beginning of a new project/piece of work;
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters under discussion/consideration); and
- Whenever a member of staff accepts or rejects an offer of hospitality or sponsorship(s) or travel and accommodation packages.

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. The Board approved Risk Appetite Statement reads:

'The RNOH's long term sustainability depends upon the delivery of its strategic objectives and on the relationships that it enjoys with its patients, workforce and strategic partners. As a consequence of this, the Trust will not accept risks that materially impact on patient safety or on clinical quality and outcomes. The Trust has its greatest appetite to pursue commercial gain/partnerships and innovation in terms of its willingness to take opportunities where positive gains can be anticipated, but within the constraints of the regulatory environment'.

The Trust's Board Assurance Framework (BAF) has the following features:

- Specific risk descriptions are provided and these have been mapped to the Trust's strategic objectives.
- Clear causes and effects of the risks are described.
- Controls are clearly separated from actions and the actions have completion dates.
- Gaps in controls and assurances are listed.
- Assurances are clearly defined for many of the risks with high risk scores.
- Key Risk Indicators show what metrics are being used to assess current risks.
- The current risk score along with the target risk score are both listed for each risk on the BAF.

RSM, the RNOH's internal auditors have given the opinion that the Board could take reasonable assurance from the Risk Management in place following the internal audit review undertaken during the year.

The Trust ensures that it learns from good practice when handling risks from undertaking root cause analyses as part of the incident management process, discussing risk matters at the various Committees and by information sharing and by referencing best practice and codes of practice.

During the year, PricewaterhouseCoopers LLP ("PwC") undertook an Independent service auditor's assurance report on controls at NHS Business Services Authority which provides and maintains the Electronic Staff Record (ESR) system. The period covered 1 April 2020 to 31 March 2021. The ESR system is a single payroll and Human Resources (HR) management system that has been fully implemented across the whole of the NHS in England and Wales. The system has replaced multiple fragmented payroll and HR systems which were previously in use within the NHS. Its implementation was completed by 31 March 2008. The basis for the qualified opinion was due to exceptions being identified in relation to the controls intended to enforce segregation of duties for changes to the NHS Hub, and ensure that unauthorised changes to the NHS Hub are detected and investigated. As a result, controls were not suitably designed to achieve Control Objective 1 ("Controls provide reasonable assurance that changes to the system software, hardware, and network components are documented and approved.") during this period.

PwC also undertook an Independent service auditor's assurance report on controls at NHS Shared Business Services Limited, another provider of services to the RNOH and issued a qualified opinion as certain control deficiencies were identified which indicated that either those controls did not operate as designed or there was not sufficient appropriate evidence to demonstrate that those controls operated effectively throughout the period 1 April 2020 to 31 March 2021. The payroll and pension services supplied to the RNOH are based on the Electronic Staff Record ("ESR") system.

CLIMATE CHANGE ACT AND THE ADAPTATION REPORTING

The Trust is undertaking risk assessments and has a draft sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with as far as reasonably practicable.

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

EQUALITY AND DIVERSITY

A focus on Equality, Diversity and Inclusion was seen as particularly important in 2020/21. The pandemic hindered some of the existing plans that were in place, however, the Trust made some significant steps forward which is highlighted on page 105 of this report.

WORKFORCE STRATEGIES

The Trust is proud to have achieved the best Staff Engagement score of any NHS Trust in the country in the 2020 NHS Staff Survey. In so doing, it has realised its commitment to staff that it would provide the best staff experience in the NHS by 2021. It is testament to the RNOH workforce that this has been possible, particularly in the context of the COVID-19 pandemic. However, this success only underlines how important it is for the Trust to continue investing in creating a healthy, supportive and compassionate workplace culture.

Much of the planned Workforce activity in 2020/21 was postponed due to the COVID-19 Pandemic, however, the following areas of work continued or were introduced to provide support to staff during this challenging year:

- Provision of practical support to staff including provision of groceries, childcare and staff accommodation.
- Provision and management of safe levels of quality personal protective equipment for each member of staff to ensure they could safely undertake their role, achieved in a highly complex and competitive PPE market.
- Establishment of staff COVID-19 testing service, internal track and trace and COVID-19 vaccination programme.
- Focus of the People Directorate to receive, interpret and disseminate high quality, accurate information about the impact of the pandemic on working lives. This enabled staff to make the best choices for themselves, their loved ones and their colleagues.
- Implementation of risk management support, including demographic risk assessments for each staff member, and workplace risk assessments to ensure the places colleagues worked were as COVID-19 secure as possible.
- Increased transparency around decision making, and use of different communication methods to ensure staff had access to information that affected their working lives as quickly as possible.
- Recognition of key cultural events including Pride, Eid-ul-Fitr, Black History Month, International

Women's Day, Disability Awareness Month and Diwali – an opportunity to reinforce community ties and to take moments of celebration in a challenging year.

- Promotion of wellbeing support including access to talking therapies and peer support.
- Provision of the Wingman Lounge (supported by the RNOH Charity).
- Appointment of Equality, Diversity and Inclusion Lead, and a Staff Wellbeing Lead (supported by the RNOH Charity) to continue and build upon the inclusion and wellbeing work done throughout the Pandemic.

The Trust also began work across the Intergrated Care System to centralise corporate support functions where it made most sense to increase quality and efficiency. This underpinning planning will be realised in 2021/22, strengthening many of our corporate services which have previously been vulnerable due to the size of the organisation.

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 is recorded.
- Regular quality assurance checks are undertaken of completed validations each week to ensure competency. Additional peer validation takes place each month to reassess breached pathways are appropriately recorded.

All booking teams are responsible for ensuring that patient appointments are booked within clinically determined timeframes and escalate to the divisional management if there is insufficient clinic or theatre 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 fortnightly Access Improvement Task Force meetings which are chaired by the Head of Elective Access. 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.

During 20/21, in addition to the usual validation of the Trust PTL, the validation team completed a piece of work focusing on patients who were potentially lost to follow up. Over 8000 patients were reviewed and 12.8% of the patients were identified to be overdue for a follow up which had not happened due to a variety of reasons (e.g. a cancelled appointment that was not rebooked). These patients are in the process of being booked appointments and approximately half have now been seen. Patients are being reviewed and assessed for any potential clinical harm, as appropriate. A number of changes have been introduced which will reduce the risk of a patient being lost to follow up; the most significant is a change of process in the booking of follow up appointments which will ensure patients are added to a waiting list before their follow up is booked. This process will mean that it is much easier to identify and rebook patients for appointments if their follow up appointment is cancelled.

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.

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.

SIGNIFICANT ISSUES

My review has highlighted the following significant issues.

1. Achieve top decile performance in outcomes: Other than the absence of a single IT platform to collect outcomes data, variable outcome data collection at individual service level and limited use of standardised care pathways could lead to the inability to capture complexity data in a standardised way.
2. Develop partnerships within NCL and nationally to facilitate long-term sustainability: The failure to join partnership models and alliances, could lead to the failure to develop clinical partnerships, operationalise a model of MSK lead provider for the North of NCL and the failure to achieve lead commissioner status for national specialist commissioning of MSK.
3. Financial Sustainability: The future financial sustainability of the Trust relies on achieving efficiencies in corporate and clinical support services via the NCL provider alliance, increasing profit from private practice income, improving operational efficiency and reducing the cost base and increasing the overall Trust turnover.
4. Best Patient and Staff Experience: The recruitment, retention and development of RNOH staff as well as the continuing improvement of the culture in the organisation remains a high priority, especially Equality and Diversity and Bullying and Harassment. It is important that the Trust adequately supports staff health and wellbeing as part of the COVID-19 response. It is also essential that the Trust prevents deterioration in access targets (RTT) leading to longer waits for treatment.
5. Infrastructure: There is a risk of insufficient funding for redeveloping the site. The RNOH has one of the highest backlog maintenance costs in the country.
6. Infrastructure - Enable a digital first environment: The availability of investment in technology, both external funding and internal investment is a key risk. Linked to this, the availability of resources (technical resources and skills within the digital team), the technological capability of the wider RNOH workforce, engagement of the workforce to the digital strategy and technological capability of patients and other external stakeholders are important factors.
7. Coronavirus: Throughout the year, Coronavirus (COVID-19) had a significant impact on the NHS

nationally and the RNOH played an important role in the system response to the pandemic. The underlying principles of decision making during this period were to protect pathways for patients where there was a risk to life or serious morbidity, identify ways that the Trust could support the wider system, in particular partner hospitals with Emergency Departments under pressure from COVID-19 admissions and to protect staff and to focus on their welfare. The NHS approach to Infection Prevention and Control (IPandC) has needed to fundamentally change to ensure that emergency pathways for patients with known or suspected COVID-19 infection could be separated from patients requiring elective care. This has required major changes to pathways, processes and infrastructure which will remain in place for the medium to long-term and in which the RNOH is a part of.

CONCLUSION

The system of internal control has been in place in the Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2021 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.

Professor Paul Fish
Chief Executive and
Chief Nursing Officer

REMUNERATION AND STAFF REPORT

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.

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

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 1.7 and Note 8.1 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 2020/21.

Pay Multiples

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

The median salary has been calculated using employees in post in March 2021. 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 salary of the highest paid director in the Trust in the financial year 2020-21 was between £155,000 and £160,000 (2019-20, £180,000-£185,000). This was 3.9 times (2019-20 4.4 times) the median salary of the workforce, which was £40,569 (2019-20 £41,044).

Salary ranged from within the £0-5,000 banding up to the £160,000 - £165,000 banding (2019-20 range £0-5000 banding up to the £180,000 - £185,000 banding). In 2020-21 one employee (2019-20 one employee) received a salary in excess of the highest-paid director. This member of the clinical workforce received a salary within the £160,000 - £165,000 banding. This employee earned more than the highest paid director due to compensation for taking on additional responsibilities and also working additional sessions.

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.

The Royal National Orthopaedic Hospital NHS Trust
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DIRECTORS' SALARY ENTITLEMENTS

			2020/21						2019/20					
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 £5000 £'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 £5000 £'000
S Chellappah	Non-Executive Director	Mar 20	10-15					10-15						
R J Shipley	Non-Executive Director	Jun 20	5-10					5-10						
J E Collins	Non-Executive Director	Feb 20	10-15					10-15	0-5					0-5
D Dodd	Chairman	Nov 19	25-30					25-30	10-15					10-15
D H Olulode	Non-Executive Director	Feb 20	10-15					10-15	0-5					0-5
M Rosehill	Non-Executive Director	Oct 17 - Nov 19							0-5					0-5
K Murphy	Associate Non-Executive Director	Sep 17	10-15					10-15	5-10					5-10
Professor D Isenberg	Non-Executive Director	Jun 11 - Jun 20	0-5					0-5	5-10					5-10
R Whitby	Non-Executive Director	Aug 13 - Jun 20	0-5					0-5	5-10					5-10
J Carlebach	Non-Executive Director	Jan-14 - Jan-20							5-10					5-10
G A Silver	Associate Non-Executive Director up to June 2020 Non-Executive Director July 2020 - March 2021	Oct 15	10-15					10-15	5-10					5-10
M A Leigh	Non-Executive Director	Oct 15 - Nov 19							0-5					0-5
M C Bramwell	Associate Non-Executive Director	Jul 18 - Dec 20	5-10					5-10	5-10	100				5-10
Professor A Goldstone	Chairman	Feb 11 - Aug 19							10-15					10-15
R Hurd	Chief Executive up to April 2020 Accountable Officer May 2020 -March 2021	Oct 08	45-50				0-2.5	45-50	180-185				115-117.5	300-305
J A Skinner	Director of Research and Innovation Centre	Jan 17	140-145		45-50		47.5-50	235-240	140-145			45-50	145-147.5	330-335
L Davies	Chief Operating Officer	Apr 15	125-130				60-62.5	185-190	115-120				10-12.5	125-130
Professor P Fish	Chief Nurse up to April 2020 Chief Executive & Chief Nurse May 2020 -March 2021	Feb 15	145-150				47.5-50	195-200	125-130				17.5-20	140-145
A Nejad	Medical Director	Jan 17 - Sep 19							90-95			30-35	0	110-115
HL Witty	Director of Finance	Sep 16 - Feb 20							110-115				30-32.5	145-150
M Masters	Director of Estates and Facilities	Dec 03	110-115				15-17.5	130-135	110-115				70-72.5	180-185
Dr S Patel	Director of IM&T and Innovation	Mar 05	125-130				12.5-15	140-145	120-125	300			0-2.5	120-125
Dr Z Huma	Director of Children›s Services	Sep 15 - Sep 19							60-65			5-10	0	55-60
F Hennessey	Director of Redevelopment	Jul 15 - May 19							10-15				2.5-5	15-20
T Nettel	Director of Workforce & Organisational Development	Apr 15 - Nov 19							65-70				22.5-25	90-95
R Dalton	Director of Allied Health Professionals	Oct 18 - Jun 19							30-35				12.5-15	45-50
J Doyle	Director of Allied Health Professionals	Jul-19	95-100				50-52.5	145-150	70-75				147.5-150	215-220
M Mahal	Acting Director of Workforce	Oct 19 - Jan 20							15-20				10-12.5	25-30
L Dinner	Medical Director	Oct 19	155-160				122.5-125	280-285	70-75				72.5-75	145-150
M Hodgkinson	Acting Director of Organisational Development	Oct 19 - Jan 20							10-15				0	10-15
LJ Bevan	Director of Workforce and Organisational Development	Jan-20	105-110				90-92.5	195-200	20-25				7.5-10	30-35
C Owusu-Bennoah	Chief Financial Officer	Mar-20	125-130				162.5-165	290-295	10-15				0-2.5	10-15
Band of highest-paid Director›s salary			155-160						180-185					
Median total remuneration			£40,569						£41,044					
Ratio			3.88						4.45					

The Royal National Orthopaedic Hospital NHS Trust
ANNUAL REPORT 2020/21

DIRECTORS' PENSION ENTITLEMENTS

Name	Title	Start/Leave Dates	Real increase in pension at pension age during 2020/21 arising while employed by Trust (bands of £2500 £000	Real increase in pension lump sum at pension age arising while employed by Trust (bands of £2500 £000	Total accrued pension at pension age 31 March 2021 (bands of £5000 £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5000 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Real increase in Cash Equivalent Value £000	Employer's contribution to stakeholder pension £000
Robert Hurd	Chief Executive up to April 2020 Accountable Officer May 2020 -March 2021	Oct-08	0-2.5	0	65-70	140-145	1120	1178	14	0
Lucy Davies	Chief Operating Officer	Apr-15	2.5-5	2.5-5	45-50	105-110	810	900	58	0
Paul Fish	Chief Nurse up to April 2020 Chief Executive & Chief Nurse May 2020 -March 2021	Feb-15	2.5-5	0	20-25	0-5	185	227	17	0
Mark Masters	Director of Estates & Facilities	Dec-03	0-2.5	0	40-45	90-95	803	855	21	0
Sarojin Patel	Director of IM&T and Innovation	Mar-05	0-2.5	2.5-5	30-35	95-100				0
John Andrew Skinner	Director of Research and Innovation Centre	Jan-17	2.5-5	0-2.5	75-80	190-195	1540	1666	64	0
John Doyle	Director of Allied Health Therapies	Jul-19	2.5-5	2.5-5	10-15	25-30	123	162	24	0
Lila Dinner	Medical Director	Oct-19	5-7.5	12.5-15	65-70	160-165	1207	1386	128	0
Laura Bevan	Director of Workforce and Organisational Development	Jan-20	2.5-5	7.5-10	20-25	45-50	324	342	-3	0
Caroline Owusu-Bennoah	Chief Financial Officer	Mar-20	7.5-10	15-17.5	25-30	50-55	280	416	112	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 of the NHS pension scheme).

Note 4: In the event of early retirement, the pension benefit will be reduced in accordance to guidance set out by the Businesss Services Authority [www.nhsbsa.nhs.uk].

Note 5: The table above is audited.

Note 6: The stakeholder pension scheme is a scheme that is offered by the Trust to the employees of the Trust and is separate to the NHS pension scheme

Note 7: R Hurd was seconded on a part-time basis to the North Central London CCG during 2020/21. The values in the Directors› Pension Entitlements table have not been abated to reflect this.

Note 8: NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Note 9: In the event of early retirement the pension benefit will be reduced in accordance with guidance set out by the Business Services Authority (www.nhsbsa.nhs.uk).

STAFF REPORT

Our staff

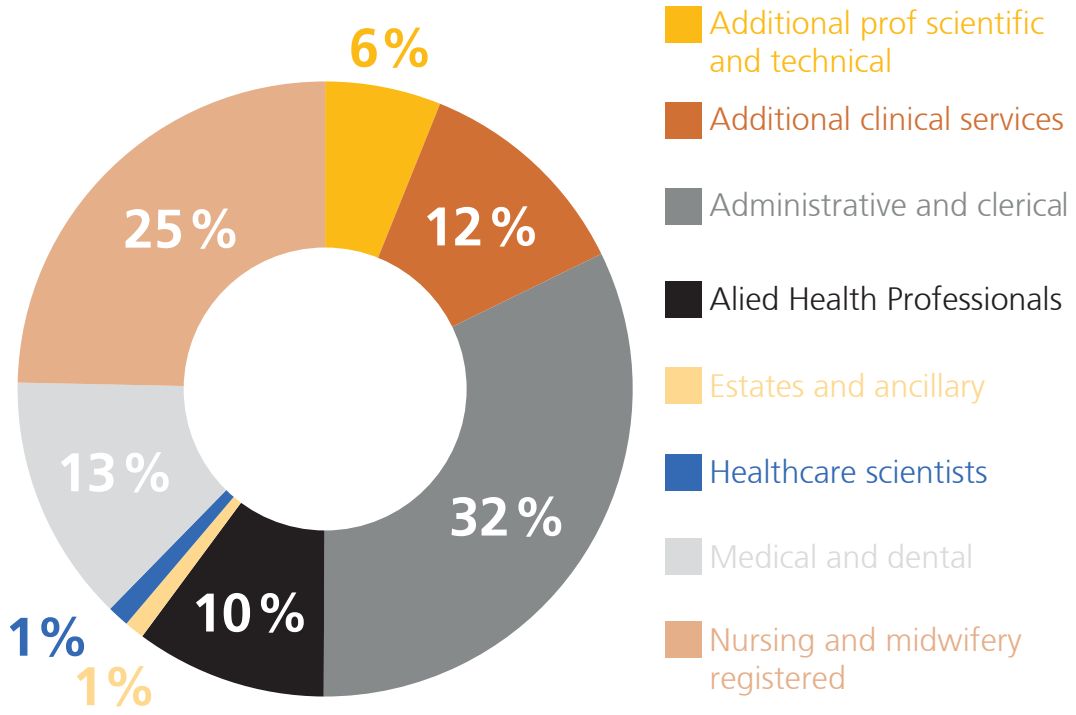
As at 31 March 2021, the Trust employed 1,529 whole time equivalents (WTEs) valuation of staff, 9 WTEs lower than last year.

The table below provides a breakdown by staff group.

RNOH Staff WTE and Headcount as at 31st March 2021

Staff Group	Headcount	WTE	%
Additional Prof Scientific and Technical	101	93	6.10%
Additional Clinical Services	191	178	11.66%
Administrative and Clerical	546	494	32.32%
Allied Health Professionals	174	154	10.06%
Estates and Ancillary	16	16	1.05%
Healthcare Scientists	19	17	1.14%
Medical and Dental	217	199	13.01%
Nursing and Midwifery Registered	411	377	24.67%
Grand Total	**1675**	**1529**	**100.00%**

AVERAGE NUMBER OF EMPLOYEES 2020/21



	2020/21 (Average WTE)	2020/21 Permanently Employed (WTE)	2020/21 Other (WTE)	2020/21 Total Employee Costs (£000s)	2020/21 Permanent Employee (£000s)	2020/21 Other Employee Costs (£000s)
Medical and dental	210	202	8	29,325	28,062	1,263
Ambulance staff	0	0	0	0	0	0
Administration and estates	540	505	35	28,602	27,212	1,390
Healthcare assistants and other support staff	179	156	23	7,298	6,539	759
Nursing, midwifery and health visiting staff	460	399	61	23,097	19,994	3,103
Nursing, midwifery and health visiting learners	0	0	0	0	0	
Scientific, therapeutic and technical staff	302	274	29	14,620	12,841	1,779
Healthcare science staff	4	1	3	122	122	
Social care staff	5	5	0	296	296	
Other	0	0	0	18	18	
Total average numbers	**1,701**	**1,543**	**158**	**103,378**	**95,084**	**8,294**

The tables are subject to audit. The breakdown of costs and the split between salaries and wages, social security costs is set out in note 7 of the financial statements.

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	11	31	77	21	27	9	3	1010	1189
Male	5	101	28	10	17	7	7	311	486
Total	**16**	**132**	**105**	**31**	**44**	**16**	**10**	**1321**	**1675**

Staff Sickness absence

The Trust's average sickness absence rate for 2020/21 is 3.28%, which is slightly above the Trust target of 3%. This is 0.16% higher than last year's figure of 3.12%.

	2020-21
Average Sickness Rates 2020/21	3.28%
FTE calendar days lost to sickness	18,311.47
FTE calendar days available	557,440.03
Average working days lost per FTE	9

Staff policies applied during the financial year

Equality and diversity (including equal opportunities and disability)

A focus on Equality, Diversity and Inclusion was seen as particularly important in 2020/2021. The pandemic hindered some of the existing plans that were in place, however, the Trust made some significant steps forward.

Our Equality Achievement Network has gone from strength to strength in this period, culminating in the appointment of two Co-Chairs of the group. This has allowed the network to gain a level of supported independence from the Trust enabling it to act credibly as a critical friend to the organisation. Regular Executive Team listening events have taken place over the year allowing network members to talk openly with members of the Executive Team about their experiences within the Trust and their ideas for improvement.

In light of the impact of the pandemic on the cultural lives of RNOH staff, the Trust focused on marking and celebrating key cultural events throughout the year, many of which were recognised for the first time. Events that were celebrated included, Pride, Eid-ul-Fitr, Black History Month, Disability Awareness Month, International Women's Day and Diwali. As part of our Pride celebrations the Trust installed a rainbow crossing outside the Stanmore Building as a permanent symbol of inclusion. The Trust also joined in solidarity with Black colleagues, volunteers, patients, friends and family in acknowledging Black Lives Matter.

The Trust also established a new Equality, Diversity and Inclusion lead, appointed in February 2021. This reflects the organisation's commitment to making real, tangible and meaningful change to the experience of all staff, particular those who are members of protected groups.

As in recent years, we have complied with all legal standards in terms of Equality and Diversity, including Gender Pay Gap reporting, the Workforce Race Equality Standard, the Workforce Disability Equality Standard, the Equality Delivery System 2 and the Public Sector Equality Duty. Full reports are available on the Trust website at www.rnoh.nhs.uk

Going forwards the Trust is developing a People Strategy for 2021 and beyond that is based on the NHS People Plan and has a strong focus on diversity and inclusion. This will help set the road map for the

next few years for priority areas of focus. Some of the initial actions planned include introducing diverse and accountable panels for roles at band 8A and above and jointly developing an EDI Charter within the Trust.

Staff Wellbeing

Staff Wellbeing has been a key focus of the Trust in 2020/21. The Trust took a multi-faceted approach, based on evidence and best practice. Fundamental needs were addressed through increased communication, greater insight and transparency around decision making and the provision of access to groceries, childcare and accommodation. The Trust was the recipient of many donations from the local community and national organisation and charities, and received generous support from the RNOH Charity enabling staff to have access to free meals, drinks and snacks, and also treats which contributed to maintaining staff morale.

The Trust opened the Wingman Lounge, a partnership with the airline industry to provide a first class lounge experience to NHS staff. In addition to the value of providing care to colleagues, aviation professionals are trained to notice individuals who may be experiencing heightened anxiety and were therefore able to be another layer of support and safeguarding for staff.

To recognise the contributions of staff from across the Trust, 'RNOH the movie' was developed at the end of 2020. This film showcased the many contributions of colleagues within the Trust and within our partner organisations over the last 12 months. The film will stand as a testament to the hard work, dedication and contribution of RNOH colleagues, partners and volunteers and was an opportunity for staff to begin processing the challenges of 2020.

A Wellbeing Lead was also appointed, generously support by the RNOH Charity. The Wellbeing Lead will provide expertise in formulating a Wellbeing Plan for the next 18-24 months and will provide training and education to staff to mitigate the potential impacts of the pandemic on wellbeing, and to build wellbeing into our core staff experience going forward.

Partnership Working

Ensuring that we continue to work in partnership with union representatives is of real importance to the Trust. We remain focused on developing workforce policies, strategies for resolving employee relations issues, and change/transition projects with our Union colleagues. We have a quarterly policy

sub group that feeds into our monthly Partnership Committee, which takes place with our Union colleagues. Numerous 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.

Staff Experience

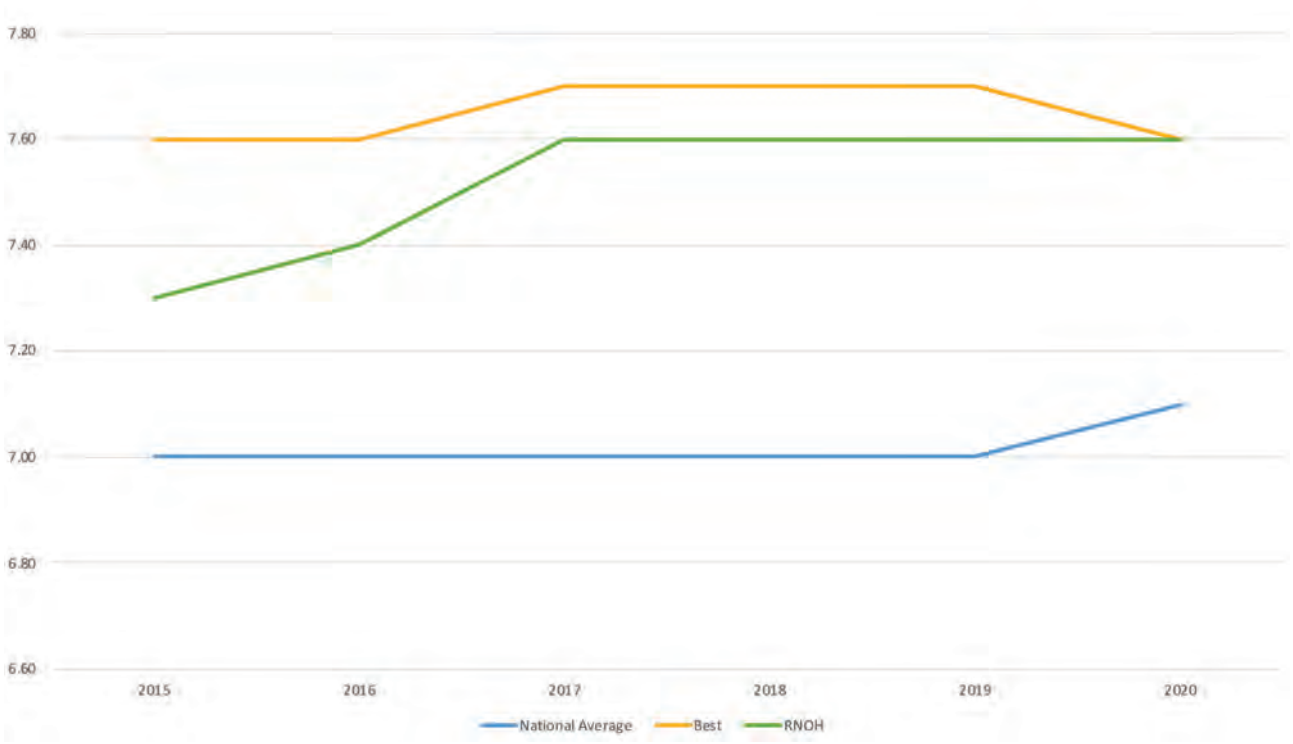
In 2016, the RNOH made a commitment to focus on staff experience and to become the best place to work in the NHS within five years. This year the Trust achieved that goal by achieving the best score amongst provider organisations for Staff Engagement in the country.

Despite a challenging year, we were pleased to see that we maintained a strong performance on our Staff Survey results. Some of the key highlights are:

- Staff Engagement – best score in the country.
- Quality of Care – second in the country, Best Acute Specialist Trust, Best in London.
- Health and Wellbeing – best in London.
- Morale – best in London.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.8	7.3	6.7	8.1	9.0	9.9	7.5	7.6	7.0
Your org	8.8	6.6	7.2	6.4	8.1	8.2	9.8	7.0	7.6	6.9
Average	9.2	6.5	7.1	6.4	7.9	8.4	9.8	7.0	7.4	6.8
Worst	8.4	6.1	6.8	6.2	7.6	7.7	9.3	6.9	7.1	6.5
Responses	862	866	868	867	723	864	865	871	871	851

The Chart below shows the results of the Staff Engagement Key Finding over the last five years. You can see that the Trust has maintained its performance over the last four years and this year has the best Staff Engagement score in the country.



The Trust has an ambitious plan for staff experience in 2021/22. In line with the requirements in the People Plan, the focus will be on Staff Wellbeing, Equality Diversity and Inclusion and introducing Just Culture and Supportive and Compassionate Leadership into the organisation.

Expenditure on Consultancies

During the year consultancy expenditure amounted to £4,225,195 (2019/20, £7,543,429). This included costs associated with site development, national orthopaedic initiatives and the Getting It Right First Time initiative.

Table 1: Length of all highly paid off-payroll engagements

Table 1 lists all off-payroll engagements as of 31 March 2021, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2021	1
The number that have existed for less than 1 year at the time of reporting	1
The number that have existed for between 1 and 2 years at the time of reporting	0
The number that have existed for between 2 and 3 years at the time of reporting	0
The number that have existed for between 3 and 4 years at the time of reporting	0
The number that have existed for 4 or more years at the time of reporting	0

Table 2: off-payroll workers engaged at any point during the financial year

Table 2 detailed all off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day.

	Number
Number of temporary off-payroll workers engage between 1 April 2020 and 31 March 2021	1
Of which:	
Number not subject to off-payroll legislation (see note)	0
Number subject to off-payroll legislation and determined as in-scope of IR35 (see note)	0
Number subject to off-payroll legislation and determined as out of scope of IR35 (see note)	1
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

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

Table 3 details any off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (see note 1)	0
Total number of individuals on payroll and off-payroll that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure must include both on payroll and off-payroll engagements (see note 2)	15

Table 4: Severance Payments

The tables are subject to audit.

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,000 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**0**	**0**	**0**
Total cost (£)	£0	£0	£0

	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Exit packages: other (non-compulsory) departure payments				
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	4	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HM Treasury approval	-	-	-	-
Total number of exit packages by type	**2**	**4**	**0**	**0**

GLOSSARY

ACAS	Advisory, Conciliation and Arbitration Service
ATP	Adenosine Triphosphate
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BPPC	Better payments practice code
CCG	Clinical Commissioning Group
CHP	Combined heat and power
COI	Conflict of Interest
COVID-19	(Coronavirus) An infectious disease caused by severe acute respiratory syndrome first identified in December 2019 and resulted in a pandemic.
CRL	Capital Resource Limit
CT	Computerised tomography
CQC	Care Quality Commission
DBFO	Design, Build, Fund and Operate
DHSC	Department of Health and Social Care
DSP	Data Security and Protection
DSPT	Data Security and Protection Toolkit
EAN	Equality Achievement Network
EEA	European Economic Area
EMT	Executive Management Team
EDI	Equality, Diversity and Inclusion
EPR	Electronic Patient Record
EPRR	Emergency Planning Resilience and Response
ERS	e-Referral Service
EU	European Union
FFT	Friends and Family Test
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
GDPR	General Data Protection Regulations
GEMS	GOSH Exceptional Member of Staff
GIRFT	Getting it Right First Time
HEE	Health Education England
HSJ	Health Service Journal
IandE	Income and Expenditure
ICS	Integrated Care system

IFRS	International Financial Reporting Standards
IP	Intellectual Property
IPC	Infection, Prevention and Control
IPCC	Infection Prevention and Control Committee
KLOE	Key Lines of Enquiry
LCFS	Local Counter Fraud Service
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSSA	Methicillin-Sensitive Staphylococcus Aureus
NCL	North Central London
NED	Non-Executive Directors
NHS	National Health Service
NHSE	National Health Service England
NHSI	NHS Improvement (Monitor)
NIHR	National Institute for Health Research
NIS	Network and Information Systems
NOA	National Orthopaedic Alliance
OPD	Out Patient Department
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
PPE	Personal Protective Equipment
PTL	Patient Tracking List
PV	Photovoltaic
QIA	Quality Impact Assessment
RCA	Root Cause Analysis
RFL	Royal Free London NHS Foundation Trust
RNOH	Royal National Orthopaedic Hospital
RTT	Referral To Treatment
SID	Senior Independent Director
SPECT	Single Photon Emission Computed Tomography
SSI	Surgical Site Infection
SSIPG	Surgical Site Infection Prevention Group
StEIS	Strategic Executive Information System
STP	Sustainability and Transformation Partnership
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
UCL	University College London
UCLH	University College London Hospital
UCLP	University College London Partners
WHO	World Health Organisation
WTE	Whole Time Equivalent
2WW	2 Week Wait (suspected cancer referrals from GPs)

ANNUAL ACCOUNTS

Annual accounts for the year ended 31 March 2021

STATEMENT OF COMPREHENSIVE INCOME

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	2	147,014	132,415
Other operating income	3	35,039	37,281
Operating expenses	5, 7	(176,719)	(179,208)
Operating surplus/(deficit) from continuing operations		**5,334**	**(9,512)**
Finance income	10	4	130
Finance expenses	11	(32)	(1,606)
PDC dividends payable	12	(3,035)	-
Net finance costs		**(3,063)**	**(1,476)**
Other gains / (losses)	13	-	(3)
Surplus / (deficit) for the year		**2,271**	**(10,991)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(802)	-
Revaluations	17	-	1,789
Total comprehensive income / (expense) for the period		**1,469**	**(9,202)**

STATEMENT OF FINANCIAL POSTION

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	1,745	1,050
Property, plant and equipment	15	113,268	112,451
Receivables	19	1,275	1,550
Total non-current assets		**116,288**	**115,051**
Current assets			
Inventories	18	2,923	2,356
Receivables	19	9,464	22,131
Cash and cash equivalents	20	38,693	24,435
Total current assets		**51,080**	**48,922**
Current liabilities			
Trade and other payables	21	(23,561)	(27,792)
Borrowings	23	(71)	(118,403)
Provisions	25	(68)	(74)
Other liabilities	22	(4,472)	(2,979)
Total current liabilities		**(28,172)**	**(149,248)**
Total assets less current liabilities		**139,196**	**14,725**
Non-current liabilities			
Borrowings	23	(1,224)	(1,292)
Provisions	25	(990)	(955)
Total non-current liabilities		**(2,214)**	**(2,247)**
Total assets employed		**136,982**	**12,478**
Financed by			
Public dividend capital		153,738	30,703
Revaluation reserve		34,858	35,660
Income and expenditure reserve		(51,614)	(53,885)
Total taxpayers' equity		**136,982**	**12,478**

The notes on pages 185 to 225 form part of these accounts.

Professor Paul Fish
Chief Executive and
Chief Nursing Officer

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2021

	Public dividend capital* £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**30,703**	**35,660**	**(53,885)**	**12,478**
Surplus for the year	-	-	2,271	**2,271**
Impairments	-	(802)	-	**(802)**
Public dividend capital received	123,035	-	-	**123,035**
Taxpayers' and others' equity at 31 March 2021	**153,738**	**34,858**	**(51,614)**	**136,982**

* On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue loans, interim working capital facility balances and interim capital loans were repaid and replaced with the issue of Public Dividend Capital (PDC). In September 2020 PDC of £117.9m was drawn down which enabled loans of an equivalent value to be repaid.

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	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		5,334	(9,512)
Non-cash income and expense:			
Depreciation and amortisation	5	5,855	6,216
Net impairments	6	2,164	62
Income recognised in respect of capital donations	3	(2,449)	(92)
(Increase) / decrease in receivables and other assets		13,012	(7,266)
(Increase) in inventories		(567)	(4)
Increase / (decrease) in payables and other liabilities		(3,191)	4,262
Increase in provisions		29	438
Net cash flows from / (used in) operating activities		**20,187**	**(5,896)**
Cash flows from investing activities			
Interest received		4	130
Purchase of intangible assets		(1,368)	(374)
Purchase of PPE and investment property		(6,761)	(5,189)
Sales of PPE and investment property		-	97
Receipt of cash donations to purchase assets		698	92
Net cash flows used in investing activities		**(7,427)**	**(5,244)**
Cash flows from financing activities			
Public dividend capital received		123,035	527
Movement on loans from DHSC		(118,122)	14,216
Movement on other loans		-	(19)
Interest on loans		(310)	(1,583)
PDC dividend (paid) / refunded		(3,105)	504
Net cash flows from financing activities		**1,498**	**13,645**
Increase in cash and cash equivalents		**14,258**	**2,505**
Cash and cash equivalents at 1 April - brought forward		**24,435**	**21,930**
Cash and cash equivalents at 31 March	20	**38,693**	**24,435**

NOTES TO THE ACCOUNTS

NOTE 1 ACCOUNTING POLICIES AND OTHER INFORMATION

Note 1.1 Basis of preparation

Accounting Standards

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 2020/21 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 the accounts.

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual (FReM), defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Board of Directors has a reasonable expectation that this will continue to be the case. See note 1.3 for further details.

Note 1.3 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:

Consolidation of Financial Statements

IFRS 10 Consolidated 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.

Going Concern

The GAM states:

'The FReM notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.

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.'

The Trust has not been informed of any intention for dissolution without transfer of services by the DHSC or relevant national body.

There is also positive evidence that the continuation of the provision of services is to be expected. The Trust forms part of the North Central London Integrated Care System (ICS) and new models of service delivery following COVID-19 are being developed with NCL ICS partner organisations and th ICS recognises that the Trust has a key role in the recovery of elective orthopaedic surgery. As a specialist provider, the Trust does not face pressures in relation to the loss of services, and market analysis has suggested that due to its specialist nature the Trust should be pursuing growth strategies as specialist activity coalesces around specialist providers in line with 'Getting It Right First Time' recommendations. Over the long term, additional opportunities are also considered to exist in the private patient market. Furthermore, there has been recent significant investment in buildings infrastructure to provide enhanced services. A new in-patient ward block was constructed in 2018 which required a business case to be approved by NHSI. This business case included DHSC capital loan funding of £48.0m to construct the new ward block.

Based on the evidence set out above and other more detailed evidence the Board of Directors has confirmed that the 2020/21 financial statements are to be compiled on a going concern basis..

Note 1.4 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. All land and 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.
- The valuation of buildings 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 valuation exercise was carried out during February 2021 with a valuation date of 31 March 2021. The valuation report was issued on 7th April 2021. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'),

The carrying values at 31 March 2021 are: buildings £78,956,000 and land £17,247,000.

Injury Recovery Scheme

The Trust receives income under the 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 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 an allowance for unsuccessful compensation claims and doubtful debts.

Note 1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

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

2020/21

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

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

Comparative period (2019/20)

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

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is, therefore, considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Revenue from private patients

The Trust generates income from providing healthcare to private patients. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the private patient, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue from the Trust Development Authority for GIRFT Services

The nature of these services are explained at note 1.2. Under the contract Trust expenditure on GIRFT services is charged to the Trust Development Authority (TDA). It is considered that the performance obligation is satisfied over time. Revenue is recognised when expenditure that is chargeable to the TDA under the contract is incurred.

Note 1.6 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants are used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.7 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. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care 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 scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as 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 1.8 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 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes.
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust.
- it is expected to be used for more than one financial year.
- 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 a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- 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 lives.

Subsequent expenditure

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

Measurement

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, 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 expenditure. 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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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.

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

Useful lives of property, plant and equipment

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

Land	Min life Years indefinite life	Max life Years indefinite life
Buildings, excluding dwellings	1	87
Dwellings	11	32
Plant and machinery	5	9
Information technology	5	9
Furniture and fittings	7	50

Finance-leased assets (including land) are depreciated over the shorter of the useful 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 1.10 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in

	Min life Years	Max life Years
Software licences	5	10

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

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

Note 1.12 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 1.13 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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

Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables and contract assets, measuring expected losses as at an amount equal to lifetime expected losses.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

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

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

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.

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

The Trust as a lessor

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 HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

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 26 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

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 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise

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.

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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-Trusts-and- foundation-Trusts.

In accordance with the requirements laid down by the Department of Health 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 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 in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. 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. 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, service or passed legislation. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.21 Early adoption of standards, amendments and interpretations

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

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

IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

HM Treasury confirmed in November 2020 that the implementation date for IFRS 16 within the DHSC group has been revised to 1 April 2022 (previously 1st April 2021). Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable.

IFRS 17 Insurance Contracts

IFRS 17 Insurance Contracts becomes effective on 1st January 2023. The impact on NHS entities is yet to be established.

Note 2 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5.

Note 2.1 Income from patient care activities (by nature)

	2020/21 £000	2019/20 £000
Block contract / system envelope income*	128,397	75,141
High cost drugs and devices income from commissioners (excluding pass-through costs)**	8,175	8,754
Other NHS clinical income **	744	36,122
Private patient income	5,507	7,605
Additional pension contribution central funding***	3,936	3,759
Other clinical income	255	1,034
Total income from activities	**147,014**	**132,415**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes.

Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

2019/20 comparative year income has been restated. For the comparative year income for Patient Transport Services of £3.866m has been included which was reflected in other operating income in the 2019/20 financial statements. This correction arises from a review of the treatment of PTS income which concluded that treatment as part of Patient Care Activities is more appropriate.

** High cost devices income is shown under 'High cost drugs and devices income' however in the 2019/20 accounts high cost devices income was included in 'other clinical income'. The prior year value for other clinical income has therefore been restated to exclude high cost devices income of £5.310m. This correction enables greater granularity for material elements of income from patient care activities.

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

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	64,117	66,075
Clinical commissioning groups*	76,385	57,466
Department of Health and Social Care	4	45
Other NHS providers	283	-
Non-NHS: private patients	5,507	7,605
Injury cost recovery scheme	255	448
Non NHS: other	463	776
Total income from activities	**147,014**	**132,415**
Of which:		
Related to continuing operations	147,014	132,415

* 2019/20 comparative year income has been restated. For the comparative year income for Patient Transport Services of £3.866m has been included which was reflected in other operating income in the 2019/20 financial statements. This correction arises from a review of the treatment of PTS income which concluded that treatment as part of Patient Care Activities is more appropriate.

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

	2020/21 £000	2019/20 £000
Amounts added to provision for impairment of receivables	4	66

Note 3 Other operating income*

	2020/21			2019/20		
	Contract income £000	Non-contract income £000	**Total £000**	Contract income £000	Non-contract income £000	**Total £000**
Research and development	1,238	-	**1,238**	1,286	-	**1,286**
Education and training	2,042	184	**2,226**	1,953	203	**2,156**
Non-patient care services to other bodies	635		**635**	434		**434**
Provider sustainability fund (2019/20 only)			**-**	469		**469**
Financial recovery fund (2019/20 only)				9,625		**9,625**
Reimbursement and top up funding*	19,775	-	**19,775**			
Receipt of capital grants and donations		2,449	**2,449**		92	**92**
Charitable and other contributions to expenditure		2,144	**2,144**		75	**75**
Other income**	6,572	-	**6,572**	23,144	-	**23,144**
Total other operating income	**30,262**	**4,777**	**35,039**	**36,911**	**370**	**37,281**
Of which:						
Related to continuing operations			35,039			37,281

*2019/20 comparative year income has been restated. Patient Transport Services of £3.866m has been excluded from other operating income which is reflected in the comparative year under Income from Patient Care Activities (note 2.1). This correction arises from a review of the treatment of PTS income which concluded that treatment as part of Patient Care Activities is more appropriate.

** Income for GIRFT services of £6.852m has been included within reimbursement and top up funding (total income for GIRFT services is £11.993m 2020/21 with £5.141m shown in other income). In the 2019/20 comparative year total income for GIRFT services was £20.034m which was included in other income.

Note 4 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	400	501

Note 5 Operating expenses

Note 5.1 Operating expenses by type of expense

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	571	715
Purchase of healthcare from non-NHS and non-DHSC bodies	2,013	1,346
Staff and executive directors costs	101,464	100,111
Remuneration of non-executive directors	117	89
Supplies and services - clinical (excluding drugs costs)	26,870	29,099
Supplies and services - general	8,078	7,243
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,274	4,709
Inventories written down	212	548
Consultancy costs	4,225	7,543
Establishment	1,146	2,648
Premises	6,292	6,088
Transport (including patient travel)	3,186	4,023
Depreciation on property, plant and equipment	5,182	5,031
Amortisation on intangible assets	673	1,185
Net impairments	2,164	62
Movement in credit loss allowance: contract receivables / contract assets	613	112
Movement in credit loss allowance: all other receivables and investments	209	4
Increase/(decrease) in other provisions	32	46
Change in provisions discount rate(s)	12	22
Audit fees payable to the external auditor		
audit services- statutory audit*	78	58
other auditor remuneration (external auditor only)	10	10
Internal audit costs	48	48
Clinical negligence	3,430	3,430
Legal fees	270	323
Research and development	1,268	1,311
Education and training	1,471	1,758
Rentals under operating leases	1,436	1,232
Redundancy	-	9
Hospitality	10	113
Other	365	292
Total	**176,719**	**179,208**
Of which:		
Related to continuing operations	176,719	179,208

* Includes VAT.

Note 5.2 Other auditor remuneration

	2020/21 £000	2019/20 £000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	10	10
Total	**10**	**10**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

Note 6 Impairment of assets

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus / deficity resulting from:		
Abandonment of assets in course of construction	-	62
Other *	2,164	-
Total net impairments charged to operating surplus / deficit	**2,164**	**62**
Impairments charged to the revaluation reserve*	802	-
Total net impairments	**2,966**	**62**

*This impairment reflects the valuation of buildings which is informed by a report compiled by a firm of professional valuers. The principle reason for the impairment is building contractor price deflation.

Note 7 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	79,719	77,700
Social security costs	8,009	8,103
Apprenticeship levy	364	355
Employer's contributions to NHS pensions	12,927	12,368
Pension cost - other	5	8
Termination benefits	-	9
Temporary staff (including agency)	2,890	3,917
Total staff costs	**103,914**	**102,460**
Of which		
Costs capitalised as part of assets	536	419

Note 7.1 Retirements due to ill-health

During 2020/21, there were no early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is 0k (£178k in 2019/20).

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

Note 8 Pension costs

Note 8.1 NHS Pension Schemes

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care 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 scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018, Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 8.2 Other Pension Schemes

The Trust also makes pension contributions towards a small number of the Trust's employees (11 employees in 2020/21, 17 employees 2019/20) who are members of the National Employment Savings Trust. The Trust's contribution to this scheme was £5,006 in 2020/21 (£7,818 in 2019/20).

Note 9 Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where Trust is the lessee.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	1,436	1,232
Total	**1,436**	**1,232**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	1,149	934
- later than one year and not later than five years;	4,116	3,149
- later than five years.	6,972	7,694
Total	**12,237**	**11,777**

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 £968k including VAT in 2020/21 (£905k including VAT 2019/20). 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.

Note 10 Finance income

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

	2020/21 £000	2019/20 £000

*The reduction in interest on bank accounts in 2020/21 compared to 2019/20 primarily reflects lower interest rates on bank account balances.

Note 11 Finance expenditure

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

	2020/21 £000	2019/20 £000
Interest expense:		
Loans from the Department of Health and Social Care *	32	1,606
Total interest expense	**32**	**1,606**

* The reduction in interest expenditure in 2020/21 compared to 2019/20 reflects the changes to the NHS cash regime which were implemented in 2020/21. On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21, existing DHSC interim revenue loans, interim working capital facility balances and interim capital loans were repaid and replaced with the issue of Public Dividend Capital (PDC). In September 2020, PDC of £117.9m was drawn down which enabled borrowing of an equivalent value to be repaid. This resulted in significantly lower interest expenditure 2020/21 compared to 2019/20.

Note 12 Dividend on Public Dividend Capital (PDC)

The calculation of the dividend on PDC is based on the Trust's relevant net assets which is explained in detail in note 1.17. The dividend on PDC in 2020/21 is £3.035m compared to £NIL in 2019/20. This increase reflects the changes to the NHS cash regime which were implemented in 2020/21. On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21, existing DHSC interim revenue loans, interim working capital facility balances and interim capital loans were repaid and replaced with the issue of Public Dividend Capital (PDC). In September 2020, PDC of £117.9m was drawn down which enabled borrowing of an equivalent value to be repaid. The increase in PDC caused expenditure on PDC dividend to increase substantially in 2020/21 compared to 2019/20. The dividend on PDC for 2020/21 and 2019/20 is reported in the SOCI.

Note 13 Other gains / (losses)

	2020/21 £000	2019/20 £000
Gains on disposal of assets	-	-
Losses on disposal of assets	-	(3)
Total losses on disposal of assets	**-**	**(3)**

Note 14 Intangible assets

Note 14.1 Intangible assets - 2020/21

	Software licences £000	Intangible Assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**7,823**	**-**	**7,823**
Additions	1,368	-	**1,368**
Valuation / gross cost at 31 March 2021	**9,191**	**-**	**9,191**
Amortisation at 1 April 2020 - brought forward	**6,773**	**-**	**6,773**
Provided during the year	673	-	**673**
Amortisation at 31 March 2021	**7,446**	**-**	**7,446**
Net book value at 31 March 2021	**1,745**	**-**	**1,745**
Net book value at 1 April 2020	**1,050**	**-**	**1,050**

Note 14.2 Intangible assets - 2019/20

	Software licences £000	Intangible Assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	**7,449**	**-**	**7,449**
Additions	-	374	374
Reclassifications	374	(374)	-
Valuation / gross cost at 31 March 2020	**7,823**	**-**	**7,823**
Amortisation at 1 April 2019 - as previously stated	**5,588**	**-**	**5,588**
Provided during the year	1,185	-	1,185
Amortisation at 31 March 2020	**6,773**	**-**	**6,773**
Net book value at 31 March 2020	**1,050**	**-**	**1,050**
Net book value at 1 April 2019	**1,861**	**-**	**1,861**

Note 15 Property, plant and equipment - 2020/21

Note 15.1 Property, plant and equipment - 2020/21

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and machinery £000	Information Technology £000	Furniture and fittings £000	Total £000
Valuation/gross cost at 1 April 2020 - brought forward	**15,699**	**79,804**	**2,048**	**5,398**	**27,341**	**9,594**	**1,406**	**141,290**
Additions	-	-	-	8,819	146	-	-	**8,965**
Impairments	-	(2,966)	-	-	-	-	-	**(2,966)**
Revaluations	1,548	(4,818)	176	-	-	-	-	**(3,094)**
Reclassifications	-	4,767	-	(7,912)	1,587	1,431	127	-
Valuation/gross cost at 31 March 2021	**17,247**	**76,787**	**2,224**	**6,305**	**29,074**	**11,025**	**1,533**	**144,195**
Accumulated depreciation at 1 April 2020 - brought forward	-	51	-	-	21,123	7,322	343	**28,839**
Provided during the year	-	2,990	107	-	1,300	610	175	**5,182**
Impairments	-	-	-	-	-	-	-	-
Revaluations	-	(2,987)	(107)	-	-	-	-	**(3,094)**
Accumulated depreciation at 31 March 2021	**-**	**54**	**-**	**-**	**22,423**	**7,932**	**518**	**30,927**
Net book value at 31 March 2021	**17,247**	**76,733**	**2,224**	**6,305**	**6,651**	**3,093**	**1,015**	**113,268**
Net book value at 1 April 2020	**15,699**	**79,753**	**2,048**	**5,398**	**6,218**	**2,272**	**1,063**	**112,451**

Note 15.2 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and machinery £000	Information Technology £000	Furniture and fittings £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	**17,384**	**78,495**	**2,052**	**4,046**	**25,152**	**8,835**	**1,406**	**137,370**
Additions	-	-	-	5,131	-	-	-	**5,131**
Revaluations	(1,685)	478	(4)	-	-	-	-	**(1,211)**
Reclassifications	-	831	-	(3,779)	2,189	759	-	**-**
Valuation/gross cost at 31 March 2020	**15,699**	**79,804**	**2,048**	**5,398**	**27,341**	**9,594**	**1,406**	**141,290**
Accumulated depreciation at 1 April 2019 - as previously stated	-	48	-	-	19,772	6,758	168	**26,746**
Provided during the year	-	2,839	102	-	1,351	564	175	**5,031**
Impairments	-	62	-	-	-	-	-	**62**
Revaluations	-	(2,898)	(102)	-	-	-	-	**(3,000)**
Accumulated depreciation at 31 March 2020	**-**	**51**	**-**	**-**	**21,123**	**7,322**	**343**	**28,839**
Net book value at 31 March 2020	**15,699**	**79,753**	**2,048**	**5,398**	**6,218**	**2,272**	**1,063**	**112,451**
Net book value at 1 April 2019	**17,384**	**78,447**	**2,052**	**4,046**	**5,380**	**2,077**	**1,238**	**110,624**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Information Technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	17,247	73,996	2,224	6,305	6,247	3,093	655	109,767
Owned - donated/granted	-	2,737	-	-	404	-	360	3,501
NBV total at 31 March 2021	**17,247**	**76,733**	**2,224**	**6,305**	**6,651**	**3,093**	**1,015**	**113,268**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Information Technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	15,699	77,460	2,048	5,398	5,771	2,272	628	109,276
Owned - donated/granted	-	2,293	-	-	447	-	435	3,175
NBV total at 31 March 2020	**15,699**	**79,753**	**2,048**	**5,398**	**6,218**	**2,272**	**1,063**	**112,451**

Note 16 Donations of property, plant and equipment

During 2020/21, donated asset acquisitions of £2,449k were recognised (£92k 2019/20). The significant donations are:

1. Creation of a patients' garden £1,605k (Horatio's Garden Charity)
2. SPECT CT imaging equipment £668k (RNOH Charity).

Note 17 Revaluations of property, plant and equipment Property

During 2020/21, 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 2021. The firm had previously undertaken a similar valuation as at 31 March 2020. The partner in charge of the valuations 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 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 90 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 18 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	246	232
Consumables	2,560	1,995
Energy	47	59
Other	70	70
Total inventories	**2,923**	**2,356**

Inventories recognised in expenses for the year were £17,355k (2019/20: £16,899k). Write-down of inventories recognised as expenses for the year were £212k (2019/20: £548k).

In response to the COVID-19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £2,003k of items purchased by DHSC.

These centrally procured inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19 Receivables

Note 19.1 Current and Non-current Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	9,037	19,531
Contract assets	10	1,914
Allowance for impaired contract receivables / assets	(1,259)	(646)
Allowance for other impaired receivables	(661)	(452)
Prepayments (non-PFI)	1,572	1,328
PDC dividend receivable	70	-
VAT receivable	688	462
Other receivables	7	(6)
Total current receivables	**9,464**	**22,131**
Non-current		
Contract receivables	796	1,119
Other receivables	479	431
Total non-current receivables	**1,275**	**1,550**
Of which receivable from NHS and DHSC group bodies:		
Current	5,407	17,269
Non-current	479	431

Note 19.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables contract assets £000	All other receivables £000	Contract receivables contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	**646**	**452**	**534**	**448**
New allowances arising	748	253	166	155
Changes in existing allowances	(135)	(44)	-	(23)
Reversals of allowances -	-		(54)	(128)
Allowances as at 31 March 2021	**1,259**	**661**	**646**	**452**

Note 20 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.

	2020/21 £000	2019/20 £000
At 1 April	**24,435**	**21,930**
Net change in year	14,258	2,505
At 31 March	**38,693**	**24,435**
Broken down into:		
Cash at commercial banks and in hand	16	46
Cash with the Government Banking Service	38,677	24,389
Total cash and cash equivalents as in SoFP	**38,693**	**24,435**

Note 21 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	3,860	8,972
Capital payables	1,921	1,468
Accruals	13,986	13,388
Social security costs	1,212	1,208
Other taxes payable	1,108	1,037
Other payables	1,474	1,719
Total current trade and other payables	**23,561**	**27,792**
Of which payables from NHS and DHSC group bodies:		
Current	**3,998**	**5,341**

Note 22 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	4,472	2,979
Total other current liabilities	**4,472**	**2,979**

Note 23 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC*	71	118,403
Total current borrowings	**71**	**118,403**
Non-current		
Loans from DHSC	1,224	1,292
Total non-current borrowings	**1,224**	**1,292**

*On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue loans, interim working capital facility balances and interim capital loans were repaid and replaced with the issue of Public Dividend Capital (PDC). In September 2020, PDC of £117.9m was drawn down which enabled loans of an equivalent value to be repaid.

Note 24 Reconciliation of liabilities arising from financing activities

Note 24.1 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC £000	Other loans £000	Total £000
Carrying value at 1 April 2020	**119,695**	**-**	**119,695**
Cash movements:			
Financing cash flows - payments and receipts of principal*	(118,122)	-	**(118,122)**
Financing cash flows - payments of interest	(310)	-	**(310)**
Non-cash movements:			
Application of effective interest rate	32	-	**32**
Carrying value at 31 March 2021	**1,295**	**-**	**1,295**

*On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue loans, interim working capital facility balances and interim capital loans were repaid and replaced with the issue of Public Dividend Capital (PDC). In September 2020, PDC of £117.9m was drawn down which enabled loans of an equivalent value to be repaid.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Other loans £000	Total £000
Carrying value at 1 April 2019	**105,456**	**19**	**105,475**
Cash movements:			
Financing cash flows - payments and receipts of principal	14,216	(19)	14,197
Financing cash flows - payments of interest	(1,583)	-	(1,583)
Non-cash movements:			
Application of effective interest rate	1,606	-	1,606
Carrying value at 31 March 2020	**119,695**	**-**	**119,695**

Note 25 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Legal claims £000	Other £000	Total £000
At 1 April 2020	**586**	**12**	**431**	**1,029**
Change in the discount rate	12	-	-	12
Arising during the year	39	6	48	93
Utilised during the year	(63)	(13)	-	(76)
At 31 March 2021	**574**	**5**	**479**	**1,058**
Expected timing of cash flows:				
- not later than one year;	63	5	-	68
- later than one year and not later than five years;	251	-	479	730
- later than five years.	260	-	-	260
Total	**574**	**5**	**479**	**1,058**

PROVISION FOR EARLY DEPARTURE COSTS

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.

PROVISION FOR LEGAL CLAIMS

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 (NHSLA) 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.

PROVISION FOR 2019/20 PENSION TAX COMPENSATION

Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in the 2019/20 tax year face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme (by completing and returning a 'Scheme Pays' form before 31 July 2021).

The Trust has made a contractually binding commitment to pay them a corresponding amount on retirement, ensuring that they are fully compensated in retirement for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement.

This provision is offset by the commitment from NHS England and the Government to fund the payments to clinicians as and when they arise which is reflected as a receivable in the Trust's financial statements. The provision and offsetting asset will initially increase year on year in line with the pension scheme growth, and be released as commitments are met, i.e. as eligible members retire under the rules of the NHS Pension Scheme. The related receivable is shown as a non-current receivable in note 19.1.

Note 26 Clinical negligence liabilities

At 31 March 2021, £42,493k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal National Orthopaedic Hospital NHS Trust (31 March 2020: £43,785k).

Note 27 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(9)	(7)
VAT repayable to HMRC	(2,077)	-
Gross value of contingent liabilities	**(2,086)**	**(7)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(2,086)**	**(7)**
Net value of contingent assets	**-**	**-**

LEGAL CLAIMS

This 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.

VAT REPAYABLE

HMRC has notified the Trust of the intention to raise an assessment for the repayment of VAT that was previously reclaimed by the Trust. It is considered that this VAT was reclaimed in accordance with HMRC regulations and HMRC have been notified of this. The resolution process that the Trust and HMRC follow is highly likely to take several months and potentially over 1 year from the end of the reporting period.

Note 28 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	1,137	1,355
Intangible assets	478	529
Total	**1,615**	**1,884**

Note 29 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2021 £000	31 March 2020 £000
Not later than 1 year	11,408	11,971
After 1 year and not later than 5 years	12,915	21,042

Total	**24,323**	**33,013**

Note 30 Financial instruments

Note 30.1 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.

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 and Social Care (DHSC). The Trust has one capital loan repayable over 25 years 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.

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 PDC or loans from the DHSC - requests are subject to a prudential borrowing assessment carried out by NHS Improvement and the DHSC. The Trust has historically had access to revenue support loans or revenue support PDC which ensure that the Trust's liquidity remains adequate when revenue deficits are incurred. In 2020/21 the Trust drew down £3.0m in the form of DHSC Interim Revenue Support PDC. There is a reasonable level of assurance that access to adequate DHSC revenue support funding will be available in 2021/22. The Trust is not, therefore, exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets

	Held at ammortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2021		
Trade and other receivables excluding non financial assets	8,369	8,369
Cash and cash equivalents	38,693	38,693
Total at 31 March 2021	**47,062**	**47,062**
Carrying values of financial assets as at 31 March 2020		
Trade and other receivables excluding non financial assets	21,890	21,890
Cash and cash equivalents	24,435	24,435
Total at 31 March 2020	**46,325**	**46,325**

Note 30.3 Carrying values of financial liabilities

	Held at ammortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2021		
Loans from the Department of Health and Social Care	1,295	1,295
Trade and other payables excluding non financial liabilities	19,096	19,096
Total at 31 March 2021	**20,391**	**20,391**
Carrying values of financial liabilities as at 31 March 2020		
the Department of Health and Social Care	119,695	119,695
Trade and other payables excluding non financial liabilities	25,291	25,291
Total at 31 March 2020	**144,986**	**144,986**

Note 30.4 Maturity of financial liabilities

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

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	19,912	143,721
In more than one year but not more than five years	368	374
In more than five years	1,102	1,192
Total	**21,382**	**145,287**

*This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 30.5 Fair values of financial assets and liabilities

Carrying value is a reasonable approximation of fair value for financial assets and liabilities.

For trade and other receivables the carrying value is a reasonable approximation to fair value as, in general, such receivables are expected to be settled within 60 days.

For trade and other payables the carrying value is a reasonable approximation to fair value as, in general, the payment is expected to be released within 60 days of recognition of the payable.

For borrowings the chargeable interest rate has been compared to the interest rates available as at the end of the financial year for loans with similar characteristics. As the difference in interest rates are minimal the carrying value for borrowings is a reasonable approximation to fair value.

Note 31 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	2	7	-	-
Fruitless payments and constructive losses	-	-	3	138
Bad debts and claims abandoned	2	57	-	-
Stores losses and damage to property	-	-	3	26
Total losses	**4**	**64**	**6**	**164**
Special payments				
Ex-gratia payments	5	1	8	8
Total special payments	**5**	**1**	**8**	**8**
Total losses and special payments	**9**	**65**	**14**	**172**
Compensation payments received		-		39

Note 32 Related parties

The Department of Health and Social Care (DHSC) is the parent department of the Trust. During 2020/21, 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 2020/21 or have receivables or payables balances greater than £1.0m as at 31st March 2021 are set out below:

Health Education England
London Regional Office (NHS England)
NHS Bedfordshire CCG
NHS Brent CCG
NHS Ealing CCG
NHS East and North Hertfordshire CCG
NHS England - Core
NHS Harrow CCG
NHS Havering CCG
NHS Herts Valleys CCG
NHS Hillingdon CCG
NHS Kent and Medway CCG
NHS Mid Essex CCG
NHS North Central London CCG
NHS Northamptonshire CCG
NHS Redbridge CCG

NHS Resolution
NHS South East London CCG
NHS South West London CCG
NHS Surrey Heartlands CCG
NHS West Sussex CCG
St George's University Hospitals NHS Foundation
Trust Trust Development Authority (NHS Improvement)
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 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 £45,900 in 2020/21 (2019/20 £45,675) 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 Trust capital expenditure of £698k in 2020/21 for medical equipment acquisitions (£92k 2019/20). During 2020/21, no more than one Trustee of the RNOH Charity at any one time was also a member of the Board of the NHS Trust.

Note 33 Events after the reporting date

On 22nd April 2021, HMRC notified the Trust that HMRC intend to raise an assessment for the repayment of VAT that was previously reclaimed by the Trust under the contracted out services regulations. This is reflected as a contingent liability in note 27.

Note 34 Better Payment Practice code

	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	23,220	99,489	25,014	99,415
Total non-NHS trade invoices paid within target	18,164	76,988	20,848	77,514
Percentage of non-NHS trade invoices paid within target	78.2%	77.4%	83.3%	78.0%
NHS Payables				
Total NHS trade invoices paid in the year	838	10,427	1,136	12,583
Total NHS trade invoices paid within target	605	6,827	733	8,586
Percentage of NHS trade invoices paid within target	72.2%	65.5%	64.5%	68.2%

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

Note 35 External Financing Limit

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

	2020/21 £000	2019/20 £000
Cash flow financing	(9,345)	12,219
External financing requirement	**(9,345)**	**12,219**
External financing limit (EFL)	16,707	15,178
Underspend against EFL	**26,052**	**2,959**

Note 36 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	10,333	5,505
Less: Donated and granted capital additions	(2,449)	(92)
Charge against Capital Resource Limit	**7,884**	**5,413**
Capital Resource Limit	8,546	5,873
Underspend against CRL	**662**	**460**

Note 37 Breakeven Duty Financial Performance

	2020/21 £000	2019/20 £000
Adjusted financial performance surplus (control total basis)	1,846	(10,783)
Remove impairments scoring to Departmental Expenditure Limit	-	62
Breakeven duty financial performance surplus / (deficit)	**1,846**	**(10,721)**

Note 38 Adjusted financial peformance (control total basis)

Surplus / (deficit) for the period	2,271	(10,991)
Remove net impairments not scoring to the Departmental expenditure limit	2,164	-
Remove IandE impact of capital grants and donations	(2,188)	208
Remove net impact of inventories received from DHSC group bodies for COVID-19 response	(401)	
Adjusted financial performance surplus / (deficit)	**1,846**	**(10,783)**

Note 39 Compliance with the Control Total agreed with NHS Improvement

	2020/21 £000	2019/20 £000
Adjusted financial performance surplus/(deficit) (Control Total basis). Further details in SOCI.	1,846	(10,783)
Adjusted deficit Control Total agreed with NHS Improvement	(838)	(1,863)
Under/(over) spend	**2,684**	**(8,920)**

Note 40 Breakeven duty rolling assessment

	1997/98 to £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000
Breakeven duty in-year financial performance		1,026	(911)	1,102	2,078	5,912	235
Breakeven duty cumulative position	(2,954)	(1,928)	(2,839)	(1,737)	341	6,253	6,488
Operating income		94,370	102,469	111,762	120,802	132,331	130,490
Cumulative breakeven position as a percentage of operating income		(2.0%)	(2.8%)	(1.6%)	0.3%	4.7%	5.0%

	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000
Breakeven duty in-year financial performance	(6,076)	(6,796)	(11,807)	(12,634)	(10,721)	1,846
Breakeven duty cumulative position	412	(6,384)	(18,191)	(30,825)	(41,546)	(39,700)
Operating income	131,628	140,587	143,653	155,126	169,696	182,053
Cumulative breakeven position as a percentage of operating income	0.3%	(4.5%)	(12.7%)	(19.9%)	(24.5%)	(21.8%)

Note 41 Segmental Reporting

Two criteria need to be satisfied under IFRS 8 Operating Segments to require the disclosure of a separate operating segment in the financial statements:

- The service meets the criteria for a separate operating segment.
- Quantitative thresholds are met.

Getting It Right First Time (GIRFT) services involve the collection, analysis, interpretation and presentation of clinical data. It does not involve the provision of clinical interventions directly to patients which is a feature of the Trust's core services. The income generated by the GIRFT service was greater than 10% of the Trust's income in 2019/20 however in 2020/21 income generated by the GIRFT service represents less than 10% of the Trust's income. Both the criteria within IFRS 8 Operating Segments were met in 2019/20 and the GIRFT service was reported as a separate operaing segment in the 2019/20 financial statements. As one of the necessary criteria is not met in 2020/21 the GIRFT service is not shown as a separate operating segment in the 2020/21 financial statements. The prior-year comparitor only for the GIRFT operating segment is included in the 2020/21 financial statements.

Balance sheet information was not held separately for the GIRFT services segment in 2019/20.

GIRFT Services Operating Segment 2019/20 (prior year)

	2019/20 GIRFT £000	2019/20 Other £000	2019/20 Trust Total £000
Income from patient care activities by nature:*			
Block contract / system envelope income	-	75,141	75,141
High cost drugs income from commissioners (excluding pass-through costs)	-	8,754	8,754
Other NHS clinical income	-	36,122	36,122
Private patient income	-	7,605	7,605
Additional pension contribution central funding**	-	3,759	3,759
Other clinical income	-	1,034	1,034
Total income from activities	**-**	**132,415**	**132,415**
Other operating income			
Other operating income from contracts with customers:*			
Research and development (contract)	-	1,286	1,286
Education and training (excluding notional apprenticeship levy income)	-	2,156	2,156
Non-patient care services to other bodies	-	434	434
Provider sustainability fund (PSF)	-	9,625	9,625
Financial Recovery Fund fund income (FRF)		469	469
Other contract income	20,034	3,110	23,144
Other non-contract operating income			
Receipt of capital grants and donations	-	92	92
Charitable and other contributions to expenditure	-	75	75
Total other operating income	**20,034**	**17,247**	**37,281**

Operating expenses

	2019/20 GIRFT £000	2019/20 Other £000	2019/20 Trust Total £000
Purchase of healthcare from NHS and DHSC bodies	-	715	715
Purchase of healthcare from non-NHS and non-DHSC bodies	-	1,346	1346
Staff and executive directors costs	11,511	88,600	100111
Remuneration of non-executive directors	-	89	89
Supplies and services - clinical (excluding drugs costs)	56	29,043	29099
Supplies and services - general	-	7,243	7243
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	-	4,709	4709
Inventories written down	-	548	548
Consultancy costs	6,846	697	7543
Establishment	1,265	1,383	2648
Premises - business rates collected by local authorities	-	701	701
Premises	138	5,249	5387
Transport (including patient travel)		4,023	4023
Depreciation on property, plant and equipment	-	5,031	5031
Amortisation on intangible assets	-	1,185	1185
Net impairments	-	62	62
Movement in credit loss allowance: contract receivables / contract assets	-	112	112
Movement in credit loss allowance: all other receivables and investments	-	4	4
Increase/(decrease) in other provisions	-	46	46
Change in provisions discount rate(s)	-	22	22
Audit fees payable to the external auditor			
audit services- statutory audit	-	58	58
other auditor remuneration (external auditor only)	-	10	10
Internal audit costs	-	48	48
Clinical negligence	-	3,430	3430
Legal fees	9	314	323
Research and development	-	1,311	1311
Education and training	32	1,523	1555
Education and training - notional expenditure funded from apprenticeship fund	-	203	203
Rentals under operating leases	-	1,232	1,232
Redundancy	-	9	9
Hospitality	88	25	113
Other	89	203	292
Total	**20,034**	**159,174**	**179,208**

* See disclosures relating to the prior year at notes 2.1, 2.2 and 2.3.

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

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of the Royal National Orthopaedic Hospital NHS Trust (the 'Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; 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, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to

continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Directors with respect to going concern are described in the 'Responsibilities of the Directors and Those Charged with Governance for the financial statements' section of this report.

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 audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the 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 in April 2020 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, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, 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 issue a report 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 refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has 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 make 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 except on 28 June 2021 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the Royal National Orthopaedic Hospital NHS Trust's breach of its breakeven duty for the three-year period ending 31 March 2021.

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

As explained in the Statement of directors' responsibilities in respect of the accounts, 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 they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit and the Audit Committee , whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and the recognition of both revenue and expenditure. We determined that the principal risks were in relation to:
  - journal entries we identified that met elevated risk criteria determined through the course of the audit;
  - potential management bias in determining accounting estimates, especially in relation to:
    - the calculation of the valuation of the Trust' s land and buildings; and
    - accruals of income and expenditure at the end of the financial year.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a particular focus on significant journals at the end of the financial year which impacted on the Trust's financial performance;
  - testing of how management made the significant accounting estimates in respect of land and building valuations and challenging assumptions and judgements made by management in making the estimate;
  - substantive procedures to confirm the completeness of income and operating expenditure with a particular emphasis on payables and transactions recorded close to and after 31 March 2021;
  - challenging assumptions and judgements made by management in making year end income and expenditure accruals; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the Trust's ongoing breach of its breakeven duty, the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to land and buildings valuations, income and expenditure accruals.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS Improvement's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:

- the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
- the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – 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 – the 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 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust , the Chief Executive, as 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. 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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for the Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

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.

Iain Murray

Iain Murray, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

29 June 2021

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

In our auditor's report issued on 29 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had:

- Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 29 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then end;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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

Report on other legal and regulatory requirements - 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 – the 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 2021.

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

Responsibilities of the Accountable Officer

The Chief Executive, as 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. 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;

- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of the Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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.

Iain Murray

Iain Murray, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London

20 September 2021

2020-21

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