

NHS
Royal National Orthopaedic Hospital
NHS Trust



ANNUAL REPORT 2022-23



About this document

The Annual Report comprises of two parts

The Performance Report

The Performance Report 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 Accountability Report

The Accountability Report is divided into the Corporate Governance Report which explains the composition and governance structures and how they support the Trust in achieving its objectives. It is made up of the Directors' Report containing the Director's details and disclosures for the financial year, the Statement of Accountable Officer's responsibilities which 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 31 March 2023. A copy of the full Annual Report and accounts can be obtained from **www.rnoh.nhs.uk**

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



Chief Executive Officer
29 June 2023


RNOH

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Part 1:
Introduction and Welcome

Welcome from Doris Olulode, Chair from April 2023, Dominic Dodd, Chair to April 2023, and Professor Paul Fish, Chief Executive and Accountable Officer



Doris Olulode
Chair
(from April 2023)



Dominic Dodd
Chair
(to April 2023)



Paul Fish
Chief Executive

Welcome to our 2022-2023 Royal National Orthopaedic Hospital (RNOH) Annual Report. As we reflect on the past year, we feel tremendously proud of our staff and what they have achieved at a time of many challenges. During this last year, their efforts have led to recognition for the RNOH as:

- One of the best orthopaedic hospitals in the world, ranking in the top ten globally and as the best in the UK (Newsweek 2022).
- Amongst the top performers in the NHS for patient experience, scoring particularly highly for how patients are involved in decisions about their care, ensuring patients know how to reach us if they're worried after they have left hospital and for our doctors communicating effectively with patients (NHS National Patient Survey).
- Amongst the top performers in the NHS for staff experience, ranking as the top acute specialist trust in London overall, number one versus all London trusts on four categories including staff engagement and morale, number one in North Central London (NCL) on all but one category and consistently above average nationally in all categories (NHS National Staff Survey).

We are however not complacent and recognise that improvement is required to ensure all our patients and staff experience the very best at RNOH.

Firstly, we remain fully committed to addressing the number one priority for our patients which is to reduce the time they have to wait. While RNOH has continued our journey of recovery from the effects of the COVID-19 pandemic, there remains a gap between when we would ideally see patients and the time they are currently having to wait.

This last year has seen a number of successful initiatives to improve our operating efficiency and ability to see more patient more effectively such as by reducing unnecessary delays in getting patients home after treatment. We have also been planning the expansion of our theatre capacity with four new theatres to help us reduce waiting times. This has required a real focus across the organisation on what can be delivered through all our facilities, and as ever, our teams have risen to the challenge. We expect the new theatre capacity to be fully up and running by the end of 2023.

In caring for our patients, our greatest assets are our people and it has been a difficult year for them. Amongst all the challenges of this year, staff have felt the effects of the cost of living crisis and there has been industrial action across the country. And we know from the national staff survey that low scores on recognition and reward were a concerning theme across the NHS alongside burnout, the RNOH being no exception. So, we have put considerable effort behind a range of initiatives supporting staff welfare including for example, through our Cost of Living Group to signpost staff to independent advice, support as well as to NHS discount schemes.

RNOH has worked hard to continue to close the gap between the experience of staff with protected characteristics and other staff, especially those with disabilities, and this focus will remain.

Alongside the work to improve patient and staff experience for today, we are continuing to work to put in place the capabilities and investments we need for an ever-stronger organisation for tomorrow. We believe that three changes in particular will prove to be critical:

New divisional structure to support our growth strategy

Through the latter part of 2022/23 the Trust prepared for the launch of its new divisional structure, which went live on 1 April 2023. The structure creates divisions called RNOH Specialist Services (within which Children's Services currently sits), RNOH Local Services, and RNOH Private Care.

The new structure will give our clinical and non-clinical leaders the freedom, authority and accountability to deliver our longer-term strategy for growth, greater value for taxpayers' money, and the best patient and staff experience in the NHS. For example, with RNOH Local, through our community hub in Enfield, we are providing our first local service for patients to access musculoskeletal services without the need to see a GP first. This and other innovations are supported by the new structure.

Innovation with partners

As part of our partnership work as part of the NCL integrated care system and UCL Health Alliance, RNOH is leading change across our local communities in how patients can access the best possible care. We're looking at the whole of the patient journey to find ways to get help to those who need it more quickly. We're excited that UCL Health Alliance is one of only nine collaboratives nationally to been accredited by NHS England with Innovator Status which will help to accelerate innovations which benefit the residents we serve. This is a real opportunity for us to affect change for our local population and be a test bed for system-wide change and innovation with the potential for establishing new best practices with national relevance.

Digital

Investing in our digital infrastructure is key to driving forward our ambitions. This year we have put in place Electronic Prescribing and Medicines Administrations and Electronic Discharge Summaries for all patients across the Trust and launched a number of new applications such as for the management of referrals, for capturing patient reported outcomes and for pre-operative assessment and patient consent. These are important milestones for us in improving patient safety and supporting continuous learning and improvement. Also the Trust has focussed on a programme to bring Electronic Patient Records to RNOH, with Board approval for an Outline Business Case, and work ongoing to develop a full business case. This is an ambitious and truly transformative programme for the whole organisation, and one which will challenge many of our traditional ways of working with the aim of ensuring the care and treatment delivered to our patients is even safer and more effective than that delivered today.

Throughout all of these changes, we have been, and remain incredibly proud to lead RNOH as it continues to strive to deliver the very best care and we would like to thank all of our staff and patients for everything they have done over the last year to work together in support of that aim.



Doris Olulode
Chair
(from April 2023)



Dominic Dodd
Chair
(to April 2023)



Paul Fish
Chief Executive

Part 2:
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" or "Trust") 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. The Trust also offers direct access to specialist MSK services through its Enfield Musculoskeletal Community Health Hub.

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. Underlining our commitment to the achievement of this vision, RNOH was within the top 9 NHS performers nationally for patient experience.

During 2022/23, RNOH provided specialist orthopaedic care to 14,440 Inpatients at the Stanmore site. Altogether, there were 143,173 outpatient attendances: 115,486 outpatient attendances at the Stanmore site, 27,158 outpatient attendances at the Bolsover street site, and 529 at other locations.

Patients from all four countries of the UK have received these high quality services from RNOH.

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

The Trust directly employs 1,637 people with hundreds more employed by partners supporting its work. It provides services on three sites; the Stanmore Hospital site which is a 189 bed hospital with capacity for 16 intensive care patients and is set in 112 acres of land in the London Borough of Harrow, the Bolsover Street site which attends to outpatient cases only and is located in Central London, and the Musculoskeletal community hub, which is located in Enfield.

Through 2022/23 RNOH clinical services were incorporated into six clinical divisions, however from April 2023 this was amended to three clinical divisions: RNOH Specialist Services (within which Children's Services currently sits, but will in time develop into a division in its own right), RNOH Local Services, and RNOH Private Care. The clinical services provided by RNOH are:

- Anaesthesia;
- Children and Young People Service;
- Chronic Pain Management;
- Clinical Neurophysiology;
- Clinical Psychology;
- Foot and Ankle Service;
- Functional Assessment and Restoration (FARs);
- Histopathology Services;
- Imaging Services;
- Implant Science;
- Integrated Back Service;
- Joint Cartilage Transplantation;
- Limb Reconstruction;
- London Spinal Cord Injury Centre;
- Myeloma Service;
- Neuromodulation;
- Neurourology;
- Nuclear Medicine;
- Orthopaedic – Specialist Hip and Knee;
- Orthopaedic Oncology;
- Orthotics Service;
- Osteoporosis and Metabolic Bone Disease;
- Pathology Services;
- Peripheral Nerve Injury Service;
- Plastic Surgery;
- Pharmacy and medicines optimisation;
- Private Care;
- Prosthetic Rehabilitation Service;
- Psychiatry;
- Rehabilitation and Therapy;
- Rheumatology;
- Sarcoma Service;
- Scoliosis;
- Shoulder and Elbow Service;
- Spinal Surgical Service;
- Sport, Exercise and Musculoskeletal Medicine;
- Urology.

Statement from the Chief Executive Officer

Throughout this year, RNOH has continued to play a critical role in providing specialist care and treatment to patients from across the UK, and has played a key role specifically across the NCL Integrated Care System, and UCL Health Alliance, providing leadership in the spheres of innovation and musculoskeletal pathway development. Also this year, the Trust has continued to focus on our people, our culture and staff wellbeing with a renewed focus on equality, diversity and inclusion.

As part of the drive to ensure we deliver the best working culture, the staff wellbeing hub was launched this year, with the kind support of RNOH Charity. I am particularly proud that this year saw the launch of RNOH Patient Charter, produced with our Patient Experience Co-Production Group and over 70 RNOH staff. After a two-year enforced absence of such face to face events, it was a pleasure this year to meet with so many colleagues at the Nurses' Day this year, to celebrate their vital contribution to RNOH. A number of events were held over the summer period to mark 100 years of RNOH on the Stanmore site, and I am so grateful to our staff at Stanmore, Bolsover Street and Enfield for all that they do.

RNOH continues to make good progress with respect to staff experience, with results of the most recent NHS staff survey being above the NHS nationally, averaged across all areas, and with RNOH being ranked first, ahead of London Acute Specialist Trusts, and London Trusts for staff engagement, morale and safe and healthy. The Trust also led the way across NCL in all but one category which relates to recognition and reward, which was an area of concern across the NHS, and which is an area of focus for the Trust as we move forward.

Throughout a year which has seen the organisation's journey of recovery from the COVID 19 pandemic continue, our staff and volunteers have continued to make an outstanding contribution to the delivery of world class care and treatment and I am immensely proud of their dedication and professionalism towards our patients and each other.

Through the NCL Integrated Care System, RNOH shares a collective commitment to deliver changes that will improve the health and wellbeing of patients and residents. Integrated Care Systems were introduced 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 residents and patients.

With respect to operational performance, staff across the organisation have worked incredibly hard to ensure patients have been able to access care and treatment as effectively as possible, despite the ongoing effects of reduced activity during 2020/21 and 2021/22 as a result of the pandemic. For Referral to Treatment, at the end of March 2023, the Trust reported one patient with a wait exceeding 78 weeks, and this patient was treated in April, ahead of the revised target of eradicating 78 week waits by the end of June 2023.

The Trust's cancer performance has seen 100% achieved against the two week wait target for the first consultation following urgent GP referral, every month this year, as well as both 31 day standards throughout 2022/23.

The Trust has remained challenged by the 62 day wait from referral to treatment, for which patient numbers are relatively low, meaning a single breach for which RNOH is accountable can cause the organisation to fail the standard in any given month. Overall for 2022/23 the Trust achieved 82.3%, with recent performance surpassing the 85% target, with 93.6% in Quarter 4.

RNOH has continued to work hard on innovation, alongside partners in the NCL Integrated Care System, as well as the UCL Health Alliance and plays a key leadership role in this system for musculoskeletal patients. Key to this is the holistic view we take of our patients, ensuring those that need help can access it more quickly and conveniently, and working hard to make sure we increase opportunities for prevention, and early diagnosis of conditions.

The NHS England Provider Collaborators Innovator Scheme for which UCL Health Alliance has been selected will assist in decreasing the time taken to develop and implement innovations. RNOH continues to play a key role with Trusts across the Federation of Specialist Hospitals, highlighting the unique work, and opportunities these organisations provide to the NHS and wider health economy, and working together on specific issues of joint interest.

The long term outlook for financial sustainability across the NHS remains challenging, with challenging performance and financial targets through the coming year, coupled with increasingly challenging Cost Improvement Plan (CIP) targets, with the target for RNOH for 2023/24 being £10.9m. The NHS, and the Trust continues to tackle the backlog of patients which grew through the COVID 19 pandemic, with a focus on safely delivering high quality services under continued pressure. Key to achieving this, is the Trust's strategic pillars of growth and efficiency, with the purpose of moving the Trust towards operational and financial sustainability in the medium to long term.

Throughout the year, and in the year to come, a key risk to delivery of the Trust's strategy remains recruitment, retention and development of clinical professionals including nurses, doctors and allied health professionals.This year international recruitment has been undertaken, for instance to fill radiographer vacancies, and to ensure the workforce is in place to support the Trust's new theatres.Greater availability of data and metrics through the shared recruitment service (North London Partners Shared Services – NLPSS) is assisting recruitment across RNOH. This year the organisation has introduced an Equality, Diversity and Inclusion strategy programme Board, which oversees a number of workstreams with good engagement and progress against initial targets.

A further ongoing risk which has emerged in the latter part of 2022/23 is that of ongoing industrial action across a number of professional disciplines within the NHS, and its potential to impact services at RNOH. I, and the Executive team will continue to work with the unions to ensure patient safety remains at the centre of planning for such action.

The Trust delivered a financial surplus for 2022/23, and a favourable variance to plan, which was largely driven by factors including Elective Recovery Funding, favourable expenditure variances linked to lower activity than plan, and divisional pay underspend. In order to achieve its strategic aims, the organisation will need to continue to focus on growth of both NHS and non-NHS income, alongside productivity improvements, coupled with effective collaboration with system partners.

Elective Recovery Funding, favourable expenditure variances linked to lower activity than plan, divisional pay underspend, prior year benefit and delayed phasing of investment spend offset by unachieved CIP, contract variances, inflation pressures and impairments.

This year the Board approved an Outline Business Case for a truly transformative Electronic Patient Record for RNOH. The organisation is now engaged in the development of a Full Business Case (FBC) for a system which will require transformation of many ways of working, as well as patient pathways, to maximise the safety and efficiency of patient care and treatment.

This year also marked 25 years of RNOH Charity, which continues to provide support for the people, research and infrastructure that make RNOH one of the best orthopaedic hospitals in the world. In 2022/23, the Charity awarded over £193k in grants. These included £65k for Stanmore Children's Outcome Orthopaedic Project (SCOOP), £17.6k for a research study into bladder over activity after spinal cord injury, £17.5k towards staff achievement awards and RNOH100 garden party, and £5k each for patient equipment for Occupational Therapy and enhancements to teenage space on Coxen Ward.

In addition, the Charity funded projects throughout the year amounting to £650k. These included £36k to fund a Faro laser scanner, £49k towards 3D MRI research projects, £77k for the CCOPER mental health research project, £210k towards the purchase of a digital histopathology scanner for the DNA sequencing of sarcoma, £110k towards the running of the Volunteer Service and £81k to fund the Wellbeing Hub and our Staff Wellbeing Lead.

Furthermore, £56k was also spent from special purpose funds on courses, small pieces of equipment, and staff away days in line with special purpose fund guidance. We are very grateful for the Charity's work in enhancing the experience of our patients and our staff.

Although relating to after the close of the year to which this report relates, it is important to recognise, that after three years at the Royal National Orthopaedic Hospital (RNOH), Dominic Dodd stepped down as Chair at the start of April 2023 to focus on his role as Chair of UCL Health Alliance. He will continue to be involved with RNOH through his role in UCL Health Alliance.

Dominic Dodd's time leading RNOH's board of directors has seen a major change in the RNOH leadership team and strategy, as well as all the challenges of the pandemic. Dominic has been instrumental in helping to set the direction of the Trust over recent years and in establishing the Trust as an important partner in the care of our local populations, as well as those patients that we see nationally. I am extremely grateful for all that Dominic has done for us over these recent years and I look forward to continuing to work with him in his role at UCL Health Alliance.

Following Dominic's departure, I am delighted that Doris Olulode, who was already serving as a Non-Executive Director at RNOH has been appointed Chair of the Trust. Doris is an exceptionally talented and experienced leader who has played a pivotal role in the Trust board over recent years and I look forward to working with her leading the board over the coming years as we continue to deliver our new strategy.

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. Currently, patients receive care and treatment within these services in around 30 hospitals in England, of which three are specialist Trusts like RNOH.

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 extend our influence as a world-leading orthopaedic hospital with the best patient care and staff experience in the NHS. The vision is supported by a strategy which was approved by the Trust Board in May 2022, and which has three strategic pillars; growth, efficiency, and people, supported by a number of enablers, as set out opposite.

This year also marked 25 years of RNOH Charity, which continues to provide support for the people, research and infrastructure that make RNOH one of the best orthopaedic hospitals in the world

We are very grateful for the Charity's work in enhancing the experience of our patients and our staff



Growth
from £140M to £400M in 5 years

- Growth in tertiary services so that 30% of national activity is undertaken at the RNOH (RNOH Stanmore/RNOH Kids)
- Growth in private practice, from £8m to £60m per year turnover and reinvest back in to our core (RNOH Private Care)
- Establish and grow first contact and secondary care MSK services in London and nationally (RNOH Local)
- Boost our Academic programmes and drive innovation in orthopaedic service delivery (RNOH Innovation)



Efficiency
reference cost index reduced to 115

- Deliver top decile performance in length of stay and theatre efficiency
- Achieve efficiency and improved service resillience through a shared service model for corporate and clinical support services
- Improve our social value impact – both sustainability and community



People
achieving the best staff/ patient experience of any provider nationally

- Achieve the best staff experience of any provider nationally – evolving our culture as we grow
- Recruit and develop a diverse talent pool
- Deliver a step change in our workforce development programme
- Achieve the best patient experience of any provider nationally



Enablers
working collaboratively across the local and national system

- Partnerships – Clinical e.g., RFL London/GOSH/NOA (GIRFT), the RNOH Charity
- Infrastructure – Digital (e.g.,EPR) and Estates
- Specialist commissioning
- System leadership for MSK – System Access/System Wide PTLs, Pathway enablers

Within 2022/23, the Trust has made progress across all areas, with some key achievements set out below.

Growth

- Investment in four new theatre
- Hub role in revision joints and upper limb
- Growth opportunities in spinal, paediatrics and pain being explored
- Over £1m investment in cancer services
- RNOH Local services being delivered through the hub in Enfield
- Strong performance of RNOH private care, closing on £8.4m, with revenue growth of 30% from 2021/22

Efficiency

- Reference Cost Index moved from 144 in 2019/20 to 124 in 2020/21
- Significant improvement in Length of Stay, with transformation of the day case mix
- Amongst the best theatre utilisation (GIRFT metrics) in the country
- Recognised as the ninth best orthopaedic provider in the world, the best in the UK and the only UK orthopaedic hospital in the top 50, by Newsweek

People

- Above the NHS national averaged across all areas of the staff survey
- Ranked number one across London Acute Specialist Trusts
- Ranked number one across London Trusts for staff engagement, morale and safe and healthy
- Top performer compared with NCL trusts in all sections except one (third place)
- Improved Workforce Race Equality Standard Metrics
- Recognised in the top nine NHS performers nationally for patient experience (National in-patient survey), scoring highly for:
  - Our involvement of patients in decisions about their care
  - Ensuring patients know how to reach us if they're worried after they have left hospital
  - Doctors communicating in a way that is easy for patients to understand

Enablers

- Leadership role in system review of musculoskeletal pathways across NCL
- UCL Health Alliance selected for NHS England Provider Collaborative Innovator Scheme – national focus on MSK pathway innovation
- Expansion of theatre capacity, to reduce elective waiting times and assist growth plans
- ePMA and Discharge Summary
- Pathpoint for the management of referrals and patient reported outcomes (PROMS), and for Pre-Operative Assessment and digitising consent
- Outline Business Case for new Electronic Patient Record approved by the Trust Board, and now progressing to Full Business Case stage

Performance Summary

Infection Prevention and Control Team

The RNOH Infection Prevention and Control Team (IPCT) are made up of a Lead Nurse, Clinical Nurse Specialist, a Surgical Site Infection (SSI) Surveillance Nurse, and a SSI Coordinator/Admin who supports the team. The IPCT works within a multi-disciplinary team consisting of a Lead Consultant Microbiologist for IPC, microbiologists and a specialist antimicrobial pharmacist. The IPCT also works alongside the Bone Infection/Outpatient Parenteral Antibiotic Therapy (OPAT) clinical nurse specialists. The IPC team reports to the Chief Nurse/Director for Infection Prevention and Control (DIPC).

During the financial year 2022/23, the team worked to ensure high standards of infection prevention and control practices were maintained in the Trust by providing an expert advisory service to the Trust and its service users. The team ensured all IPC policies and procedures are aligned with recommendations from current guidance from the Department of Health[1] and NHS England[2]. IPC policies are reviewed every 3 years or where there is a change in guidelines. Compliance with these policies is monitored through regular audits including hand hygiene, vascular access device care, environmental spot-checks, urinary catheter care, etc.

The IPC team supported work across the Trust to promote elective recovery by updating protocols and guidelines on testing, isolation and management of patients and staff with respiratory infections, and continued to work with IPC colleagues within the NCL Integrated Care Board to implement coordinated patient pathways. The IPCT continued to provide expert advice to ensure the recovery programme is delivered in the Trust without compromising patient and staff safety.

The IPC Lead through the DIPC, provided assurance to the Board using the NCL Integrated Care Board Assurance Framework (BAF). This provides detail of the systems, and infrastructure, in place to deliver infection prevention and control requirements in the Trust. Any gaps were supported with appropriate action plans and mitigation.

The IPC team continued to carry out surveillance and prompt reporting of healthcare associated infections (HCAIs) to the UK Health Security Agency (UKHSA), which are reported internally to the Infection Prevention and Control Committee (IPCC) and the Integrated Risk and Governance Committee (IGRC) for assurance and monitoring.

All HCAI incidents are reported on the Ulysses incident reporting system. A root cause analysis (RCA) is carried out with the multi-disciplinary teams (MDTs) providing care to the patient. Identified areas requiring improvement and learning from good practice are discussed at the IPCC and the IGRC.

The HCAIs requiring mandatory reporting to UKHSA are:

- Blood-stream infections (BSI) caused by the following organisms:
  - *Staphylococcus aureus*
    - Methicillin-resistant *Staphylococcus aureus* (MRSA)
    - Methicillin-sensitive *Staphylococcus aureus* (MSSA)
- Gram-negative bacteria
  - *Escherichia coli*
  - *Pseudomonas aeruginosa*
  - *Klebsiella species*
- *Clostridioides difficile* infection/colitis
- Surgical Site Infections (SSI) under the mandatory orthopaedic categories of:
  - Spine surgeries
  - Hip surgeries
  - Knee surgeries

NHS England publishes target thresholds annually for all trusts in the country, for each category. For the year 2022-23, RNOH reported HCAI incidents against the threshold shown in the following table.

Financial Year	Blood Stream Infections					Clostridioides difficile Infection	
			Gram-Negative				
2022/23	MRSA	MSSA	Esherichia coli	Klebsiella sp	Pseudomonas aeruginosa	GDH/PCR+ Toxin-	GDH/PCR+ Toxin+
Threshold	**0**	**0**	**4**	**3**	**2**		**3**
Qtr 1	0	0	0	0	0	1	1
Qtr 2	0	0	0	0	0	1	1
Qtr 3	0	1	1	0	1	1	2
Qtr 4	0	1	0	0	0	2	0
			1	**0**	**1**		
Total	**0**	**2**	**2**			**5**	**4**

The Trust has not had a MRSA BSI to report in the last 13 years.

SSI surveillance is carried out by the SSI Surveillance Nurse with the support of the SSI Surveillance Coordinator. While the national requirement by UKHSA is for Trusts to submit at least one quarter's data annually, RNOH continues to report every quarter. SSIs are classified as either superficial, deep or organ space. The surveillance nurse monitors inpatients during their primary admission or when readmitted due to wound problems, and outpatients via a post-discharge questionnaire follow-up.

In the past year, there were 7 outbreak incidents involving patients and staff, all related to COVID-19. These were investigated and managed by IPC working in collaboration with various teams and departments. Each outbreak incident was reported and monitored internally via IPCC and externally to NHS England via the NCL Integrated Care Board.

Compliance with infection prevention practices in the Trust, is monitored via monthly hand hygiene, vascular access device care, and environmental spot-check audits. These audits carried out by ward/clinical teams with the support of the IPC Link Practitioners for their area. Audit outcomes are presented to the IPCC. For areas with low audit outcomes, the nursing leadership teams with the support of IPC, implement an action plan and relevant improvement initiatives.

Other routine audits carried out by the IPC team include:

- Urinary Catheter Care audit, done bi-annually;
- Pre-operative Skin Decolonisation Compliance audit, done bi-annually;
- Pre-admission Screening (MRSA and CPE) audit;
- Theatre Temperature Monitoring audit, both done annually.

Outcomes and learning from audit are shared at the Trust's Clinical Audit Mornings run by the Clinical Audit and Effectiveness Team.

The team continue to participate in ward accreditation and works closely with the Estates Team to oversee standards of cleanliness and risk management. The IPC Lead and the Infection Control Doctor are members of the Water Safety and Ventilation Safety Committees chaired by the Director for Estates which monitor safe water source and ventilation issues across all areas in the Trust. The IPC team has also continued to work with the Winter Vaccination Team to deliver the COVID-19 and Influenza vaccines to staff in the 2022-23 winter campaign.

The IPC team has continued to deliver IPC trainings to all staff during clinical induction, doctors' induction, training days, and ward-based sessions as well as providing incidental teaching as the need arise. All members of staff access the IPC mandatory refresher via eLearning on the Trust's Learning Hub.

This year, the IPC team run successful campaigns in the Trust to mark the annual:

- World Hand Hygiene Day on 5 May 2022;
- World Infection Prevention Week in October 2022;
- World Antimicrobial Awareness Week in November 2022.

The Trust has not had a MRSA BSI to report in the last 13 years

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 a number of 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, you said we did, 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 of contact for members of the public/patients who wish to raise complaints, concerns, and compliments or have a request for information/signposting. The service is responsible for coordinating the process and managing responses once the investigations and updates are received from relevant services.
There were 2,493 PALS contacts recorded (which includes 277 compliments and 2,216 PALS queries (excludes complaints). The overall PALS contacts have increased by 20% compared to the previous year.

Year	2018/19	2019/20	2020/21	2021/22	2022/23
Number of PALS contacts	855	842	938	2,068	2,493

The Trust responded and closed 2,162 of the 2,216 PALS enquires (not including compliments) within 5 working days, a performance figure of 98%. Some PALS queries are complex and require greater scrutiny and time for review.

Performance April 2022-March2023	2021/22	2022/23
No of Complaints received	124	187
% responded to within time	83%	45%
% of complaints acknowledged within 2 working days	100%	100%

There were multiple factors at play in relation to the complaints not responded to within the timeframe including:

- A 50% increase volume of complaints
- Divisional delays caused by annual leave and sickness within the frontline operational teams,
- Quality checking procedure

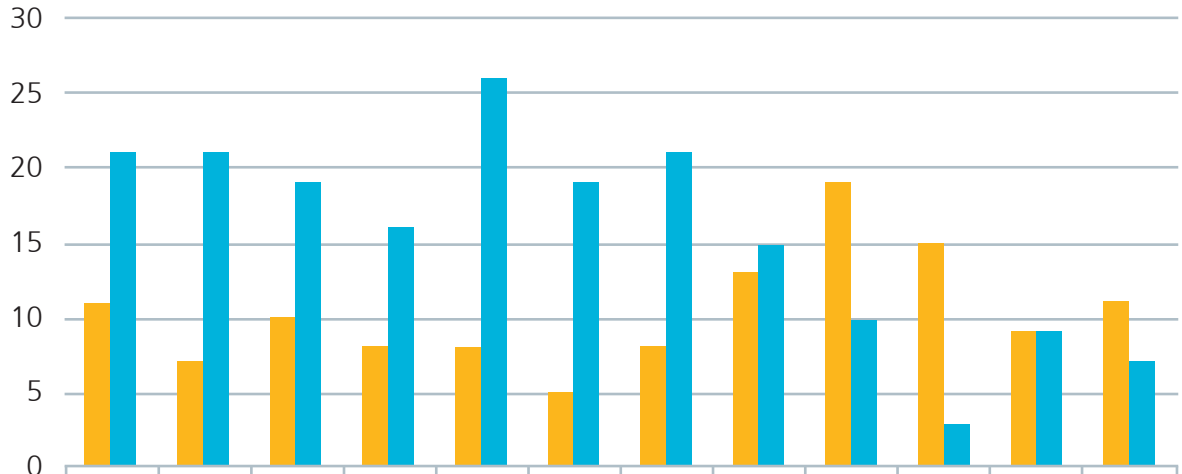
These factors have all led to an increase in the average number of days and the time taken to respond.

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 towards the Trust ambition to ensure that each and every patient and their carer, family and/or friends have a positive, person-centred, experience of care across our Trust. Learning, identifying and sharing good practice from the investigations into complaints and concerns raised remain fundamental to achieving this.

Between the 1 April 2022 and 31 March 2023, the Trust received 187 Complaints compared to 124 complaints in 2021/22. This equates to an average of 16 complaints per month. The increase in the number of complaints has presented a challenge for the complaints team and clinical colleagues in terms of workload and timely responses. The majority of complaints related to communication, attitude of staff, access to services (cancellation and rebooking of appointments or procedures) and Clinical Management.

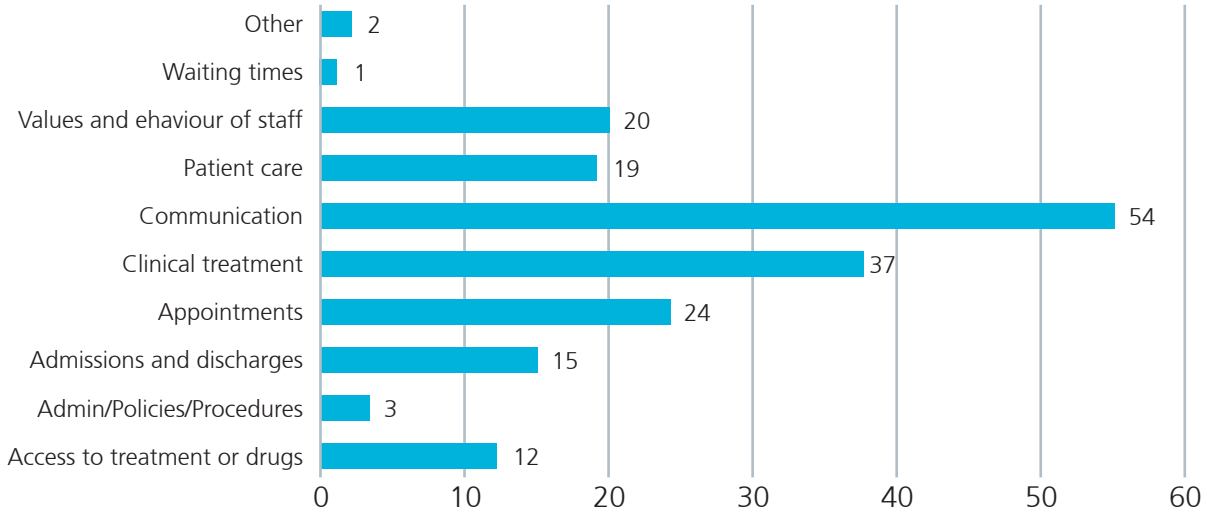
Complaints received 2021/22 and 2022/23



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/2022	11	7	10	8	8	5	8	13	19	15	9	11
2022/2023	21	21	19	16	26	19	21	15	10	3	9	7

The top three themes for the year were; communication, clinical treatment and issues related to appointments. Communication was 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.

Categories of Complaints 2022/2023



Parliamentary and Health Service Ombudsman (PHSO)

Complainants who are dissatisfied with the Trust response have a right to ask that the Parliamentary and Health Service Ombudsman (PHSO) reconsider their complaint. Of the formal complaints received from 1 April 2022 and 31 March 2023, no complainant took their case to the PHSO.

Key improvements during 2022/23:

- Rolled out comprehensive Complaints E Learning course to improve staff confidence in managing and responding to feedback, comments, concerns and complaints.
- Continued to ensure patients/relatives/carers have full accessibility to making a complaint, compliment or PALS. This includes updating information on the Trust's web pages for this service, and any interaction with users of the service.
- Supporting the Trust in preparation for the national Complaints Standards Framework in development by the Parliamentary and Health Service Ombudsman.
- Continued to work on the quality of complaint responses to ensure they meet the needs of the recipient.
- Continued to work on improving and reducing the divisional response times to complaints. As such a weekly divisional meeting was established to better manage the complaint response
- The complaints team continued to make early contact with complainants to pursue informal resolution of complaints.
- Updated Complaints Policy to include processes for making a complaint when a private patient.
- Lesson learnt by the Trust continue to be included in the response letter and any improvements made as a result are shared with the complainant.

Friends and Family Test (FFT)

Friends and Family Test: The Trust continues to learn from the Friends and Family Test (FFT) each month. The feedback is reviewed and shared through the Trust's reporting systems and provides an opportunity to reflect on themes and identify areas for improvement.

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 further escalation as Serious Incident or Never Event.

Serious incidents undergo a detailed investigation and a Clinician led root cause analysis, the results of which are shared with the patient and relatives. Sharing the learning from patient safety incidents plays an important role in the prevention of future errors and improving the quality of care. At RNOH, learning is shared widely through a number of routes. There is a monthly Big4 bulletin shared trust-wide covering the 4 key safety topics of the month. The monthly Medicines Matters newsletter shares the key trends and lessons from Medication incidents.

Staff are supported with the management and investigation of incidents. A trust-wide training programme has been ongoing with weekly and monthly sessions. Staff also have access to additional training via the induction programme.

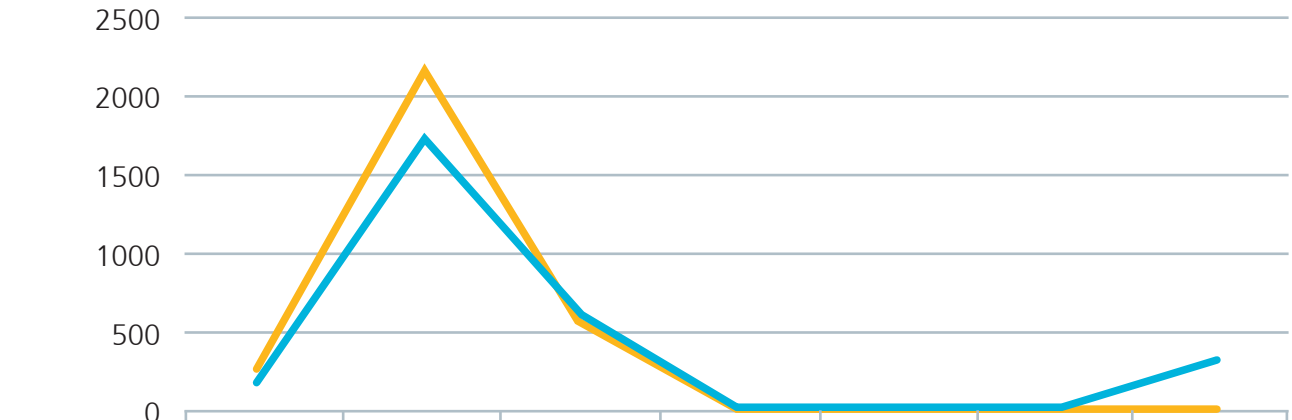
Incident Reporting

The Trust incident-reporting rate is tracked and demonstrates a good and consistent reporting culture. All types of incidents are logged with a broad spectrum of harm including no harm and low-harm incidents.

Staff feel comfortable reporting incidents, and transparency and accountability are valued. By encouraging our staff to report incidents, we are better able to identify patterns and areas for improvement, ultimately leading to a safer environment for our patients. Our focus on patient safety is at the forefront of our mission, and we will continue to prioritise the reporting and analysis of incidents to ensure that we provide the highest quality of care possible.

Incidents by Level of Harm

A comparison of harm levels between 2021/22 and 2022/23 shows a decline in levels of harm and in particular the number of no harm and near-miss incidents. Moderate incidents and deaths have also showed a decrease over the previous year. A significant increase can be noted in the number of low harm incidents in this reporting year.



	1-Near-Miss	2-None (No Harm Occurred)	3-Low (Min.Harm-Patient Req. Extra Ob)	4-Moderate (Short Term Harm)	Severe (Permanent or Long Term Harm)	6-Death	Level of Harm TBC
2021/22	322	2187	578	28	1	9	6
2022/23	220	1740	627	23	2	7	351

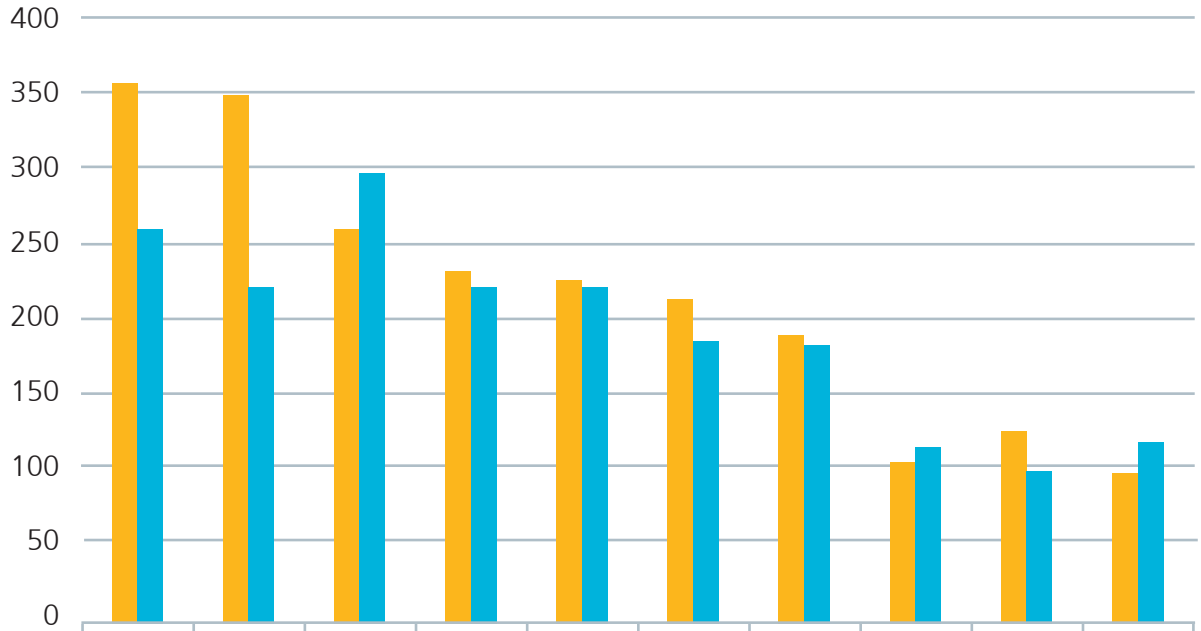
Top 10 Clinical incidents (2021/22 – 2022/23)

Data from the previous two years indicate that our most frequently reported clinical incidents have remained relatively consistent and relates to the following categories:

- Medication
- Communication/Consent
- Allegation/Abuse/Aggression related incidents
- Skin Issues
- Treatment / Procedure
- Abuse/Violence / Aggression
- Documentation
- Slips / Trips / Falls
- Implementation of care
- Clinical assessment
- Staffing issues

The notable change is around two key categories: Medication and Communication incident both of which is showing a slight decline in 2022/23 compared to the previous year.

Top 10 incidents



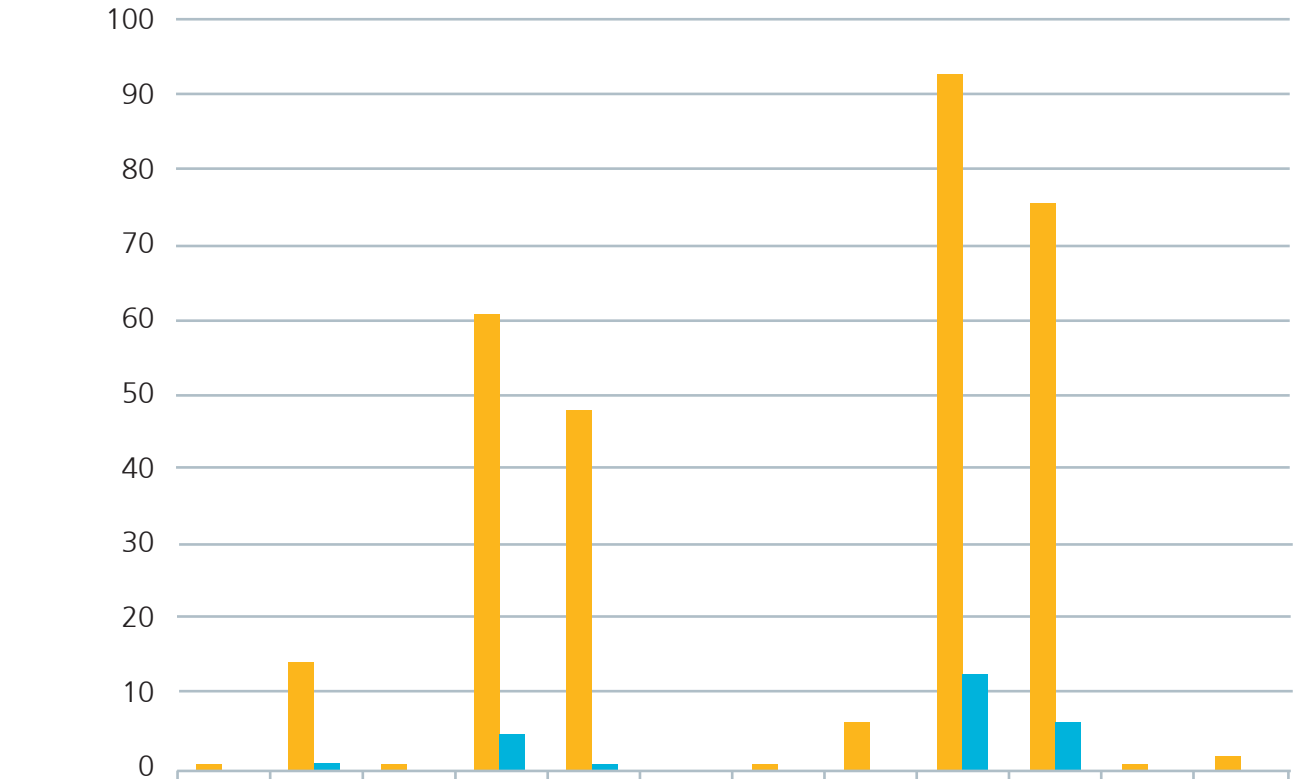
	Medication	Communication /Consent	Skin Issue	Treatment /procedure	Abuse/Violence /Agression	Documentation	Slips, Trips and Falls	Implementation of Care	Clinical Assessment	Staffing Issues
2021/2022	354	348	262	234	228	214	188	103	126	94
2022/2023	262	219	295	223	221	183	178	114	96	119



Staff feel comfortable reporting incidents, and transparency and accountability are valued

Non-clinical incidents (2021/22 – 2022/23)

Reporting of non-clinical incidents shown in the chart below demonstrates a significant difference in trend between the two-year periods. There has been an overall decline in non-clinical reporting in 2022/23 compared to the previous year. In 2021/22 there has been higher recorded number of non-clinical incidents and at its peak it remained significantly higher than the previous year in particular around incidents involving Medical Devices, Security, Fire and Environmental Issues. Incidents of Allegation against staff have also seen a significant decline in the last year.



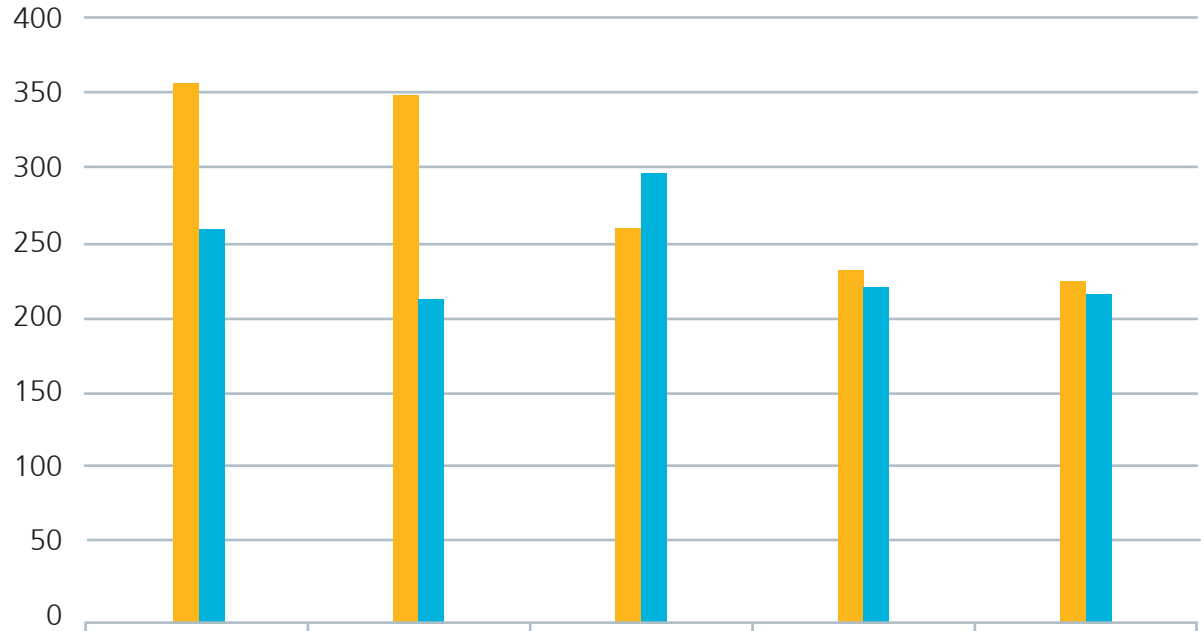
	Abuse/ Violence/ Aggression	Allegation Against Staff	Digital Services	Enviromental Issues	Fire	Harm/ Injuries	Information Governance	Infrastructure	Medical Device/ Equipment	Security	Slips, Trips and Falls	Staffing Issues
2021/2022	1	14	1	61	48	0	1	6	93	76	1	2
2022/2023	0	1	0	4	1	0	0	0	12	7	0	0

Top 5 Incidents (all incidents)

Data from the last two financial years indicate that our most frequently reported incidents has remained consistent with marginal variation across the two years related to:

- Medication
- Communication / Consent
- Abuse / Violence / Aggression
- Skin Issues
- Treatment / Procedure

Top 5 Incidents



	Medication	Communication/Consent	Skin Issue	Treatment/procedure	Abuse/Violence/Agression
2021/2022	354	348	262	234	229
2022/2023	262	219	295	223	221

Mortality

Learning from a review of the care provided to patients who died is integral to a provider's clinical governance and quality improvement work.

To fulfil the standards and reporting requirements, the Trust ensures the governance arrangements and processes give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care and avoidable.

The Trust mortality reporting has noted a downward trend this year when compared to last year. In 2022/23, the Trust reported 7 deaths compared to 9 deaths reported the previous year.

The Trust has a robust Learning from Death (LfD) process established to review deaths associated with a healthcare intervention and any concerns of sub-optimal care are escalated through the Patient Safety governance process to investigate and identify learning and take necessary action to mitigate the risk of reoccurrence. Some deaths will be subject to further detailed review in order to identify any learning.

The LfD group also act as the strategic hospital mortality overview group with senior leadership and support with the purpose of reducing all avoidable deaths. The Group reports on mortality performance to the Integrated Governance and Risk Committee and Clinical Standards and Innovation Committee.

Key achievements in 2022/23

- The successful implementation and roll-out of the national Learn from Patient Safety Events (LFPSE) system
- Delivery of a comprehensive training programme for Learning Response Leads and Oversight Leads as one of the key deliverables of the Patient Safety Incident Response Framework (PSIRF) project
- Supporting and mentoring the newly appointed Patient Safety Partners and integrating them into the Trust safety and governance groups.
- Supporting the on-going implementation of the PSIRF project due for completion and roll-out in Autumn 2023/24
- Conducting the safety culture survey and identifying safety recommendations to enhance the trust's safety awareness
- The development of a Risk Management e-module accessible on the Trust Learning Hub to offer an increased understanding of how to manage risks in the Trust.
- The launch of a new monthly patient safety drop-in session held across all three sites
- The development of a new Patient Safety Intranet page to include news of current patient safety events, updated resources, newsletters, training schedules, guides, policies and much more.
- A Trust-wide refresher training programme for staff on all Ulysses modules including the newly designed LFPSE incident reporting form
- Working with the divisions to reduce the number of outstanding incidents and actions from RCA investigations
- The trust-wide roll out of the Patient Safety Syllabus – Level 1 and Level 2 modules
- Participation in the yearly World Patient Safety Day events with engagement and awareness activities for all staff groups to join in and participate.

The Trust is committed:

To enable 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.

To equip 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.

To work 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 Royal National Orthopaedic Hospital (RNOH) is committed to putting the service user and carer at the centre of everything we do and strives to improve patients' and service users' experience of our service.

The Trust makes every effort to support people with complex needs through understanding the patient's requirements, their support networks and the patient's capacity for independence and emotional support.

We plan admission through to discharge at our complex case multi-disciplinary team meetings, involving RNOH professionals and external agencies where appropriate. Children, young people and adults with special needs are supported through the multi-disciplinary teams across the Trust, ensuring reasonable adjustments are made to support their admission.

Homeless patients have equal access to the full range of our services, and any patient who is identified as being homeless is referred to the RNOH Social work and discharge team, and referrals are made to services provided by statutory, voluntary and private agencies as appropriate.

The Trust takes all issues of abuse or neglect of adults at risk and children very seriously. All staff who come into contact with vulnerable children, young people and adults in their everyday work have a duty to safeguard and promote their welfare. The Trust has specialist roles, policies and training in place to ensure that it meets its responsibilities under Section 11 of the Children's Act (2004) and the Care Act (2014).

The Chief Nurse is the executive lead for safeguarding and chairs the quarterly safeguarding group. The Safeguarding Team offer specialist advice, support and guidance to ensure patients are safeguarded. In regard to training, the Trust follows the recommendations set out in the Intercollegiate Documents for Children and Adults* staff are aligned to the correct training competence requirements for their role.

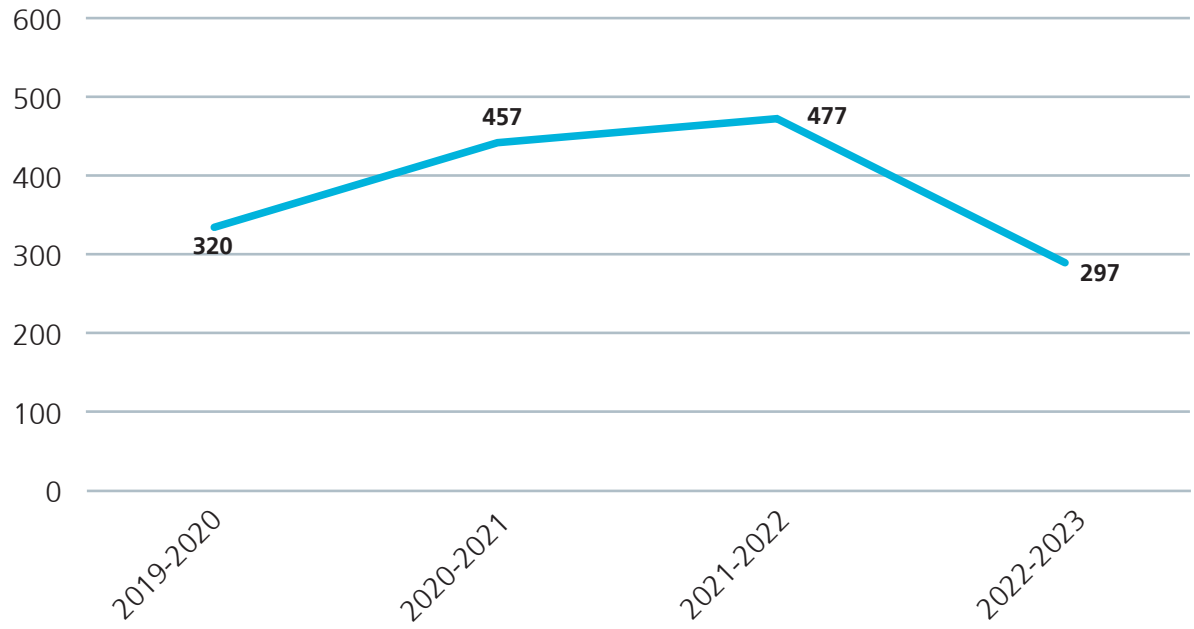


*Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Intercollegiate Document 4th Ed. (2019)
*Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate Document 1st ed. (2018)

Medicines Safety

The Trust has significantly decreased incident reporting levels since the last financial year. This may be due to either reduced reporting or a reduction in medication errors since the Trust wide implementation of electronic Prescribing and Medicines Administration system (ePMA). The decreased trend in reporting can be seen in the chart below.

Trend of Medication Errors reported between April 2019 and March 2023



From April 2022 to March 2023, there was a total of 297 medication-related incidents. Out of these, 71% led to no harm to patients (categories of zero harm and near-miss). The MSO works with the multidisciplinary team to support in identifying contributory factors and takes steps to mitigate these. 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, Trust audit meetings, and at the bi-monthly MSC. RNOH medicines safety team also produce a monthly Medicines Matter Newsletter which is published onto the Trust Grapevine 2 news page for all clinical users to access.

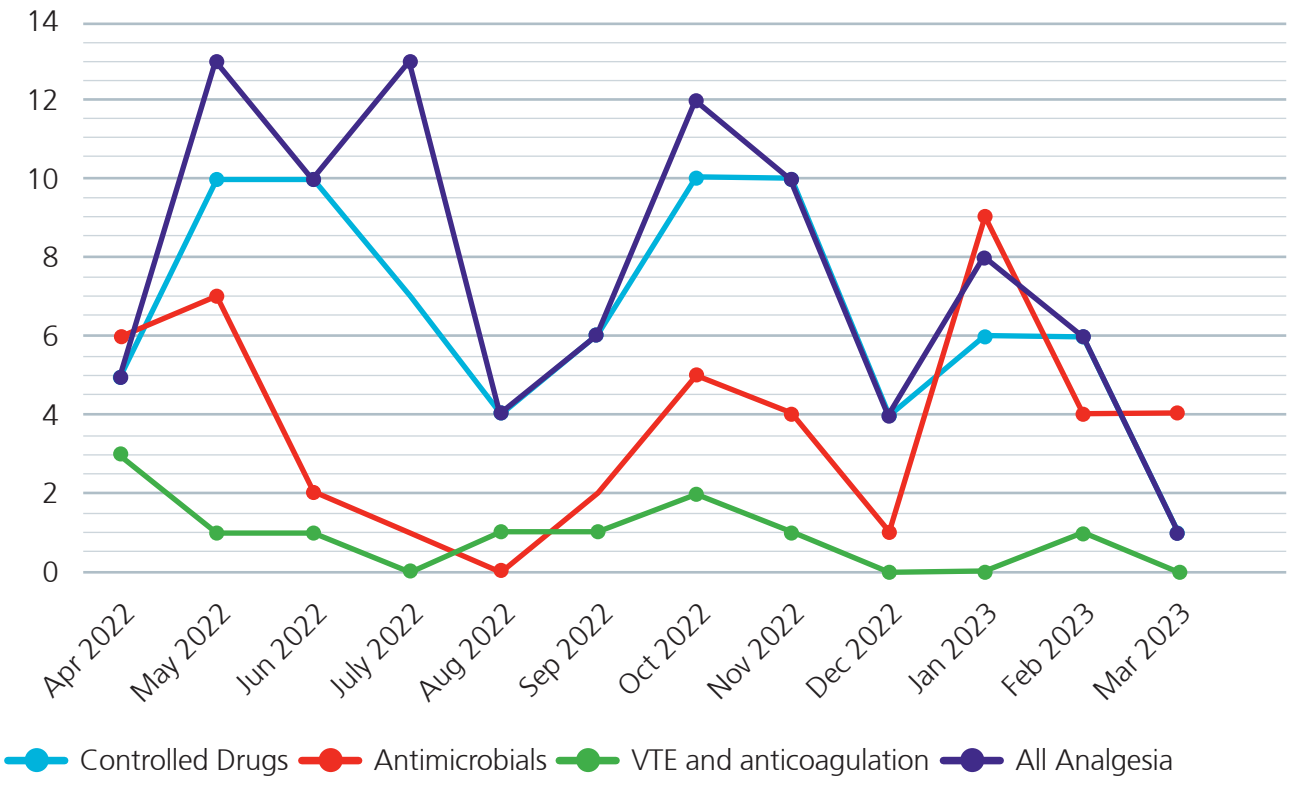
RNOH is committed to firstly reducing the risk of avoidable harm caused to patients due to medicines, and secondly developing leaders who will advocate on the delivery of outstanding medicines safety and governance practice. This will be achieved by developing a culture whereby patients, staff and relevant carers feel empowered to promote medication safety in their clinical area or sphere of influence. RNOH continues to endeavour to create a positive medication safety culture whereby there will be no stigma towards reporting and where this is seen as an opportunity for learning and growth where staff feel comfortable and empowered to report any and all medication related incidents, for the good of our patients, our staff, and our Trust. This will be delivered through the provision of excellence in all aspects of the reporting and learning process to a level that other Trusts aspire to replicate.

The Trust also has links with NCL for pan-London medicines safety strategies and initiatives, through the NCL IPMO Safety activities. The medicines safety strategy aligns to national priorities, particularly around the NHS sign up to the WHO global patient safety challenge. This enables RNOH to work towards meeting national standards.

The successful introduction of ePMA on pilot wards in March 2022 (Jubilee Rehab Ward, Infusion Suite on PNW and Spinal Cord Injuries Centre) was followed by the Trust wide implementation in October 2022 (excluding paediatrics). The benefits of the implementation of ePMA include improved legibility of prescriptions, better traceability, accountability and reporting.

An ePMA dashboard has been created for reporting and includes data on the total number of medicines prescribed, data on missed and delayed doses with reasons for intentional omissions, data on the time taken for medicines reconciliations and medication histories completed from the patient's admission and the types of medicines prescribed including data on critical medicines. This is the first time that data is available on the total number of medicines prescribed and doses administered which provides a denominator for analysis. Further work is being undertaken to enhance the data obtained to include specialist areas such as antimicrobials, diabetes, VTE and pain dashboards. The ePMA dashboard is currently separate to the medicines safety dashboard which contains details on all medicines related incidents.

Incidents relating to the most commonly prescribed medicines at RNOH April 2022-March 2023 (%)



Emergency Planning Resilience and Response (EPRR)

The Trust has continued to work with the wider system supporting neighbouring Trusts. We continue to develop, monitor and test our plans for responding to business continuity, critical and major incidents for the safety of our patients, staff and neighbouring Trusts.

Each year, every NHS funded provider must undertake an assessment on compliance against the Emergency Preparedness, Resilience and Response (EPRR) core standards. This is in line with NHS Emergency Preparedness, Resilience and Response (EPRR) statutory requirements, placed upon the NHS Trusts by the Civil Contingencies Act (2004) and the NHS Act (2006) as amended by the Health and Social Care Act (2012).

In 2022, NHSE added 26 new standards and other modifications were made to set the expectations for all NHS Trusts. In total, for RNOH, compliance was assessed against 69 standards i.e. 56 core standards and 13 deep dive standards.

The assurance process was carried out by the NHSE in collaboration with the Integrated Care Board (ICB) EPRR lead, as well as the EPRR lead from a peer Specialist NHS Trust. The Trust was deemed FULLY COMPLIANT against all core and deep dive standards.

Compliance levels	Criteria to achieve this level of compliance	
Fully compliant	100% compliant	The organisation is 100% compliant with all core standards

In addition, the Trust was commended for maintaining a high level of standard for EPRR arrangements and the involvement of the Emergency Planning Officer and Accountable Emergency Officer in local, network and regional planning meetings. Of the 45 organisations that participated in the process, 14 were fully compliant, 26 were substantially compliant, 3 were partially compliant and 2 were non-compliant.

The Trust has continued to maintain the EPRR processes, policies and continue to share the learning throughout the organisation. The Trust has developed a work plan to further strengthen areas of key importance as detailed within the EPRR Work plan 2023.

- The Trust has established the Silver on call learning forum in addition to the Emergency Planning Steering Group and bi-daily clinical and operational sitrep meeting. The purpose of these group is to share the learning from individual's on call experience, address any challenges and be prepared, responsive and resilient to a wide range of incidents that could impact on the delivery of patient care;
- The Trust continues to participate in the NHSE EPRR Communications exercise throughout the year. The NHS England (London) EPRR team expects NHS organisations to respond to pager messages within 10 minutes of the message receipt, or as soon as reasonably possible, within 30 minutes of the RED1 message being sent. The Trust continuously achieved high compliance in the 10 minute targets.
- The Trust has also participated and learnt lessons from the regional Arctic Willow exercise which was aimed at preparing Trusts for Industrial actions and Severe Weather incidents.

a. 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. The focus of this standard has shifted in recent years, to reducing the number of patients experiencing significant waits for treatment. The focus of elective waiting time targets in 2022/23 was to eliminate 78 week waits by the end of March 2023. This was later extended to the end of June 2023 due to the strike action that took place towards the end of the year.

There were continued challenges to delivering elective activity in 2022/23 as a result of infection, prevention and control measures which meant COVID testing needed to take place for patients shortly before or on admission to the hospital which meant that when admissions were cancelled at short notice they were often not possible to replace, reducing the total number of patients that could be treated.

Prior to the pandemic, it was an anomaly for RNOH to have any patients waiting more than 78 weeks RTT, but as a result of the significantly reduced elective activity delivered across the NHS in 2020/21 and 2021/22, RNOH had 65 patients waiting more than 78 weeks at the peak (September 2021). At the end of 2022/23, the Trust reported 1 patient with a wait exceeding 78 weeks. This patient was treated in April, ahead of the revised target of eradicating 78 week waits by the end of June 2023.

The Trust has also been able to reduce the number of patients waiting over 65 weeks RTT by 76% to 12 patients at the end of March 2023. The Trust expects to continue to reduce this figure throughout 2023/24 and eliminate waits over 65 weeks earlier than the target of the end of March 2024.

RNOH continues to provide support to other Trusts both within the sector and the wider NHS. In 2022/23, within the sector, the Trust provided capacity to Royal Free London and UCLH (National Hospital for Neurology and Neurosurgery) to carry out 56 operations for spinal, joint replacement and paediatric orthopaedic patients (figures until end of March 2023) to increase equity of access across North Central London. The Trust has also provided mutual aid support to a number of Trusts outside of North Central London, taking transfers where waits have been extensive for spinal and orthopaedic services elsewhere.

Whilst RTT performance across the whole of the NHS has notably dropped as a result of COVID-19, RNOH performs very well when comparing performance both nationally and regionally. For the specialty of Trauma and Orthopaedics, the RNOH, with a performance of 73.0%, significantly outperformed England (54.5%) and London (58.1%). RNOH's overall RTT performance of 72.9% also compares well against the other standalone specialist orthopaedic Trusts, namely Royal Orthopaedic Hospital, Birmingham (59.0%) and Robert Jones and Agnes Hunt, Oswestry (54.2%). (March 2023)

b. Never Events

Never Events are serious, largely preventable, safety incidents. During 2022/23, there was 1 Never Event and 4 Serious Incidents reported on the Strategic Executive Information System (StEIS).

The Never Event related to the case of a patient who was admitted for midline sarcoma en-block excision. There was pre-operative discussion about excision of biopsy tract as it was performed at a different Trust and was unmarked. The patient was consented for the partial sacrectomy, and explained that the excision may or may not include the biopsy tract. The pre-operative and intraoperative review of the images were duly completed and the linear tract on the image from the right paraspinal area was seen and thought to be the biopsy tract, and therefore the soft tissue around the area was excised. During the post-operative period, it transpired that the biopsy was approached from left paraspinal rather than right, thus the error was identified.

The incident was a wrong side of surgery for the soft tissue excised, although the main aim of the surgery for partial sacrectomy was in the midline and performed at the correct vertebral level.

The 4 serious incidents logged relate to:

- The incorrect diagnosis of plasmabalstic lymphoma
- A patient was lost to follow-up leading to metastatic disease
- A patient experiencing lower limbs paralysis following a total knee replacement
- An unexpected imaging reporting backlog

c. 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.

d. Risks and Uncertainties

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

During the year, the Trust has continued to utilise a governance system for managing risk and patient safety. Further detail is available in the Governance Statement.

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.

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.

Part 3:
Performance Report – Performance Analysis

How performance is measured

The Trust Assurance Dashboard replaced the Trust Balanced Scorecard in December 2022 and encompasses key indicators used by the Trust Board and its Committees to monitor RNOH's performance. For 2022/23, 100 key indicators were monitored covering:

- Elective Recovery;
- Quality of Service;
- Finance;
- People;
- Growth;
- Efficiency and Sustainability

The process of agreeing which key performance indicators or 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 may have targets are set internally based on historical performance with some improvement factored in.

The Trust Assurance Dashboard collates information which is used during the month from various reports into a more cohesive and informative format through a single dashboard. 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 Executive Team prior to its publication in the Trust Assurance Dashboard. The Executive Directors who are in attendance at both the Trust Board and at various Committee meetings are held accountable for the results.

For 2022/23, the Trust reviewed the indicators and agreed those which measure the Trust's performance most effectively, and are aligned with the Trust's Strategy.

Performance during 2022/23

	Target	2019/20	2020/21	2021/22	2022/23
Outpatient Attendances	-	136,227	123,083	140,445	143,173
Inpatient Admissions	-	15,841	9,742	13,564	14,440
Mortality Numbers	-	9	34	4	5
Number of formal complaints received	- -	126	67	124	187
Number of PALS Contacts	-	708	939	2068	2493
Friends and Family Inpatients % of patients responded	>=70%	44.2%	17.1%	54.3%	18.4%
Friends and Family Inpatients Unlikely/Likely to Recommend Hospital?	-	0.8%/ 95.4%	2.9%/ 94.6%	2.9%/ 94%	8.4%/ 91.6%
Diagnostic Waits Compliance	>=99.0%	99.3%	73.3%	96.9%	96.3%
Referral to Treatment Open Pathways	>=92.0%	87.98%	71.3%	72.41%	73.26%
Cancer 2 Week Wait	>=93.0%	96.1%	99%	96.8%	100%
Cancer 31 day first treatment	>=96.0%	97.2%	99.1%	98.1%	100%
Cancer 31 day subsequent treatment	>=94.0%	96.7%	96.7%	98%	100%
Cancer 62 day standard treatment	>=85.0%	80.5%	88.5%	74.1%	82.3%
Operations cancelled not operated within 28 days (Breaches of the standard)	-	19	32	32	23
Reportable DoH Last Minute Cancelled Operations	-	2.5%	1.4%	1.8%	1.6%
Trust Staff Turnover Rate (%)	<=13%	11.63%	8.94%	10.33%	10.97%
Trust Staff Sickness Absence (% based on calendar year figures in line with the Department of Health and Social Care Group Accounting Manual requirement).	<=3%	**2019** 2.99%	**2020** 3.33%	**2021** 3.32%	**2022** 3.78%
Staff Engagement (annual figure)	-	7.6	7.6	7.4	7.4
Paediatric Referral to Treatment Open Pathways	>= 92.00%	95.08%	71.3%	79.18%	76.06%
SUS Data Quality - Data Validity Summary	-	97.6%	95.6%	97.7%	98.1%

Performance Analysis

Referral to Treatment and Cancer Performance

The formal national target to measure Trust performance on elective waiting times has historically 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. The focus of this standard has shifted in recent years, to reducing the number of patients experiencing significant waits for treatment. The operational planning guidance for 2022/23 stated that waits exceeding 104 weeks should be eliminated by July 2022 and waits in excess of 78 weeks should be eliminated by the end of March 2023. The target for 78 week waits was later extended to the end of June 2023 due to the strike action that took place towards the end of the year.

The Trust has had very few patients with extended waits over 104 weeks RTT during 2021/22 and those that the Trust had were often patients referred on from other organisations that had existing RTT clocks that RNOH inherited. The Trust had no patients waiting over 104 weeks in May 2022, 2 months ahead of target. The Trust also met the target of eliminating 78 week waits in April 2023, 2 months ahead of the revised June 2023 target.

Whilst formally the operational requirement for elective care now focuses on the number of patients experiencing extended waits, data for the overall 'incomplete pathways' performance is still collected nationally. Though 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.

In terms of performance against cancer targets, the Trust has achieved 100% against the two week wait target for first consultation following urgent GP referral every month of 2022/23. The Trust achieved compliance with both 31 day standards (for diagnosis to first treatment and for subsequent treatment) with 100% throughout 2022/23.

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 Trust's overall 2022/23 performance was 82.3%, with more recent performance above the 85% target. The target has been achieved the target every month September 2022. The Trust achieved 93.6% in the 4th quarter of the year (Jan-March 2023).

The number 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 117% of 2019-20 levels when compared to 2022-23, demonstrating suspected cancer referrals have recovered to significantly exceed pre-COVID levels.

Any breach of the cancer waiting time standards is reviewed to understand delays or bottlenecks in the pathway to improve processes to lead to better patient care and access times. Many of the patients managed on a cancer pathway under RNOH also require input from another organisation (e.g. for radiotherapy). As such, smooth transitions between organisations and ongoing communication is key. The Trust continues to work closely with external partners to minimise waiting times.

Sickness absence

All managers have access to sickness absence data on the Workforce Dashboard and the Trust dashboard is discussed at the People Committee and Partnership Committee and is circulated to Trust Board. The absence rate is monitored at Divisional Performance Review meetings and monthly meetings which take place between HR and line managers to support and monitor.

Retention Rate

The Trust retention rate for 2022/23 was 89.14%, 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's retention rate continued to be above target throughout 2022/23.

The retention figure is collated, monitored and discussed monthly at the Divisional Performance Review meetings. Furthermore, the data is part of the Trust's Dashboard and is discussed at the Partnership Committee and People Committee as well as being circulated to Trust Board.

To aid retention the Trust has recruited an Apprenticeship and Early Careers Manager to establish other recruitment options to grow our own talent and develop new roles. In addition, following the appointment of the Staff Wellbeing Lead, a Wellbeing Hub has been created, webinar runs on key topics and a wellbeing reference guide created for staff on wards.

The staff group with the highest leavers in 2022/23 was 'Administrative and Clerical' and the main reason for staff leaving the Trust is promotion.

Safe staffing Nursing

Safe staffing levels are monitored daily using the Allocate SAFECARE app which utilises the Shelford Safer Nursing Care Tool (SNCT) to assess patient acuity and dependency, and informs the professional judgment of the senior nursing team, who ensure staffing resources are allocated safely across the clinical areas.

The Board receives assurance through a bi-monthly safe staffing report, which highlights any safe staffing shortfalls and actions taken to mitigate risk. Also a six monthly report is presented, which gives detail of the nursing establishment reviews, completed using the SNCT. Nurse staffing reviews undertaken this year indicated a sustained increase in patient acuity following the pandemic. Consequently, an uplift in staffing establishment was agreed by the Trust Executive, with the support of the Board, and actioned accordingly.

Financial Performance

Annual report Statement

The 2022/23 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.

2022/23 Financial Performance

The Trust reported an adjusted surplus of £3.24m for the financial year ended 31 March 2023, after adjusting for donated asset transactions and impairments. Prior to these adjustments, a headline surplus of £1.574m was recorded for the financial year.

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

Financial Summary (£'000)	2022/23 Plan	2022/23 Actual	Actual Variance
Total Income*	178,826	190,213	11,387
Total Operating Costs**	(169,514)	(175,229)	(5,715)
EBITDA	**9,312**	**14,984**	**5,672**
RETAINED (DEFICIT)/SURPLUS FOR THE YEAR	(823)	1,574	2,397
Adjusted retained (deficit)/surplus	**(1,150)**	**3,240**	**4,390**
Cash at end of the period	45,599	54,184	8,585
Capital Expenditure	19,689	22,678	2,989
I&E cost improvement programme (CIP)	8,281	6,393	(1,888)

*Total income excludes donations

** Total operating costs exclude depreciation and impairments

The 2022/23 favourable variance to plan (£4.4m) was largely driven by Elective Recovery Funding, favourable expenditure variances linked to lower activity than plan, divisional pay underspend, prior year benefit and delayed phasing of investment spend offset by unachieved CIP, contract variances, inflation pressures and impairments.

Capital expenditure amounted to £22.678m in 2022/23. This included significant investment in a New Theatre block which is due to complete in 2023/24. Capital expenditure at category level is shown in the 'Capital Investment' section below.

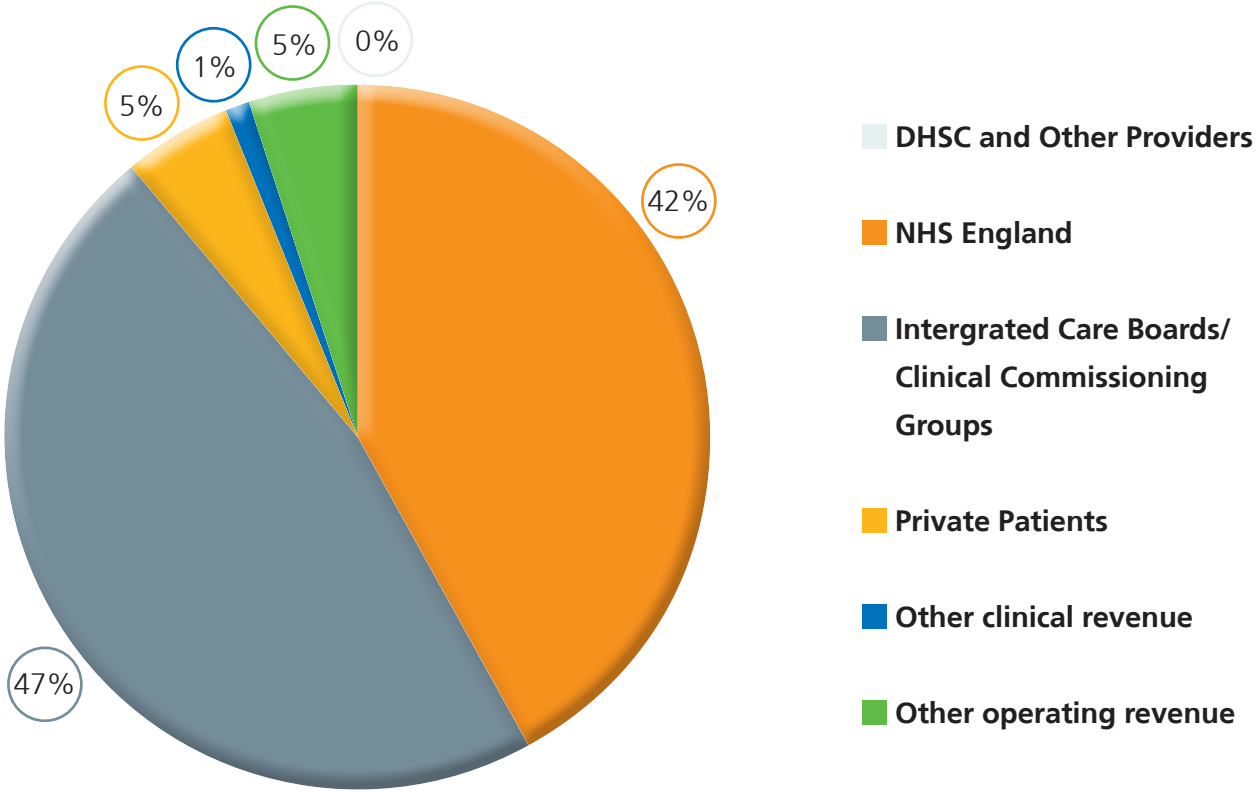
Delivery of cost improvement plans for the year was adverse to plan – with savings of £6.393m recorded against a plan of £8.281m. The Trust achieved its External Financing Limit, which is the centrally set cash target for the organisation, and the Capital Resource Limit, which sets out the quantum of capital expenditure.

Income and Expenditure analysis

Income

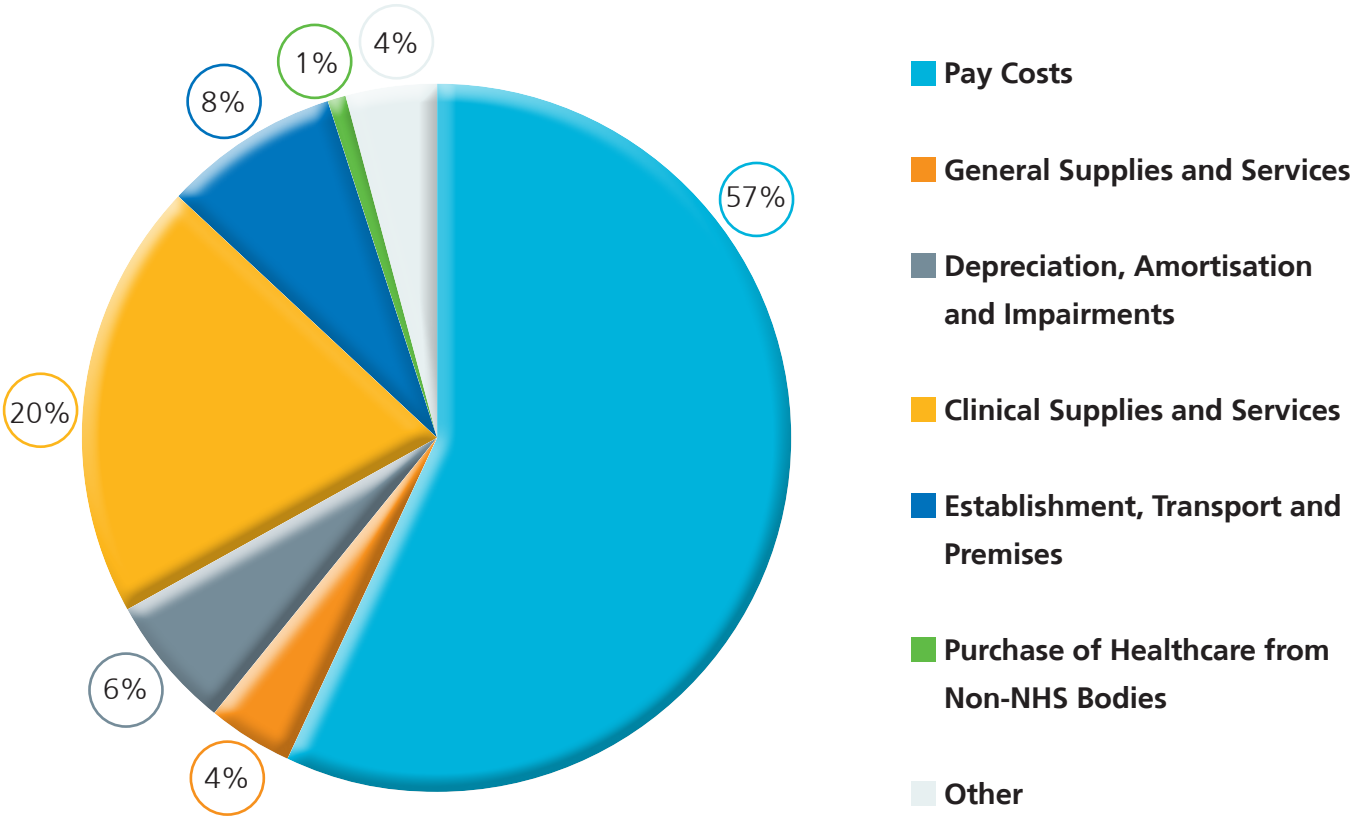
Income of £190.3m was recorded by the Trust in 2022/23. Clinical income from Integrated Care Boards (previously Clinical Commissioning Groups) was the highest proportion, accounting for £89.9m or 47% of the total income of the Trust, with the purchase of healthcare services by NHS England also being a highly significant item (£80.5m or 42%). The remaining material items were comprised of Private Patient income (£8.4m or 5% of income) and other operating revenue (£8.8m or 5% of income) which includes education, training and research (£3.6m).

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



Operating Expenses

Total operating expenses for 2022/23 were £186.1m, and are set out in the chart below.



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

The Trust spent £106.7m on staff pay costs during 2022/23, and within this amount £7m was spent on bank (£5.1m) and agency staff (£1.9m), 6.6% of the total pay cost.

Expenditure on other costs

The Trust's non-pay operating expenses of £79.4m were due to the costs of clinical supplies (£37m – 47% of non-pay expenditure), utilisation of healthcare capacity outside of the Trust (£1m – 1% of non-pay expenditure), and general supplies and services (£7.8m – 10% of non-pay expenditure) required to maintain the operational services of the Trust. The residual costs were incurred on establishment, transport and premises costs (£14.4m – 18% of non-pay expenditure), depreciation, amortisation and impairments (£10.9m – 14% of non-pay expenditure), and other expenditure (£8.3m – 10% of non-pay expenditure).

Capital Investment

Capital expenditure during 2022/23 was £22.7m. An analysis by category is provided below.

	£'m
Estate - New Build	11.2
Estate - Maintenance	3.5
Medical Device Replacement and other medical equipment	2.4
Digital	5.7
	22.7

The Trust achieved its capital allocation or capital resource limit in 2022/23.

Estate valuation

During 2022/23, 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 2023. 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.

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

Financial Summary (£'000)	**Plan 2023/24**
RETAINED SURPLUS	269
Adjusted retained surplus	**41**
Cash at end of period	44,487
Capital Expenditure	17,995
I&E cost improvement programme (CIP)	10,925

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 31 to the Accounts, with a summary provided below:

	2022/23 Number	2022/23 £000	2021/22 Number	2021/22 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	25,493	115,690	23,316	103,002
Total non-NHS trade invoices paid within target	23,857	100,392	20,475	82,726
Percentage of non-NHS trade invoices paid within target	93.6%	86.8%	77.8%	80.3%
NHS Payables				
Total NHS trade invoices paid in the year	732	10,293	922	11,044
Total NHS trade invoices paid within target	599	8,392	437	5,552
Percentage of NHS trade invoices paid within target	81.8%	81.5%	47.4%	50.3%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or 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 1.5 and Note 9 in the Annual Accounts and further details on pension entitlements of Directors are given in the Remuneration Report.

During 2022/23 there were no early retirements from the Trust agreed on the grounds of ill-health (0 in the year ended 31 March 2022). The cost of ill-health retirements are borne by the NHS Pension Scheme.

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.

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.

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 2022/23 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 2 year term commencing April 2017. Further one year extensions were agreed with Grant Thornton for the years commencing April 2019 to April 2021. Grant Thornton has subsequently been appointed for the 3 financial years commencing April 2022.

The cost of the statutory audit services work performed by Grant Thornton in 2022/23 was £104,040 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.



Surendran Chellappah
Audit Committee Chair



Dr Jane Collins
Non-Executive Director



Doris Olulode
Non-Executive Director in the reporting Year

Digital Services

2022/23 marked a new direction as the Digital Strategy was refreshed to support the Trust's vision and strategic aims. The year started with a review of our current state and the strategy sets out the roadmap to ensure that the RNOH is at the forefront in the use of modern and innovative digital healthcare solutions.

As well as continuing to provide support for the COVID-19 pandemic effort, we have continued to deliver new Digital services and support the changes in the Trust strategy and business needs. Despite this, and in addition supporting new initiatives identified during the year, much of the agreed Digital programme of work for the 2022/23 financial year has been completed. Key deliverables include:

- Maintaining modern, robust, and resilient Digital services and infrastructure to deliver a high-quality service with 99% availability of systems and networks together with excellent customer satisfaction scores.
- Strengthening the IT infrastructure 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 to improve speed and resiliency across our key clinical areas. Creation of new data backup strategy/systems vastly improving our BCP/DRP capabilities and reduce system restores in the event of a disaster from days to hours.
- A shift to cloud readiness has been initiated with Azure with our first landing zone ready for migration, a move to the cloud is underway which will help meet our "cloud first adoption" strategy as well as meeting our environmental delivers with a reduction in carbon emissions.



- Protecting the Trust against cyber-attacks. This has been one of the biggest challenges, with a huge increase in workload as the National Cyber Security Centre upgraded the risk of cyber-attack to very high/severe alongside stringent compliance mandates and deadlines. We have maintained and enhanced our protection from cyber-attacks with further investment in technology by securing national funding through a competitive process.
- With regard to agile working, we continue to support how our staff operate with new technology and work to enable (BOYD). New technology in this area will be based around Cloud based services such as Microsoft 365/windows 11 with a shift in desktop strategy will allow/enable our staff to access systems, receive information and work with each other from any location. Security will be paramount, and all our infrastructure and systems will be based around IT Cyber Security protocols thereby ensuring our clinical data is fully protected.
- Successful delivery of Electronic Prescribing and Medicines Administration (EPMA) Systems and many other related clinical modules has contributed significantly to enhance safe patient care coupled with network and configuration improvements with the stability of the platform vastly improved with faster response times for our clinical teams.
- With the shift in the Trust strategy to implement a single Electronic Patient Record (EPR) system and move away from the current Best of Breed - Connect All approach, EPR readiness initiatives have launched across the estate with core focus on continuous improvement of our core Network services, DRP, security. Work will continue in this area as we move through the EPR Programme.
- To facilitate the Trust objective of working more closely with the wider system, digital services have been working on many new developments with funding secured externally. Key ones includes Health Information Exchange, Population Health Management system, GP Connect and Patient Held Record.



Sustainability Report

Overview

The Trust is committed to delivering world-class healthcare and providing best value for taxpayers' money, while ensuring the most effective, fair and sustainable use of finite resources.

Our Green Plan sets out the aims and ambitions towards a sustainable future, establishing a pathway towards net zero. Every area of the Trust will need to act if net zero is to be achieved. To be successful, we need collective action from all staff, supporting this with collaborative partnerships, clear delivery goals and with a drive to embrace and implement innovative solutions. The plan has key delivery theme areas, working towards clear and measurable carbon reduction targets.

The Trust has employed a part time Sustainability Manager to help the Trust achieve its green ambitions and drive our green/net zero agenda, The post holder will work closely with corporate teams to improve the Trust's collection, analysis and reporting of sustainability information, including establishing and implementing key performance indicators, and be responsible for looking for further opportunities both within and external to the organisation for driving and embedding our sustainability agenda

There is more work to do with engaging staff and shifting the culture but there is a real interest from our staff and a desire to make a difference.

Performance Report 2021/22 Carbon Emissions

Targets

The Royal National Orthopaedic Hospital Trust has set carbon dioxide equivalent emission targets to match the NHS targets i.e. a 34% reduction in carbon emissions by 2020 followed by the new NHS target for direct emissions (scope 1 and 2) of net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 and for indirect emissions (scope 3), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The NHS targets use 1990 as the baseline and RNOH has chosen 2007/8 as a baseline on the basis that the 2007/8 baseline is similar to the 1990 baseline. The basis for achieving 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.

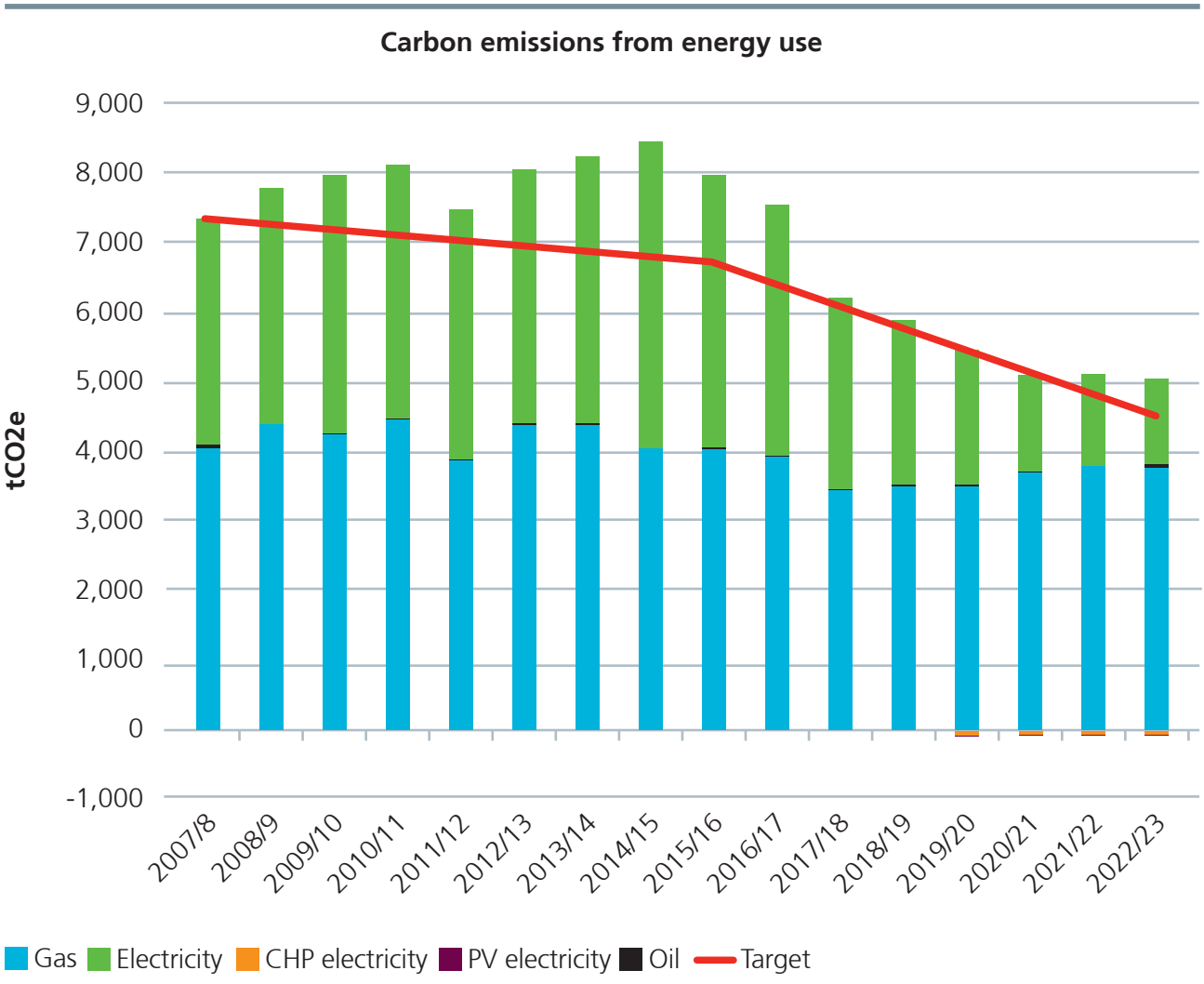
Energy (scope 1 and 2 emissions)

There have a few changes to the estate in 2022-23 which has improved the Trust's energy efficiency. Jackson Burrows Ward has changed from an in-care ward to a patient day surgery care unit. Air conditioning has been installed in Spinal Cord Injury Centre (SCIC) and new hot water boilers have installed in theatre 1, SCIC, and the Jubilee Rehabilitation Centre.

The electricity generated by the combined heat and power plant (CHP) and photovoltaic (PV) panels 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.

The Trust spent £2,276,296 on energy in 2022/23, an increase of 30.4% in energy spend compared with last year. Electricity consumption has increased by 0.2% whilst gas consumption decreased by 0.03% compared with last year and hence the increase in cost is due to the sharp increase in the global price of gas. The CHP plant operated at reduced output in June and July 2022 and also March 2023. Nevertheless, electricity generation by the CHP increased by 29.9% and PV panels by 4.2% compared with the previous year. Last year, the CHP was not operational due to the difficulty of arranging engineers to service the CHP plant once it had entered into 'service mode'.

The Trust has set a carbon reduction target of an 80% reduction in carbon emissions by 2032 for direct emissions and the same percentage reduction for indirect emissions by 2039 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 below against the 2015/16 (10% reduction) and 2020/21 (34% reduction) and 2032 (80% reduction) targets (note the carbon emissions include scope 3 emissions only for energy transport and transmission).

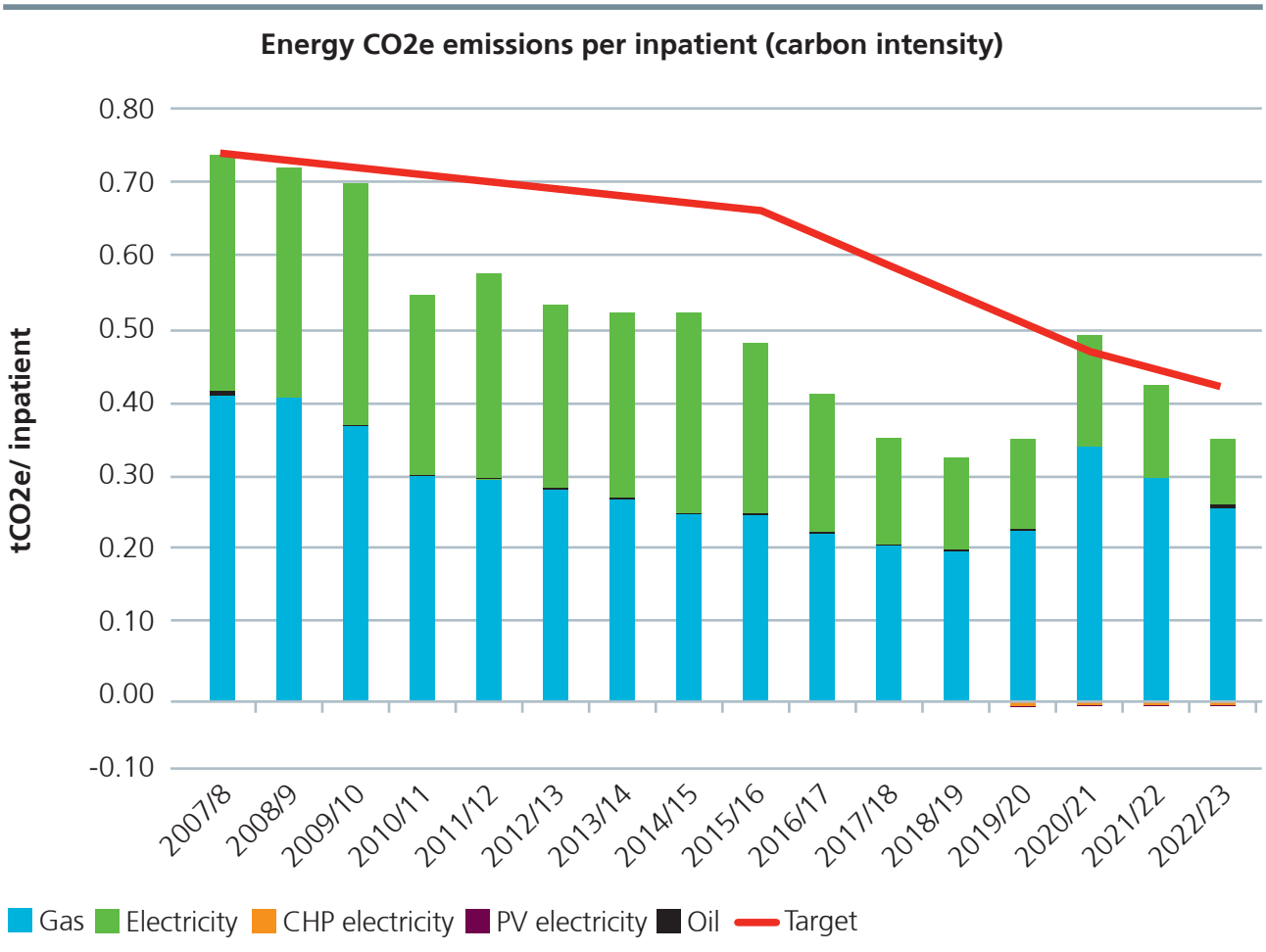


The carbon emissions associated with electricity production from the CHP plant and solar PV panels have been included as negative values to represent a saving in carbon emissions but the quantities are small and only just visible on the chart.

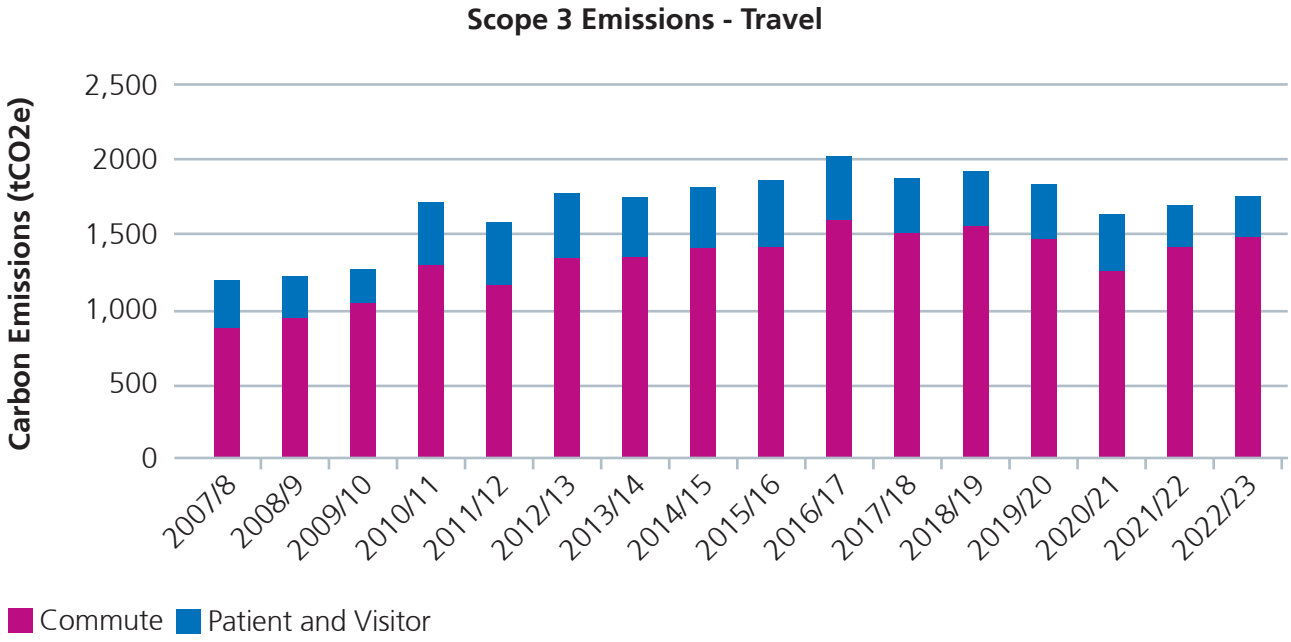
In absolute terms, the Trust has not met its carbon emission target and the trend over the last three years is a slowing down in emission reduction such that the gap between emissions and target is widening. The reduction in carbon conversion factor for UK electricity in 2022/23 by 8.9% would produce a reduction in carbon emissions compared to 2021/22 if electricity consumption had remained the same as, nationally, coal generation has decreased significantly and gas and renewables electricity generation increased. However, an increase in patient contacts has increased energy consumption as discussed in the next section.

Energy carbon intensity

The chart 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 2022/23 and shows that annual carbon intensity has returned to below the target in 2021/22 and this has continued into 2022/23. The rate of decrease in carbon intensity is similar to the decrease in the carbon intensity target. In-patient numbers have been chosen, rather than out-patient or staff numbers, as they have the greatest impact on energy use through the consumption of electricity and heating for an overnight stay and for food preparation.



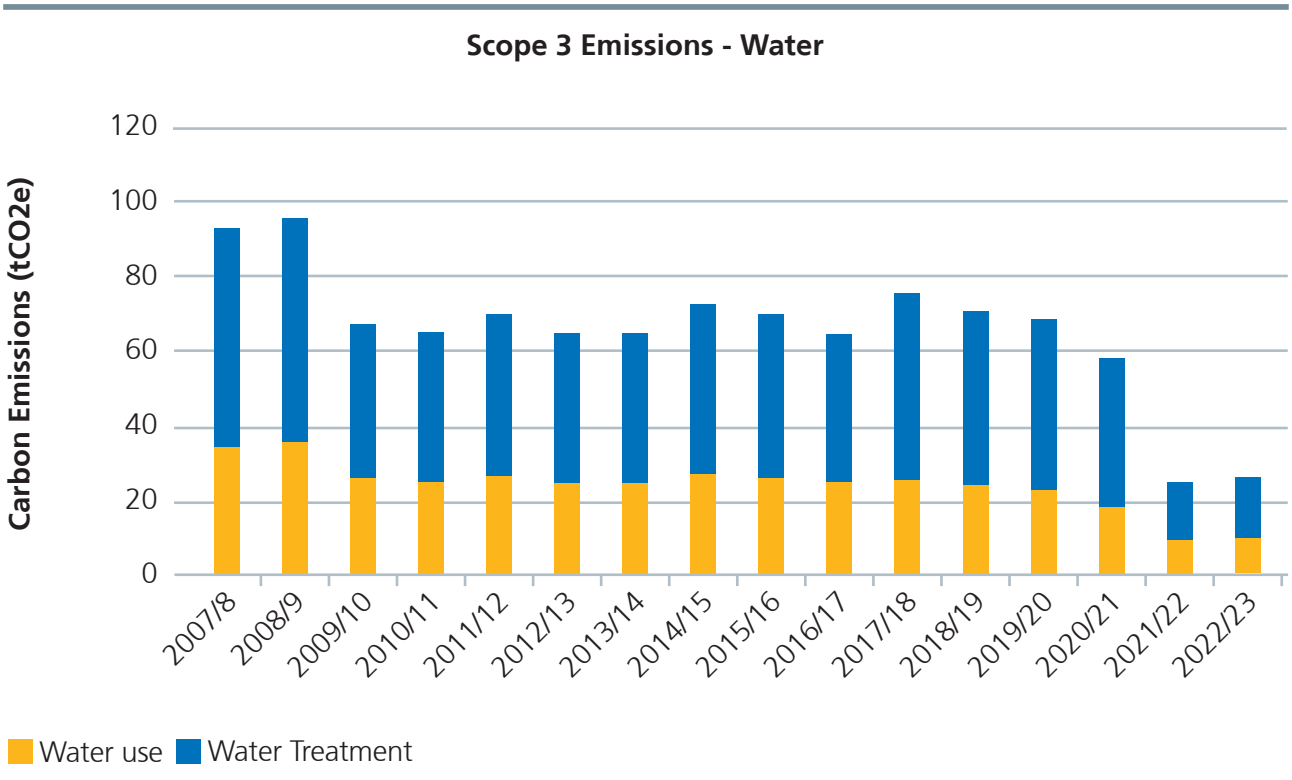
Scope 3 emissions attributable to commuting and patient and visitor journeys



Use of natural resources

The cost of water and sewage was £112,352 in 2022/23, an increase of 0.03% on the previous year, and water consumption and sewage volumes rose by 3% this year compared with 2021/22. The chart below shows the contribution to scope 3 carbon emissions from water consumption.

Scope 3 emissions attributable to water consumption and sewage treatment



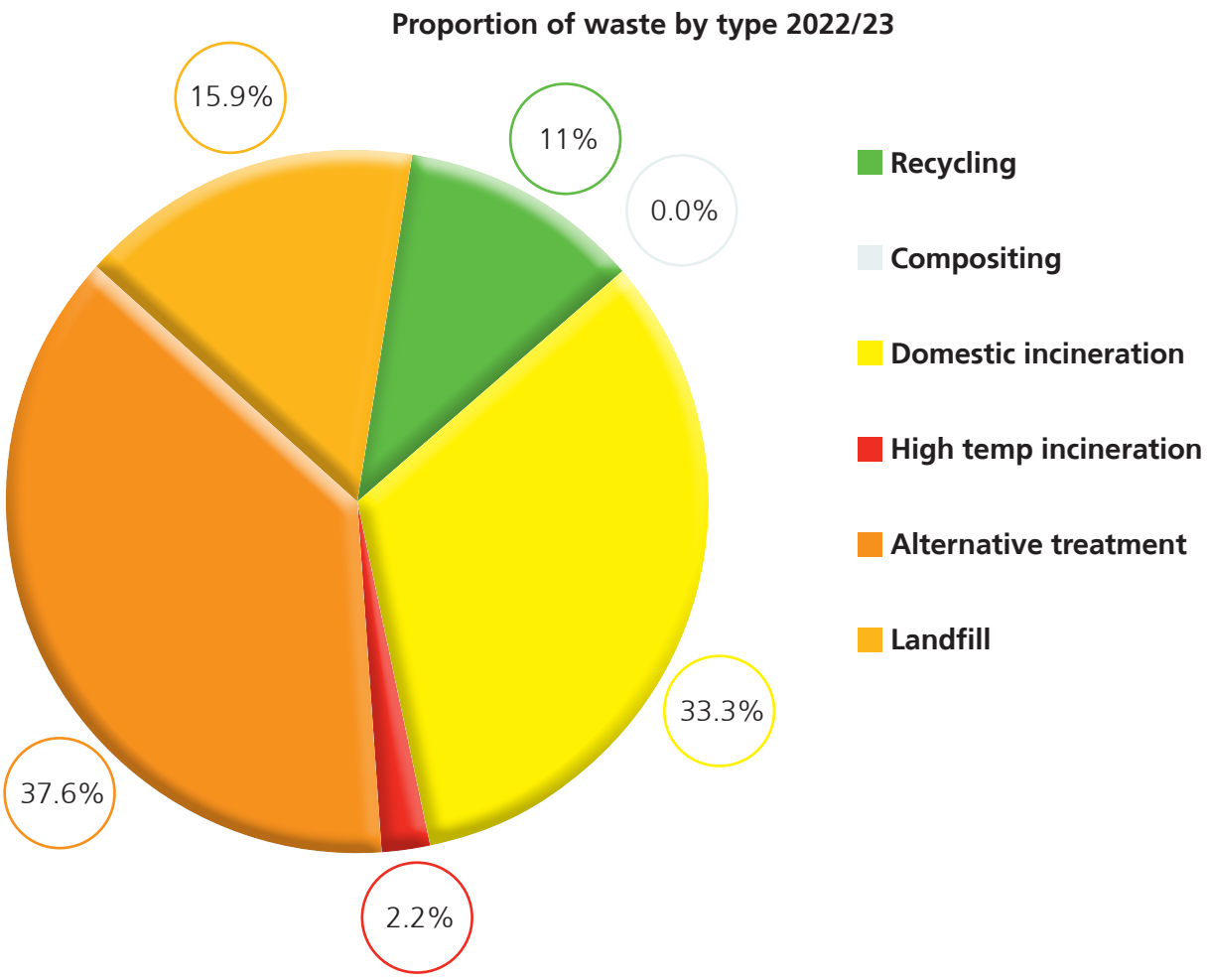
There has been a large reduction in the carbon emissions associated with water supply and water treatment of 51% and 57% respectively from 2020/21 to 2021/22. This is largely due to a reduction in the carbon conversion factors as the basis for the calculation has changed. The water supply and water treatment factors are now calculated based on the 2020 data from the UK water companies Carbon Accounting Workbooks (CAW). Previously the values were coming from a publication of the UK water industry from 2012 that has now been discontinued. We therefore cannot draw any conclusions from the drop in carbon emissions in 2021/22 and 2022/23.

Waste generation

The cost of waste management in 2022/23 was £153,260 a decrease of 4.6% compared with 2021/22. The overall weight of waste increased by 1.4%. There was an increase in the quantity of waste sent for high temperature incineration (21.4%), alternative treatment (6.7%) and landfill (4.4%) and a decrease in the quantity of waste sent for incineration (3.7%) and for recycling (6.5%). 11% of waste was recycled, less than in the previous year.

33.3% of waste is classed as domestic waste. 75.1% of domestic waste is sent for incineration. About 2% of waste, classed as clinical waste, is sent for high temperature incineration, 38.2% is sent for alternative treatment and 16.2% is sent for landfill. The proportions of waste are shown in the chart below.

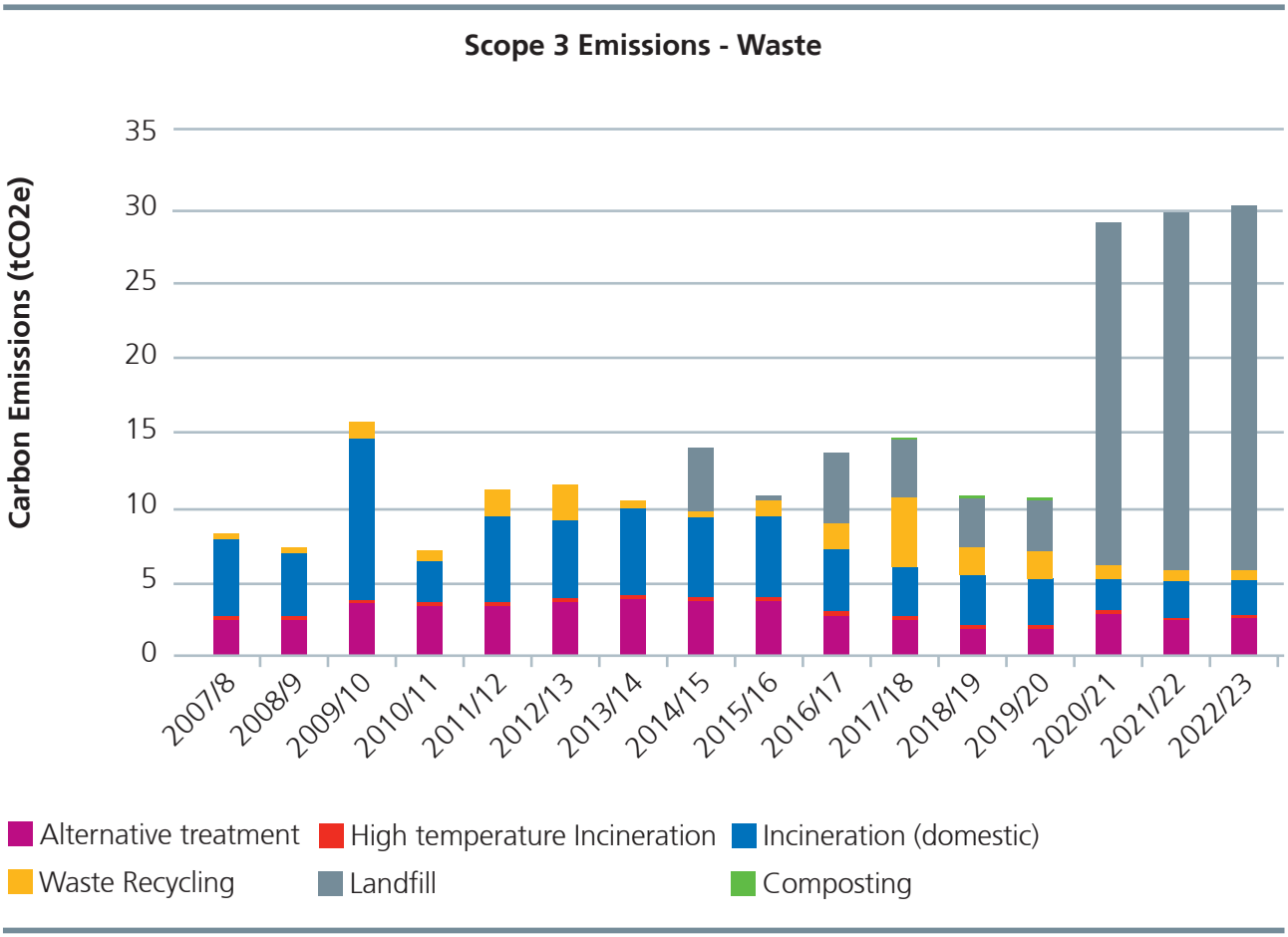
Proportion of waste disposed by disposal route



The level of waste recycling is lower during the years of the COVID-19 pandemic as some of the waste destined for recycling had to be changed to general waste due to the risk of contamination. This appears to have continued into 2022/23

The chart 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. Carbon emissions associated with waste can be reduced by diverting more waste away from landfill into recycling and composting.

Scope 3 emissions attributable to waste disposal and recycling



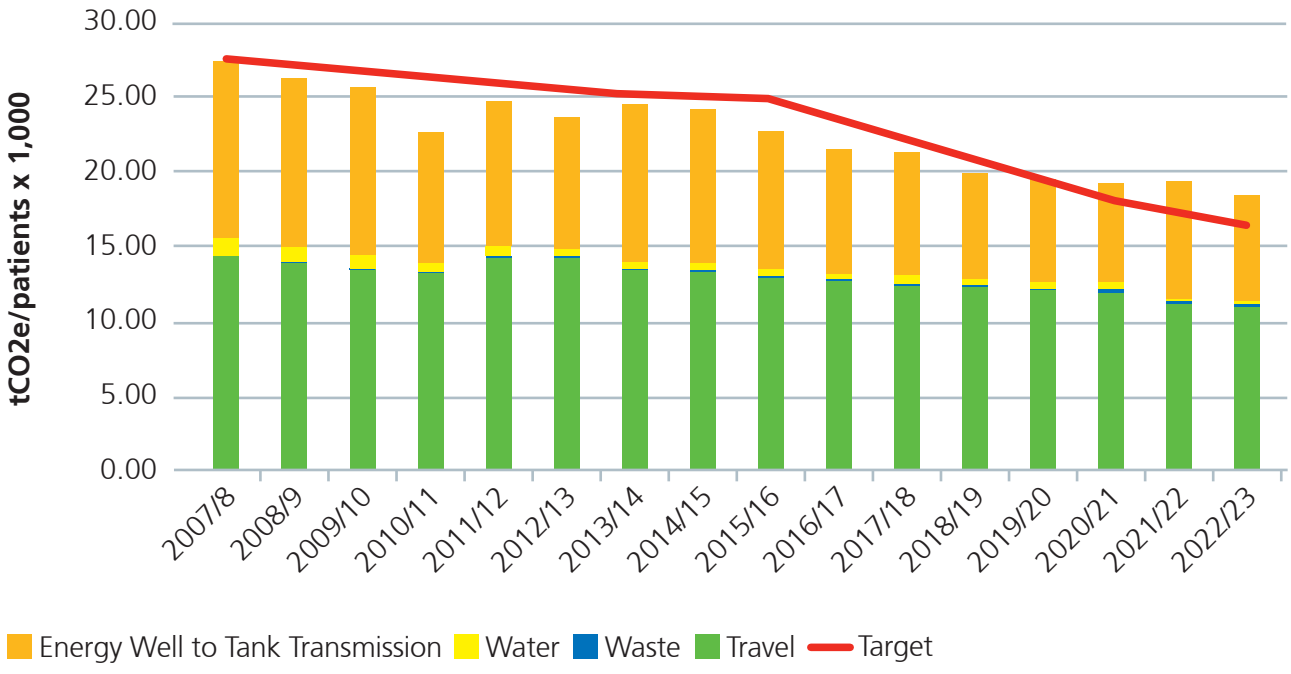
Scope 3 Carbon intensity

The scope 3 carbon emissions produced by the Trust will increase with the number of patient contacts (inpatients and outpatients). The chart below 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, then a 34% reduction in emissions by 2020/21 and an 80% reduction in emissions by 2039 with 2007/8 as the baseline year. The scope 3 carbon intensity from 2019/20 to 2021/22 (19.2) are above the carbon intensity target 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. As the main contributor to travel emissions comes from patient and visitor travel the focus should be upon encouraging them to use public transport or provide a hospital run service.

The scope 3 carbon intensity has decreased by 4.8% in 2022/23 compared with 2021/22, largely as a result of a decrease in the energy well-to-tank conversion factors for UK electricity. Consumption of electricity has increased only slightly from the previous year.

Scope 3 carbon intensity (CO2e emissions per 1,000 patients)



Biodiversity

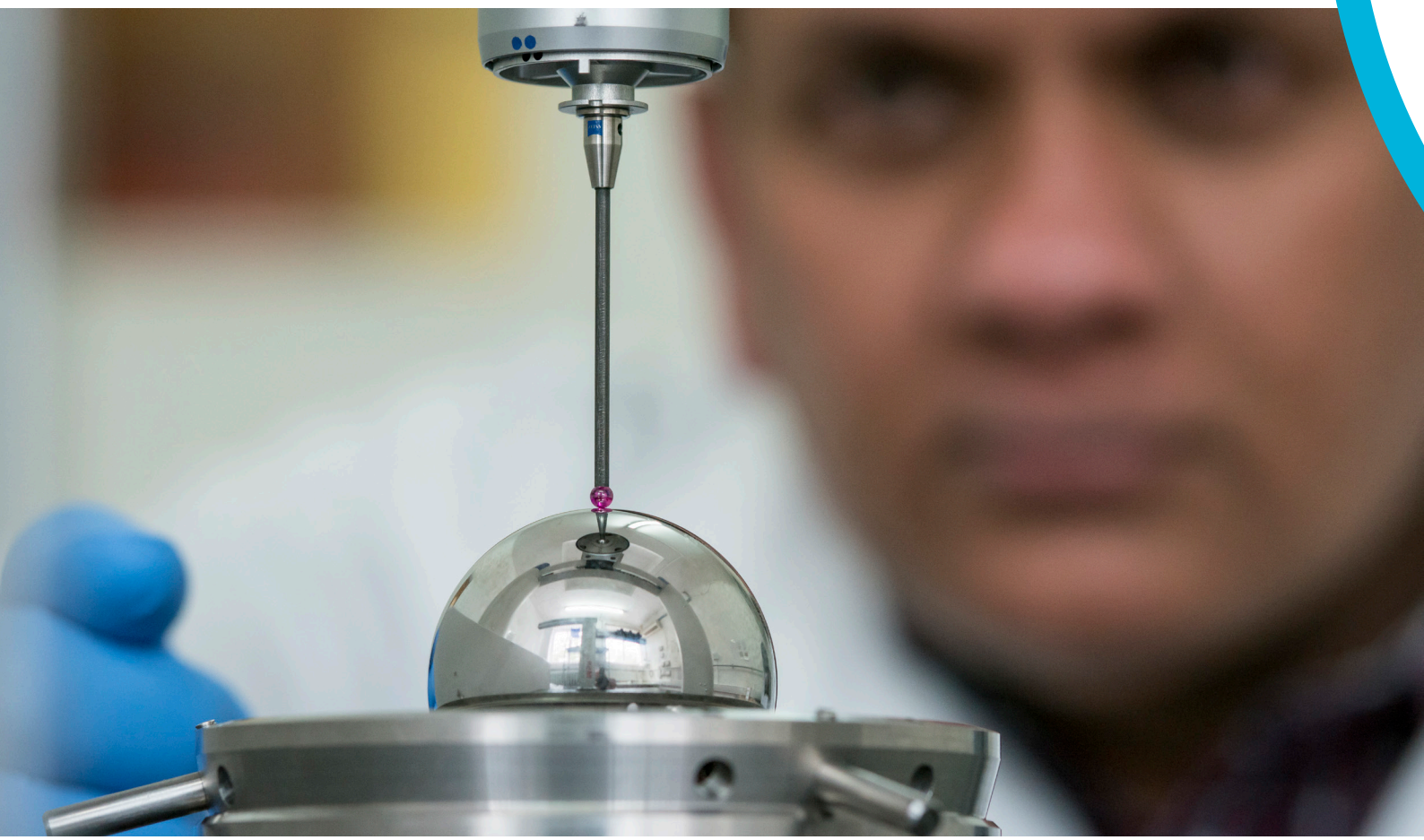
The lake forms one of the key features located on our site and is used by many staff in good weather as somewhere to have a break away from the working environment. Earlier in 2023 the lake was dredged, dead plants and invasive vegetation, sludge, rubbish and other debris were removed to improve water quality and water circulation. These works will also assist the Trust with its surface water drainage system which helps prevent flooding across our site. In addition, the Trust has being planting over a 100 trees around the site. This will help to combat global warming by absorbing carbon dioxide, removing and storing carbon while releasing oxygen back into the air and provide a canopy and a habitat for many species of wildlife.



Chief Executive Officer
29 June 2023



The lake forms one of the key features located on our site and is used by many staff in good weather as somewhere to have a break away from the working environment





Part 4:
Accountability Report – Corporate Governance Report

Directors' report

Director's responsibilities in respect of the preparation of the annual report and accounts

The Directors are responsible for preparing the annual report including the financial statements in accordance with applicable law and regulations. By law, the Directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs at 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 HM 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 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 2022/23



Dominic Dodd
Chair
Voting member

In post since:
November 2019

Trust Roles:
Chair: Trust Board, Finance and Compliance Committee
Member: Clinical Standards and Innovation Committee, People Committee, Remuneration Committee

Experience:
Dominic was appointed chair of the RNOH in November 2019. He is also chair of UCL Health Alliance, the health care provider partnership based in North Central London, and of Skin Analytics, an AI health tech company. From 2010-2021 he was chair of The Royal Free London NHS Foundation Trust and a director of UCL Partners, the academic health partnership.

Prior to that, he was a managing partner of Marakon Associates, a strategy advisory firm. He is a trustee of The Kings Fund and UK Biobank.



Professor Paul Fish
Chief Executive and Accountable Officer
Voting member

In post since:
June 2021 - Chief Executive
May 2020 - June 2021 - Interim Chief Executive and Chief Nurse
February 2015 - May 2020 - Chief Nurse

Trust Roles:
Chief Executive
Chair of the Executive Committee
Member: Trust Board, Finance and Compliance Committee and Executive Committee
Attendance at the following: Remuneration Committee and Audit Committee

Other roles:
Executive Director, UCL Health Alliance (NCL Provider Alliance)
Senior Responsible Officer for Sustainability, North London Partners (NCL Integrated Care System)
Visiting Professor, London Southbank University

Experience:
Paul has worked in the RNOH since February 2015, when he joined as Chief Nurse. Prior to joining the RNOH Paul held a number of senior posts in hospitals in both London and the North-East of England, including extensive experience in specialist hospitals, university hospitals and integrated care organisations.

In May 2020 Paul took up the role of Interim CEO alongside his Chief Nurse role and provided leadership for the organisation through the Covid19 pandemic.

In addition to leading a number of changes in the trust in support of the wider NCL system, Paul lead the trust through a review of its strategic direction which has resulted in a confident new vision for the organisation.



Dr Jane Collins
Vice Chair
Voting member

In post since:
February 2020

Trust Roles:
Chair: Clinical Standards and Innovation Committee
Member: Trust Board, 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. She was awarded an honorary doctorate from the University of Birmingham in 2019.



Doris Olulode
Non-Executive Director
Voting member

In post since:
February 2020

Trust Roles:
Senior Independent Director
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 is Chair of Trustees for Prostate Cancer UK, and 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.



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:
Suren is Global Head of Risk and European and Chief Operating Officer of the financial services firm Sanford C. Bernstein; he was also the European Chief Financial Officer for the period 2003-2020.

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 a BSc in Civil Engineering, 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:
Member: 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.

In 2020, Becky co-led the UCL-Ventura programme to manufacture non-invasive breathing aids at scale for treating COVID-19 patients, both within the National Health Service in the UK and globally. The devices were delivered to 130 NHS Hospitals, and are in use in 15 other countries. The team was awarded the Royal Academy of Engineering President's Special Awards for Pandemic Service in 2020, the Health Service Journal (HSJ) Awards 2020: Acute Sector Innovation of the Year, and Becky was awarded an OBE in the Queen's Birthday Honours (2021).



Dr Lila Dinner
Deputy Chief Executive and Chief Medical Officer
Voting member

In post since:
October 2019

Trust Roles:
Responsible Officer, CCIO
Co-Chair: Clinical Standards and Innovation Committee
Member: Trust Board, Executive Committee, Finance and Compliance Committee, and People Committee, SRO for Health Inequalities

Experience:
Lila joined the RNOH as Chief Medical Officer in October 2019, having been Consultant Anaesthetist at the Royal Free Hospital London for 18 years and most latterly, Divisional Director of Surgery since 2017. She has a strong background in education, dealing with doctors in difficulty, clinical governance and change management. She manages the RNOH Academic portfolio, is SRO for a number of major clinical digital projects, and manages a number of programmes to enhance clinical governance and digital safety. She took on the role of Deputy Chief Executive in December 2021 with a focus on growth and clinical efficiency. She took up the role of Regional Clinical Director for Anaesthetics for NHS E/I London Elective Surgery Recovery and Transformation Programme in April 2021 and holds a number of ICS leadership roles, as NCL Covid Oxygen and Equipment Resilience Lead and co-chair of the NCL Evidence Based Interventions Committee. She is an NHSE London Responsible Officer Appraiser. She continues to work as a Consultant Neuroanaesthetist at the National Hospital for Neurology and Neurosurgery, UCLH part time.



Caroline Owusu-Bennoah
Deputy Chief Executive and 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 is 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)



Louise Morton
Chief Nurse
Voting member

In post since:
January 2022

Trust Roles:
Co-Chair: Clinical Standards and Innovation Committee and People Committee
Member: Trust Board and Executive Committee

Experience:
Louise is a children's nurse with many years' experience in senior roles within nursing leadership, operations and education. She has worked across acute, community/mental health and specialist/tertiary services, as well as Health Education England (HEE). Her most recent role was Director of Nursing at Central and North West London NHS Foundation Trust. Louise holds an MSc in Nursing. She has a particular interest in practice development and improving communication skills, particularly with children and young people. Louise has been the clinical lead for the Capital Nurse Preceptorship programme since its inception in 2017.



Laura Bevan
Chief People Officer
Voting member

In post since:
January 2022

Trust Roles:
Member: Trust Board, Executive Committee and People 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.

In January 2020, Laura joined the RNOH as the Chief People Officer. 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).



Professor John Skinner
Director of Research, Stanmore Musculoskeletal Academic Research Teams (SMART) 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.



Kate Cox
Director of Operations
Non-voting member

In post since:
October 2022

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

Experience:
Over 30 years' experience in the health service including working at acute and mental health services. Worked at various parts of the NHS including Department of Health; a high security psychiatric hospital in Liverpool; and inpatient and community mental health services in Islington.

Switched to the acute setting first to Chelsea and Westminster Hospital and then to the Royal Free Hospital. Appointed to RNOH May 2020 as Deputy Chief Operations Officer.

Immediately prior to that worked in a range of roles at the Royal Free London including work on service redesign and amalgamating services. Qualifications include BSc Economics and MSc Health Economics, Policy and Management.



Mark Masters
Director of Estates and Facilities
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.



John Doyle
Director of Allied Health Professionals
Non-voting member

In post since:
July 2019

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

Experience:
John joined the RNOH as Director of Allied Health Professions 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. He is currently undertaking an Executive MBA at Ashridge Business school.

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.



Daryl Lutchmaya
Deputy Director of Corporate Affairs (Trust Secretary)
Non-voting member

In post since:
November 2015 – April 2023

Trust Roles:
Attendance at the following: Trust Board, Clinical Standards and Innovation Committee, Audit Committee, Remuneration 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).



Fraser Rogers
Chief of Staff
Non-voting member

In post since:
September 2022

Trust Roles:
Attendance at the following: Trust Board, Executive Committee, Finance and Compliance Committee, People Committee, Audit Committee and Clinical Standards and Innovation Committee.

Experience:
Having initially completed an honours degree in Sports Science, Fraser spent the early years of his career in the fitness industry.

He joined the NHS in 2004 and since then has held a number of leadership roles spanning Estates and Facilities, Operations Management, and Corporate Governance, gaining an MA in Corporate Governance in 2012. Fraser spent six years as Chief of Staff for two consecutive Chief Executives at Cambridge University Hospitals, and is an Associate of the Chartered Governance Institute of the UK and Ireland.

Trust board members' who left during the year



Dr Gabrielle Silver
Non-Executive Director
Non-voting member

In post since:
November 2015 – December 2022

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

Experience:
Dr. Silver was formerly the Chief Executive of CHS Healthcare, the leading independent provider of hospital discharge services and Continuing Healthcare in the UK. She oversaw the successful sale of CHS to a trade buyer in 2021. Prior to joining CHS Healthcare, she ran Specialty Operations for McKesson UK.

She has headed the global healthcare practice at Brunswick, advising clients across the life sciences sector with a focus on corporate positioning, crisis management and campaigns. She previously led the GE Global Strategic Marketing Organization with a focus on Neuroscience and Primary Care offerings. She also spent nine years in global roles within the pharmaceutical sector, including Eisai and Bristol Myers Squibb, where she was responsible for the development, launch and commercialisation of innovative therapies in the fields of neuroscience, psychiatry and pain management.

Having qualified as a doctor in London and practiced as an anaesthetist, she is fully familiar with the UK public sector. Dr. Silver received her BSc in Anatomical Science from the University of Bristol and her medical degree from the Royal Free Hospital School of Medicine in London. She also serves as an Independent Director at Opiant Pharmaceuticals, a NASDAQ listed biopharmaceutical company, focused on developing drugs for addiction disorders.



Ms Lucy Davies
Chief Operating Officer and Director of Strategy and Improvement
Voting member

In post since:
May 2015 – April 2022

Trust Roles:
Executive Director for Operational Performance
Member: Trust Board, Clinical Standards and Innovation Committee, People Committee, Finance and Compliance and Executive Committee
Other Roles: Trust lead for Decontamination

Experience:
Having initially completed an honours degree in Sports Science, Fraser spent the early years of his career in the fitness industry.

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.



Dr Saroj Patel
Chief Digital and Innovation Officer
Non-voting member

In post since:
March 2005 – June 2022

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 IM&T. 2009: Appointed the Trust's Senior Information Risk Officer (SIRO).

October 2011: Appointed a Trustee of Aspire (Spinal Injury Charity) based at Stanmore, Middlesex.

2011: Role extended to include Workforce and Corporate Affairs and as a subsequence became a voting member of the Trust Board.

Qualifications include: BSc Statistics and MSc Computer Science (University of London), MBA, Diploma in Marketing, PhD (Cranfield School of Management) and MSP Practitioner.

RNOH Trust board members' declarations of interests

Name	Title	Organisation Name	Nature of Interest
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
Mr Dominic Dodd	Non-Executive Director (Chair)	Wildwood Square Ltd	Director
Mr Dominic Dodd [1]	Non-Executive Director (Chair)	Disinformation Index 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)	UK Biobank	Trustee
Mr Dominic Dodd [2]	Non-Executive Director (Chair)	NHSEI London	Advisor
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
Mrs Doris Olulode	Senior Independent Non-Executive Director	Royal Free London NHS Foundation Trust	Non-Executive Director
Mrs Doris Olulode	Senior Independent Non-Executive Director	Chartered Institute of Legal Executives	Non-Executive Director
Mrs Doris Olulode	Senior Independent Non-Executive Director	Clarion Housing Group	Non-Executive Director
Mrs Doris Olulode	Senior Independent Non-Executive Director	HM Courts and Tribunals Service	Lay Member
Mrs Doris Olulode	Senior Independent Non-Executive Director	University of East London Higher Education Corporation	Independent Governor

Name	Title	Organisation Name	Nature of Interest
Mr Suredran Chellappah	Non-Executive Director	Autonomous Research LLP	Partner
Mr Suredran Chellappah	Non-Executive Director	Sanford C. Bernstein Limited	Director
Mr Suredran Chellappah	Non-Executive Director	Sanford C. Bernstein (Ireland) Limited	Director
Mr Suredran Chellappah	Non-Executive Director	Sanford C. Bernstein (Autonomous UK) 1 Limited	Director
Mr Suredran Chellappah [3]	Non-Executive Director	Sanford C. Bernstein (Hong Kong) Limited	Director
Mr Surendran Chellappah [4]	Non-Executive Director	Sanford C. Bernstein (Singapore) Limited	Director
Professor Rebecca Shipley	Non-Executive Director	International Medical Education Trust 2000 (IMET2000)	Member of the Board of Trustees
Professor Rebecca Shipley	Non-Executive Director	Meliora Innovation	Director
Professor Rebecca Shipley	Non-Executive Director	EPSRC EP/W007096/1 Oncological Engineering – A New Concept in the Treat-ment of Bone Metastases (£2M) (Co-I)	Research award
Professor Rebecca Shipley	Non-Executive Director	EPSRC EP/V034537/1 Assessing Placental Structure and Funtion by Unified Fluid Mechanical Modeling and in vivo MRI (£500K) (Co-I)	Research award
Professor Rebecca Shipley	Non-Executive Director	EPSRC EP/T017791/1 CHIMERA: Collaborative Healthcare Innovation through Mathematics, Engineering and AI (£1.1M) (PI)	Research award
Professor Rebecca Shipley	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

Name	Title	Organisation Name	Nature of Interest
Professor Rebecca Shipley	Non-Executive Director	Cancer Research UK – EPSRC Multidisciplinary Award. Understanding and Improving the Delivery of Nanoparticles to Tumours (£500K) (Co-PI)	Research award
Dr Gabrielle Silver [5]	Non-Executive Director	Genflow Biosciences	Chief Executive Officer
Dr Gabrielle Silver [5]	Non-Executive Director	Opiant	Non-Executive Director
Ms Kate Cox [6]	Board Level Director	NIL	NIL
Mrs Laura Bevan	Board Level Director	NIL	NIL
Ms Lucy Davies	Board Level Director	NIL	NIL
Dr Lila Dinner	Board Level Director	NHSE/I London Elective Surgery Recovery and Transformation Programme	Clinical Director, Anaesthetics
Dr Lila Dinner	Board Level Director	Medical Advisory Group for NHS Professionals	Member
Dr Lila Dinner	Board Level Director	Healthcare Management Trust	Trustee
Dr Lila Dinner	Board Level Director	Healthcare Management Trust	Chair of Clinical Governance Committee
Dr Lila Dinner	Board Level Director	Anaesthetics NHSE/I London Elective Surgery Recovery and Transformation Programme	Clinical Director
Dr Lila Dinner [7]	Board Level Director	MIAD	Faculty for Responsible Officer Training Course
Mr John Doyle [8]	Board Level Director	Chartered Society of Physiotherapy Charitable Trust	Trustee

Name	Title	Organisation Name	Nature of Interest
Mr John Doyle	Board Level Director	'The OT Practice' of [an independent provider of occupational therapy services]	Wife is a Director
Professor Paul Fish	Board Level Director	UCL Health Alliance [NCL Provider Alliance]	Executive Director
Professor Paul Fish	Board Level Director	North London Partners [NCL Integrated Care System]	Senior Responsible Officer for Sustainability,
Professor Paul Fish	Board Level Director	North London Partners (NCL Integrated Care System]	Senior Responsible Officer for MSK and Orthopaedics
Professor Paul Fish	Board Level Director	London Southbank University	Visiting Professor
Mr Mark Masters	Board Level Director	NIL	NIL
Ms Louise Morton	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 Trustee Board
Professor John Skinner	Board Level Director	London Implant Retrieval Centre	Director
Professor John Skinner	Board Level Director	British Orthopaedic Association	President
Professor John Skinner	Board Level Director	Joint BOA, BHS NJR and MHRA Expert Advisory Group on MoM bearing hips	Chair (2010-2020)
Professor John Skinner	Board Level Director	Council of the Royal College of Surgeons of England	Member

Name	Title	Organisation Name	Nature of Interest
Professor John Skinner	Board Level Director	Editorial Board Bone and Joint Journal	Member
Professor John Skinner	Board Level Director	Steering Committee Beyond Compliance	Member
Professor John Skinner	Board Level Director	London Implant Retrieval Centre	Published papers that audited and validated the NJR by linking Registry data with explant analysis – level V Registry reporting. Sabah et al BJJ 2015 and 2016
Professor John Skinner	Board Level Director	Bone and Joint Journal, the Knee, BMJ, Lancet	Paper reviewer
Professor John Skinner	Board Level Director	Versus Arthritis	Grant applications reviewer
Professor John Skinner	Board Level Director	NIHR	Grant applications reviewer
Professor John Skinner	Board Level Director	Medacta	Educational consultant (previously)
Professor John Skinner	Board Level Director	Adler	Educational consultant (previously)
Mr Daryl Lutchmaya	Trust Secretary	NIL	NIL
Mr Fraser Rogers [9]	Chief of Staff	NIL	NIL

[1] Mr Dominic Dodd ceased being a Director of Disinformation Index Ltd in February 2023.
[2] Mr Dominic Dodd ceased being an Advisor for NHSEI London in September 2022.
[3] Mr Surendran Chellappah became a Director of Sanford C. Bernstein (Hong Kong) Limited on 26 September 2022.
[4] Mr Surendran Chellappah became a Director of Sanford C. Bernstein (Singapore) Limited on 9 November 2022.
[5] Dr Gabrielle Silver's ceased being a Non-Executive Director of the Board on 31 December 2022.
[6] Ms Kate Cox became a Board Level Director on 28 July 2022.
[7] Dr Lila Dinner became the Faculty for Responsible Officer Training Course at MIAD in September 2022.
[8] Mr John Doyle ceased being a Trustee of the Chartered Society of Physiotherapy Charitable Trust in May 2022.
[9] Mr Fraser Rogers commenced employment with the Trust on 23 September 2022.

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 2022/23 financial year, 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.

Directors' disclosure to the Trust Auditors

The law requires that all directors take active steps to ensure that the Trust's auditors are made aware of all information that is, or might be, relevant to their work in reviewing the annual report and accounts.

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

a. As a Director, they have taken all of the necessary steps to ensure awareness of any relevant audit information; and to establish that the auditor is also aware of that relevant audit information;

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

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



Chief Executive Officer
29 June 2023



Deputy Chief Executive and Chief Finance Officer
29 June 2023

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 (now merged along with Monitor and NHS Improvement into NHS England), 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.

I confirm, as Accountable Officer, that the Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

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.



Chief Executive Officer and Accountable Officer
29 June 2023

Governance Statement Introduction

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

Scope of responsibility

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

As the Chief Executive Officer, I am accountable to the Trust Board, Chairman, and to NHS England. 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:

- During the year, RNOH has continued to support the development of stronger working relationships and productive partnership across NCL Partners Integrated Care System;
- UCL Health Alliance;
- Meetings between RNOH and NHSE with ICS representatives in attendance, known as the Clinical Quality Review meeting;
- Regular meetings with RNOH Patient Group, Healthwatch, and the Local Authority Health and Social Care Scrutiny Committee;
- RNOH Accountable Officer is Chair of the NCL Partners MSK Programme Board, working with partners across the system;
- 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 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;
- RNOH is a member of the Federation of Specialist Hospitals (FOSH) and contributes fully to the work of that organisation;
- The Accountable Officer of RNOH was included in the appointment process for a new Chair of RNOH Charity, and there are ongoing discussions to ensure that fundraising strategy of the charity aligns with the strategy of the organisation;
- RNOH is a leader of the National Orthopaedic Alliance (NOA). 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.

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 Royal National Orthopaedic Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Governance framework

The Trust Board

Royal National Orthopaedic Hospital NHS Trust is a statutory body that was formed on 1 April 1991 under The Royal National Orthopaedic Hospital NHS Trust (Establishment) Order 1991. The Trust Board membership consists of 5 Voting 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;
- Deputy Chief Executive and Chief Medical Officer;
- Deputy Chief Executive and Chief Finance Officer;
- Chief Nurse;
- Chief People Officer.

During the year, Dr Gabrielle Silver resigned as a Non-Executive Director at the Trust following many years of service. This vacancy for a Non-Executive Director was carried to the end of 2022/23, and a replacement for Dr Silver, Anita Panchmatia, was appointed as a Non-Executive Director from April 2023.

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 six 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 Chief of Staff and Director of Corporate Affairs, who fulfils the role of 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:

- Welcome, apologies for absence, quorum, and declarations of interest;
- A patient story read by a member of the Board;
- A quality improvement update;
- Minutes of the previous meeting, and action log;
- Summary of items discussed at the previous closed Board;
- Chairman's report;
- Chief Executive's report;
- Trust Assurance Dashboard and Board Assurance Framework;
- Remuneration Committee update;
- Audit Committee update;
- Finance and Compliance Committee update;
- Clinical Standards and Innovation Committee update;
- Staffing report;
- Activity and Access report;
- People Committee update;

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

Board attendance

Name	Title
Mr Dominic Dodd	Chairman
Professor Paul Fish	Chief Executive Officer
Dr Jane Collins	Vice Chair/Non-Executive Director
Mrs Doris Olulode	Non-Executive Director
Dr Gabrielle Silver	Non-Executive Director
Mr Surendran Chellappah	Non-Executive Director
Professor Rebecca Shipley	Non-Executive Director
Dr Lila Dinner	Deputy CEO and Chief Medical Officer
Mrs Caroline Owusu-Bennoah	Deputy CEO and Chief Finance Officer
Ms Louise Morton	Chief Nurse Officer
Mr Mark Masters	Director of Estates and Facilities
Mrs Laura Bevan	Chief People Officer
Professor John Skinner	Director of Research, (SMART) Centre
Mr John Doyle	Director of Allied Health Professionals
Ms Kate Cox	Director of Operations (from October 2022)
Dr. Saroj Patel	Chief Digital and Innovation Officer
Mr Daryl Lutchmaya	Deputy Director of Corporate Governance (Trust Secretary)
Mr Fraser Rogers	Chief of Staff (Trust Secretary) (from September 2022)

A: Absent

There were no Board meetings in August 2022.

Board Dates April 2022 to March March 2023

05 May	26 May	30 Jun	28 Jul	01 Aug	29 Sep	20 Oct	24 Nov	15 Dec	26 Jan	23 Feb	30 Mar	Attendance Record
✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11
✓	✓	✓	✓		✓	✓	✓	✓	A	✓	✓	10/11
✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11
✓	A	✓	✓		✓	✓	✓	✓	A	✓	✓	09/11
✓	A	✓	✓		A	✓	✓	✓				06/08
✓	✓	✓	✓		✓	A	✓	✓	✓	✓	A	09/11
✓	A	✓	✓		A	✓	✓	A	✓	✓	A	07/11
✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11
✓	✓	✓	A		✓	✓	✓	✓	✓	✓	✓	10/11
✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11
✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11
✓	✓	✓	A		✓	✓	✓	✓	✓	✓	A	09/11
✓	✓	✓	✓		A	A	✓	✓	✓	✓	A	08/11
✓	✓	✓	✓		A	✓	✓	✓	✓	✓	✓	10/11
						✓	✓	✓	✓	A	✓	05/06
A												00/01
✓												01/01
					✓	✓	✓	✓	✓	A	✓	06/07

Board Committees

Board Committees

The Trust Board Committees report to the Board through Committee up - dates. 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.

Membership of the Board Committees was as follows. This membership reflects those who sat on the committees during the 2022/23 reporting period rather than reflecting the membership at the time of publication of this report:

- 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 – Dr Gabrielle Silver (Chair), Mr Surendran Chellappah, Dr Jane Collins, Mrs Doris Olulode, Professor Rebecca Shipley and Mr Dominic Dodd (Chair following the resignation of 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, Ms Louise Morton, 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 Ms Louise Morton.
- Finance and Compliance Committee: Membership – Mr Dominic Dodd (Chair), Mr Surendran Chellappah, Mrs Caroline Owusu-Bennoah, Dr Lila Dinner, Ms Kate Cox, Professor Paul Fish and Ms Lucy Davies.
- Executive Committee: Membership – Professor Paul Fish (Chair), Mrs Laura Bevan, Ms Lucy Davies, Dr Lila Dinner, Ms Kate Cox, Mr John Doyle, Mr Mark Masters, Mrs Caroline Owusu-Bennoah, Dr Saroj Patel, Professor John Skinner and Ms Louise Morton.

The Trust Board

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 2022 –March 2023	
Name of Committee	**Meetings held**
Audit Committee	4
Remuneration Committee	3
Clinical Standards and Innovation Committee	5
Finance and Compliance Committee	11
People Committee	4
Executive Committee	47

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

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 NHSE 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.

Dr Gabrielle Silver is a non-Executive Director of Opiant, a US biopharmaceutical business focusing on drugs for addiction.

Doris Olulode holds Non-Executive Directorships at Royal Free London NHS Foundation Trust, Clarion Housing Group 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, and in early 2023 was appointed Chair of Trustees in Prostate Cancer UK.

Surendran Chellappah is Global Head of Risk and European Chief Operating Officer of the financial services firm Sanford C. Bernstein. Mr Chellappah was also the European Chief Financial Officer for the period 2003-2020.

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, 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

Audit Committee

- The Committee is chaired by a Non-Executive Director who is a finance professional and has 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 one of the Non-Executive Directors and includes all of the other Non-Executive Directors in its membership. 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 four 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 two 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 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, and has produced a new Executive governance structure ready for introduction at the start of 2023/24.

Quality Governance

The Trust has robust arrangements in place (supported by a comprehensive committee structure) to seek and to provide assurance on the clinical quality and safety of care provided at RNOH. This is principally led by the Clinical Standards and Innovation Committee which is configured as a monitoring and assurance committee of the Board.

The Integrated Governance and Risk Sub-Committee takes an operational lead providing assurance to external stakeholders including Commissioners, NHSI and NHSE. The meeting is executive chaired by the Chief Nurse, Deputy Chief Executive and Chief Medical Officer or the Associate Medical Director with attendance by senior clinical, quality and operational staff. Other mechanisms to ensure quality within the Trust include:

- Chief Nurse acting as 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, clinical audit, regulatory compliance, health and safety, risk management and emergency planning and response and legal matters.
- Monthly Quality Report and scorecard system covering Trust wide and divisional performance in relation to Quality.
- Accreditation for Excellence (SAFE) in patient care is the RNOH ward/departmental quality accreditation scheme. This scheme provides support to teams in their journey to delivering outstanding quality of care. SAFE was co-designed in partnership with stakeholders including patients and frontline staff. It is linked to Trust objectives and cross-referenced to the care quality commission's key lines of enquiry. Le by a multi-disciplinary assessment team, key clinical performance indicators are reviewed followed an unannounced visit. Following the assessment, the results and feedback from the accreditation are shared with the Divisional Head of Nursing, Ward Manager, QI Team and the Nurse Education Tea.
- The fortnightly Safety Learning Walks were newly established in 2022 to support the delivery of safe and effective care that also focuses on the holistic patient experience lending itself to the RNOH Patient Charter. Safety Walks use a variation on mystery shopping observational approaches to understand what service users and carers experience when they are in a healthcare setting. A small team of 2-3 staff from across the Trust visit wards and other service user areas for no more than 1 hour and take note of their impressions and provide immediate feedback (including areas of excellence and opportunities for improvement).
- A dedicated Freedom to Speak Up Guardian is in post acting as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, or if necessary, outside the organisation. They support staff to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.

- The Learning from Deaths Group (chaired by the consultant mortality lead) continues to contribute to the improved quality and patient safety in relation to patient deaths through the analysis by a multidisciplinary group of clinicians of the circumstances surrounding the outcomes of deaths, making recommendations which focus on measures that can prevent similar incidents and learning and ensuring the completion of Structured Judgement Reviews (SJRs).
- The Clinical Audit function within the Trust is well embedded and ensures participation in national clinical audits, promotion of audit best practice as well as ensuring that local audits are completed on key priority areas. It is led by the Clinical Audit and Effectiveness steering group chaired by a consultant lead for clinical audit. Outcomes audits and learning are fed into the Trust via the bimonthly Trust wide Quality Improvement and Clinical Audit Presentation sessions.
- Recruitment of dedicated Patient Safety Partners (PSPs) to participate in key governance committees and groups focusing on safety, risk, and quality. The PSP role is to reflect the voice and needs of people who use hospital and community-based health services including patients, family members, carers and the public. The PSPs are actively involved in the design of safer healthcare at all levels within the Trust including but not limited to participation in investigations, developing hospital policy and contributing to developing the hospital strategy and objectives
- Recruitment of Patient Safety Specialists tasked with providing dynamic senior patient safety leadership. Each Patient Safety Specialist is dedicated to providing expert support to the Trust, and has direct access to their executive team, which facilitates the escalation of patient safety issues or concerns. They also play a key role in the development of a patient safety culture, safety systems and improvement activity.
- As well as coordinating and supporting local patient safety priorities, Patient Safety Specialists help with the implementation of the NHS patient safety strategy and other national safety priorities. The specialists have close links with the NHS England and NHS Improvement National Patient Safety Team who host a national network for Patient Safety Specialists, including regular meetings and information sharing through a dedicated online forum.
- Implementation and rollout of the Academy of Medical Royal Colleges National Patient Safety training syllabus including modules covering the Essentials for Patient Safety (Systems thinking and Human factors) and Access to Practice (Risk expertise and Safety culture) to all staff
- Learning from Excellence' (LfE) was implemented and is an innovation that focuses on capturing and learning from episodes of excellence in an attempt to further improve the quality and safety of care within a front-line clinical environment . Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. It is an initiative for noticing, reporting, appreciating and learning from episodes of good practice in a similar way to reporting adverse incidents. It is based on the premise that we can learn from what goes well and showing appreciation to colleagues cultivates a positive workplace and learning environment.

Risk assessment

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

The RNOH Trust Board is committed to leading the organisation to deliver quality services and excellent patient outcomes and recognises that embedded proactive and integrated risk management is an essential feature to achieve this. The Audit Committee, Clinical Standards and Innovation Committee and the Integrated Governance and Risk Sub-Committee assist the Board in identifying whether risk processes are adequate, and in overseeing the required improvements.

The Trust (extreme) Risk Register is used to inform the Board Assurance Framework (BAF) 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 BAF. The BAF assesses the major internal and external risks which could impact on the Trust's ability to deliver its strategic objectives. Each Trust (extreme) 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 at the Executive Committee meeting 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.

A summary of the Trust's strategic risks as contained in the BAF as at March 2023 are as follows:

Strategic Risk	Corporate Objectives	Key Risk Indicators
SR1 **Dr Lila Dinner** **Louise Morton**	Achieve top decile performance in outcomes	PROMS data >95% capture GIRFT data Non-PROMS outcomes Model hospital data CQC insights profile CRAB data
SR2 **Professor Paul Fish**	Develop partnerships within NCL and nationally to facilitate long-term sustainability	Reference Costs Grow NHS income > £200m Grow PP income > £21m Commissioning tertiary MSK in London MSK lead role for NCL MOU with RFL MOU with GOSH
SR3 **Caroline Owusu-Bennoah Professore**	Financial sustainability	Contribution by Service (PLICS Data) PPU Turnover Growth indications Model Hospital Data
SR4 **Laura Bevan** **Louise Morton**	Best Patient and Staff Experience	WRES - 9 WRES indicators Staff Survey – engagement score WDES – 10 WDES indicators Balanced Scorecard Access Report
SR5 **Mark Masters**	Infrastructure – Redevelopment	Infrastructure and building availability Six Facet Appraisal Estates Risk Register
SR6 **Dr Lila Dinner**	Infrastructure – Enable a digital first environment	EPR Business Case progress Infrastructure resilience Cybersecurity Action Plan Vacancy and turnover rate in Digital Contract Management

	Risk Rating Movement **Same** ◀ ▶ **Improved** ▼ **Worsened** ▲	Historic Current Risk Rating	Inherent Risk	Current Risk March 2023	Target Risk	Strength of Controls	Strength of Assurance
	◀ ▶	Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb	25	10	10		
	◀ ▶	Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb	12	12	4		
	◀ ▶	Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb	20	16	15		
	◀ ▶	Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb	16	12	8		
	◀ ▶	Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb	25	20	10		
	◀ ▶	Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb	15	15	10		

Extreme Risk Register

Risk registers are dynamic documents, which are populated through the organisation's risk assessment and evaluation processes. The Trust take a proactive and integrated approach to managing risk. In order to support the overall Trust-wide risk management process, work continues to ensure that local clinical and operational teams are supported to identify, assess, and manage and to escalate risks using the Trust's comprehensive Risk Register process. The Risk Registers inform the Board Assurance Framework.

As of the end of March 2023, there were 14 risks on the Trust's extreme risk register with a residual score of 15 and above. In summary the risk themes related to:

- Patient access, imaging reporting and waiting times for treatment
- Recruitment and retention of staff
- Private Patient Unit growth ambitions and sustainability
- Mechanical ventilation systems
- New patient referral pathways and clinical networks
- Financial (underlying deficit, system recovery, central funding streams, EPR and system capital funds)
- Digital (infrastructure architecture, specialist workforce, ransomware resilience)
- Mandatory training

The Trust reviews the actions and mitigation arrangement for each of these extreme risks as described in the Risk Management Policy and risk management approach. This includes but not limited to presentation of the risk and the mitigating actions reviewed on a monthly basis at the Executive Committee meeting 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.

Incident Reporting

The Trust process for reporting incidents is through the Safeguard Incident Management System (Ulysses) which is continuously 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 ongoing basis until closure. These incidents are also reviewed on a weekly basis at the Incident Review Group (IRG) to discuss concerns, identified learning, confirm investigation pathways (if not agreed prior to the meeting), review grading and decide which incidents meet the external Serious Incident criteria for external notification and/or regulator notifications.

The Patient Safety Team work alongside the services to support with root causes analysis investigations. Learning themes are shared across key governance meetings including but not limited to: The Trust Audit morning, divisional quality meetings, Clinical Standards and Innovation Committee (CSIC), Divisional Performance Reviews (DPR) and the Integrated Governance and Risk Sub Committee (IGRC) and action and assurance on implementations are followed up with divisions via a centralised action tracker.

Never Events are serious, largely preventable, safety incidents. During 2022/23, there was one Never Event and 4 Serious Incidents reported on the Strategic Executive Information System (StEIS).

The Never Event related to a wrong side of surgery for the soft tissue excised as part of a correctly completed partial sacrectomy surgery.

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. 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.

The Quality department (part of the Nursing 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:

- The Trust's risks are recorded in the Ulysses risk management platform;
- The risk register is divided into Divisional risks, risks that affect corporate services and extreme risks;
- 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 and assessments, clinical audits, external recommendations and guidance, financial challenges, underperformance against internal and external metrics;
- 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;
- Divisional risks are reviewed monthly at Divisional Board meetings and quarterly at the dedicated Quality, Safety and Risk divisional meeting;

- 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. Extreme risks (score of over 15) are reviewed on a monthly basis by the Executive Committee;
- Risk register reviews take place at a series of local and Trust wide meetings, including monthly Divisional Performance Reviews (with scrutiny by the Operational Leadership Team), 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, Clinical Standards and Innovation Committee and Integrated Governance and Risk Sub-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 patient and staff safety, patient experience and involvement, clinical effectiveness, clinical audit, regulatory compliance, health and safety and emergency planning and response, risk management and legal matters
- 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 and Social Care 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 and Risk 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 (including frequency of review based on risk score). 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.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have the responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the 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;
- 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 2022/23 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 2022/23 was based on the following positive assurance opinions:

- Data Quality (Reasonable Assurance);
- Transformation and Efficiency Savings (Reasonable Assurance);
- Risk Management (Reasonable Assurance);
- Cyber Security – Follow Up (Reasonable Assurance).

Internal Audit also issued one Advisory review in relation to Financial Sustainability, with no significant issues identified, and also completed an Assurance Map.

Internal Audit completed an advisory review on the HFMA Financial Sustainability checklist that the Trust completed at the request of NHSE. The Trust scored itself 4 or 5 (positive scores) on 63 out of 72 questions within the self-assessment (87.5%) and identified themselves as a 3 (scores of 1-3 required supporting actions to demonstrate improvement) on eight questions, and 1 on one question; this related to 'Culture, Training and Monitoring', in relation to financial governance training being included in induction starter packs. From their review, Internal Audit were satisfied that the checklist had been largely completed appropriately and that an action plan was in place/is being developed for the Trust in relation to the identified gaps.

Internal Audit did not issue any 'no assurance' or 'partial' opinion reports in 2022/23 to date. In the audits shown as providing Reasonable assurance, Internal Audit identified some areas where enhancements were required and in each of these cases management actions had been agreed, the implementation of which will improve the control environment.

During 2022/23, there were 33 open management actions (24 medium and nine low), which included those management actions carried forward from previous years. 21 management actions (15 medium and six low) had been implemented, two management actions (one medium and one low) had been superseded, and 10 management actions (eight medium and two low) were not yet due as they had not yet reached the original or revised implementation dates.

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 has reported a cumulative adjusted deficit since 2016/17 and is non-compliant with this duty in 2022/23. 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 31 March 2023.

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 via regular virtual meetings and with the assistance of the Communications Team.

Further assurance is provided by fraud and bribery risk assessments, local proactive exercises in known and high risk areas, and participating in the National Fraud Initiative. Assurance is also provided by 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 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 CFFSR (Counter Fraud Functional Standard Return), against GovS:013 Counter Fraud as adapted by the NHS CFA to the Requirements for the NHS. This is approved by the Deputy Chief Executive and 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 2022/23 covered Ethical Phishing - testing RNOH defences. There was also a fraud risk and bribery assessment in 2023/24 to assess and identify RNOH fraud risks.

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 Chief Executive, Deputy Chief Executive and Chief Financial Officer and Director of Operations in attendance. Management reports on the achievement of key financial targets are scrutinised and challenged effectively by the members of the Committee.

g. 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.

h. 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 Deputy Chief Executive and Deputy Chief Executive and 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.

i. 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.

j. 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.

k. 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 International Fraud Awareness Week.

m. 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.

n. 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.

o. 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 Deputy Chief Executive and Chief Financial Officer.

Fraud awareness material is made available on the Trust 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 Deputy Chief Executive and Chief Financial Officer and attends Audit Committee meetings to provide updates against the counter fraud work plan.

p. 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 2022/23 which could give rise to the significant risk of fraud.

q. Eight new referrals have been received by the LCFS since 1 April 2022, noted within the Audit Committee papers and where required reported to the NHS CFA. One of these cases led to financial loss to the Trust.

r. 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.

s. 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.

t. 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 2023 Audit Committee at which the draft 2022/23 financial statements are considered. Reports are received at every Audit Committee setting out losses and special payments.

u. 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 2022/23 financial statements.

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.



Chief Executive Officer
29 June 2023

NHS Provider Licence

The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future. All NHS foundation trusts and NHS trusts are required to hold a licence. NHS controlled providers and independent providers of NHS services are required to hold a licence unless exempt. The NHS provider licence was first introduced for NHS foundation trusts in 2013 and extended to NHS trusts from April 2023.

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 NHSE, to be brought to the attention of the Board in a timely manner. The Trust's Standing Orders are 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. The Remuneration Committee meets to discuss Executive Directors' performance. Board members comply with the annual Fit and Proper Person Test. The Board Committee Structure is fit for purpose 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. 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 Patient Stories 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.

NHS Oversight Framework 2022/23

The NHS oversight framework for 2022/23 replaces the NHS system oversight framework for 2021/22, which described NHS England and NHS Improvement's approach to oversight of Integrated Care Boards and trusts. The framework outlines NHS England's approach to NHS oversight for 2022/23 and is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance. It also reflects the significant changes enabled by the Health and Care Act 2022 including the formal establishment of integrated care boards and the merging of NHS Improvement (comprising of Monitor and the NHS Trust Development Authority) into NHS England.

The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate, supporting NHSE's ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England, and the government's white paper on integration – Joining up care for people, places and populations.

Review of Effectiveness and 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.

The Trust is able to demonstrate that it has used resources economically, efficiently and effectively. Despite the ongoing challenges presented by the pandemic and pressures relating to Elective Recovery, the Trust was able to achieve its financial targets. The Trust continues to reduce its agency spend, with a reduction of c£2m compared to pre pandemic levels. This is against a backdrop of national recruitment and retention challenges. In addition the Trust delivered 77% of its efficiency target which included 44% (£3.7m) recurrent saving.

Information Governance

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 DSP assessment period for 2021/22 is from 1 September 2021 to 30 June 2022 and the Trust met the standards.

The Trust DSP assessment period for 2022/23 is from September 2022 to June 2023 and therefore the compliance rating has yet to be published*.

*information accurate at time of publication, results for the DSP assessment publication after June 2023 can be located https://www.dsptoolkit.nhs.uk/OrganisationSearch/RAN.

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 Assurance Dashboard encompasses National indicators and key indicators used by the Trust Board and its Committees to monitor performance. The Dashboard 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 draft dashboard is provided to the Executive Team prior to publication for review. The KPI data is used at Trust Board and meetings of the Board's Committees ensuring that information is reported consistently.

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 data quality dashboards where datasets can be reviewed to identify errors and omissions for correction.

Review of Economy, Efficiency, Effectiveness and Use of Resources

The National Audit Office introduced a new Code of Audit Practice which came 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 2022/23 is required to be issued no later than 31 July 2023. 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 31 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 2021/22 data can be found at: https://www.rnoh.nhs.uk/about-us/corporate-information At the time of publishing this Annual Report the 2022/23 data was not available however it will be uploaded on to the RNOH website by 31 July 2023.

Fraud deterrent

RNOH is committed to tackling fraud, corruption and bribery. An Anti-Fraud and Anti-Bribery policy is in place to provide advice to all employees, suppliers, contractors, stakeholders in dealing with fraud or suspected fraud and there is 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 strives for full compliance with the Government Functional Standards GovS:013 Counter fraud, which were adapted for the NHS by the NHS Counter Fraud Authority into 13 NHS Requirements in February 2021.

The Trust will take all necessary steps to counter fraud and corruption in accordance with the Trust's Antifraud 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 2022/23, the Counter fraud team have received eight new 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.

Carbon intensity

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

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

This year there were a number of key achievements around Inclusion, including; developing an EDI Strategy and launching the EDI Strategy Programme Board, embedding the Equality Impact Assessment and process; further developing the Trust recruitment training with a focus on fairness and inclusion of recruitment practices; and; the delivery of various listening events and for staff which have contributed to the 2023/24 Inclusion Plan.

Workforce strategies

A People Strategy for the Trust

The People Directorate, led by the Chief People Officer, has been working to refresh an overarching Trust People Strategy for the next three years. This is being structured on the same basis as the NHS People Plan so that there is clear read across between the national approach and local approach. The strategy has four pillars – looking after our people, inclusivity and belonging, new ways of working and growing for the future. This strategy will ensure that the Trust has a clearly articulated vision and plan for how to achieve its ambition to offer the best staff experience in the NHS.

System working – North Central London Integrated Care System

Throughout 2022/23 the Trust has continued to work across the North Central London Integrated Care System in relation to the centralisation of corporate support functions, where it made most sense to increase quality and efficiency. The Trust is a partner organisation of North London Partners Shared Service (NLPSS) and having transferred its recruitment service and staff to NLPSS in December 2021 it now also has the Occupational Health service provided by NLPSS. The Trust continues to partner with Royal Free London Hospital NHS Trust for the provision of it's shared medical workforce service.

The Trust has also worked collaboratively with North Central London and benefits from a jointly procured payroll service and a jointly procured legal service framework.

Key performance indicators (waiting list validation)

- Every validation for each cohort must have a validation outcome (and associated comment, 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 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 for escalating to divisional management if there is insufficient clinic or theatre capacity. In addition to this, units validate and review waiting times in team level Patient Tracking List (PTL) meetings which are held weekly, and then again at the fortnightly Access and Waiting List meetings which are chaired by the Head of Elective Access. The Operational Managers and Unit Directors attend this meeting and are held to account for waiting times in their areas. 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.

In addition to the usual validation of the Trust PTL, the validation team continue to focus on regular validation of cohorts of patients who are potentially at risk of becoming lost to follow up. This can be as a result of various scenarios but a notable cause is previously cancelled outpatient appointments that are not rebooked at the time of cancelling the appointment. Any patients found, through these reviews, to not have future plans are managed appropriately (e.g. added to the follow up waiting list, discharged or sent to the relevant clinical team for a decision on future management). Themes are reviewed, assessing the reasons that patients meet the criteria for a review due to potentially being lost to follow up and are addressed directly with the areas as required. For example, an MDT process has been changed to better ensure a decision regarding future management is communicated to administrative teams, allowing them to action the relevant steps on the system.

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:** The absence of a single IT platform to collect outcomes data, variable outcome data collection at individual service level, a requirement for further embedding of reporting and clinical reviewing of outcomes data to drive continuous improvement, insufficient workforce to deliver top decile care, and lack of a complete electronic patient record.

2. **Develop partnerships within NCL and nationally to facilitate long-term sustainability:** The potential failure to embed partnership models, could lead to the failure to develop and operationalise a model of MSK lead provider for the north of NCL, coupled with a failure to achieve lead commissioner status for specialist commissioning of MSK. Alongside this there is a risk of failure to generate sufficient capital to build RNOH at Chase Farm Hospital site.

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. In addition there are risks associated with the failure to increase profit from private practice income, a failure to improve operational efficiency and reduce the cost base, as well as the failure to increase the overall Trust turnover via the NHS income growth strategy.

4. **Best Patient and Staff Experience:** Issues relating to patient and staff experience relate to workforce supply and retention and its impact on patient safety and experience, the potential failure to progress with equality and diversity, and a deterioration in staff health and wellbeing. There are also risks associated with potential deterioration in access target (specifically RTT) performance leading to longer waits for treatment. In addition there are risks presented by limited data to review patient access and experience regarding equality, diversity and inclusion, and the potential for poor experience due to long waits along with communication and telephone issues.

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. **Digital 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), clinical engagement with digital platforms, and infrastructure resilience gaps are significant risks.

Conclusion

The system of internal control has been in place in the Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2023 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.



Chief Executive Officer
29 June 2023

Part 5:
Accountability Report – Remuneration and Staff

Remuneration Policy

The Remuneration Committee, in line with NHS guidance, determines remuneration and terms of service for the Chief Executive and other Executive Directors. A Non-Executive Director chairs the Committee and the remaining membership comprises the Trust Chairman and 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 Note 1.5 and Note 8 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 2022/23 (see the severance payments table and the Directors' salary entitlements table below for further details).

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member of staff in their organisation compared to the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. Remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component. This is set out in the table below. The median/25th percentile/75th percentile remuneration and salary has been calculated using employees in post in March 2022. The individual remuneration/salary has been converted to full-time equivalents and annualised. The median salary is that lying in the middle of the linear distribution and the same methodology has been applied to the 25th and 75th percentile. Remuneration includes salary, nonconsolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pension.

2022/23	25th Percentile	Median	75th Percentile
Remuneration (£)	30,390	43,503	53,703
Salary Component (£)	30,390	43,503	53,703
Ratio - Remuneration compared to highest paid employee	7.02:1	4.90:1	3.97:1

2022/23	25th Percentile	Median	75th Percentile
Remuneration (£)	30,390	43,503	53,703
Salary Component (£)	30,390	43,503	53,703
Ratio - Remuneration compared to highest paid director	6.58:1	4.60:1	3.72:1

Remuneration in 2022/23 ranged from within the £1 – £5,000 banding up to the £210,000 – £215,000 banding (2021/22 £1 – £5,000 to £200,000 – £205,000).

The percentage change (increase) in the highest paid director pay from 2021/22 to 2022/23 was 7.77%. The average percentage change for employees (excluding the highest paid director) from 2021/22 to 2022/23 was 2.46%.

In 2022/23 one employee (2021/22 one employee) received remuneration in excess of the highest-paid director which is due to remuneration received for Clinical Excellence Awards and additional responsibilities.

The Pay Multiples (Fair Pay) disclosure is audited.

Directors' salary entitlements 2022/23

Name	Title	Start/ Leave Dates	2022 Salary (bands of £5000 £'000	Expense Payments (Taxable) total to nearest £100 £	Performance pay and bonuses (bands of £5000) £'000
S Chellappah	Non-Executive Director	Mar-20	10-15		
R J Shipley	Non-Executive Director	Jun-20	10-15		
J E Collins	Non-Executive Director	Feb-20	10-15		
D Dodd	Chairman	Nov-19	35-40		
D H Olulode	Non-Executive Director	Feb-20	10-15		
G A Silver	Non-Executive Director	Oct-15 - Dec-22	5-10		
J A Skinner	Director of Research and Innovation Centre	Jan 17	150-155		45-50
L Davies	Chief Operating Officer	Apr-15 - Apr-22	5-10		
Professor P Fish	Chief Executive	Feb-15	160-165		
M Masters	Director of Estates and Facilities	Dec-03	115-120		
Dr S Patel	Chief Digital and Innovation Officer	Mar-05 - Jun-22	155-160		
J Doyle	Director of Allied Health Professionals	Jul-19	95-100		
L Dinner	Medical Director	Oct-19	190-195		
LJ Bevan	Chief People Officer	Jan-20	115-120		
C Owusu-Bennoah	Chief Financial Officer	Mar-20	140-145		
L Morton	Chief Nurse	Jan-22	120-125		
C Cox	Chief Operating Officer	Apr-22	110-115		

Notes

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

Note 2: Dr S Patel, Chief Digital and Innovation Officer was notified of redundancy in 2021/22 and Dr Patel ceased working for the Trust in June 2022. The redundancy payment is within the £125,001 - £130,000 banding and was paid in June 2022. This payment is included within 'salary' in the table above. This redundancy was reflected in the Severance Payments section of the Remuneration and Staff report within the 2021/22 Annual Report.

Note 3: The table above is audited.

/23			2021/22					
Long term performance pay and bonuses (bands of £5000)	All pension related benefits (bands of £2500)	Total (bands of £5000)	Salary (bands of £5000)	Expense Payments (Taxable) total to nearest £100	Performance pay and bonuses (bands of £5000)	Long term performance pay and bonuses (bands of £5000)	All pension related benefits (bands of £2500)	Total (bands of £5000)
£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
		10-15	10-15					10-15
		10-15	10-15					10-15
		10-15	10-15					10-15
		35-40	35-40					35-40
		10-15	10-15					10-15
		5-10	10-15					10-15
	15-17.5	215-200	140-145		45-50		45-47.5	235-240
	0-2.5	5-10	125-130				37.5-40	165-170
	42.5-45	205-210	155-160				47.5-50	205-210
	32.5-35	150-155	110-115				32.5-35	145-150
	0	140-145	125-130				7.5-10	135-140
	20-22.5	115-120	90-95				12.5-15	100-105
	70-72.5	260-265	180-185				82.5-85	260-265
	30-32.5	150-155	115-120				32.5-35	145-150
	35-37.5	175-180	130-135				32.5-35	165-170
	122.5-125	240-245	20-25				67.5-70	90-95
	125-127.5	235-240						

Directors' pension entitlements 2022/23

Name	Title	Start/ Leave Dates
L Davies	Chief Operating Officer	Apr-20 - Apr-22
Professor P Fish	Chief Executive	Feb-15
M Masters	Director of Estates and Facilities	Dec-03
Dr S Patel	Chief Digital and Innovation Officer	Mar-05 - Jun-22
J A Skinner	Director of Research and Innovation Centre	Jan-17
J Doyle	Director of Allied Health Professionals	Jul-19
L Dinner	Medical Director	Oct-19
LJ Bevan	Chief People Officer	Jan-20
C Owusu-Bennoah	Chief Financial Officer	Mar-20
L Morton	Chief Nurse	Jan-22
C Cox	Chief Operating Officer	Apr-22

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 3: In the event of early retirement, the pension benefit will be reduced in accordance to the guidance set out by the Business Services Authority (www.nhsba.nhs.uk).
Note 4: 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 5: In the event of early retirement the pension benefit will be reduced in accordance with guidance set out by the Business Services Authority (www.nhsba.nhs.uk).
Note 6: The impact of the McCloud judgment enabling members of the NHS pension scheme to choose the preferred scheme for the remedy period (1/4/15 – 31/3/22) is not reflected in the table.
Note 7: The table above is audited.



Chief Executive Officer
29 June 2023

	Real increase in pension age during 2022/23 arising while employed by Trust	Real increase in pension lump sum at pension age arising while employed by Trust	Total accrued pension at pension age at 31 March 2023	Lump sum at pension age related to accrued pension at 31 March 2023	Cash Equivalent Transfer Value at 31 March 2022	Cash Equivalent Transfer Value at 31 March 2023	Real increase in Cash Equivalent Transfer Value	Employers's contribution to stakeholder pension
	(bands of £2,500) £'000	(bands of £2,500) £'000	(bands of £5000) £'000	(bands of £5000) £'000	£'000	£'000	£'000	£'000
	0-2.5	0-2.5	55-60	115-120	962	1073	3	0
	2.5-5	0.2-5	25-30	0-5	269	317	16	0
	2.5-5	0.2-5	45-50	95-100	914	1002	43	0
	0	0	30-35	100-105				0
	2.5-5	0	85-90	200-205	1778	1911	42	0
	0-2.5	0	15-20	25-30	176	200	6	0
	5-7.5	2.5-5	80-85	175-180	1517	1685	84	0
	0-2.5	0-2.5	25-30	45-50	377	423	18	0
	2.5-5	0-2.5	30-35	55-60	456	513	24	0
	5-7.5	10-12.5	50-55	110-115	795	950	114	0
	5-7.5	10-12.5	50-55	115-120	940	1119	66	0

Staff report

Our staff

As at 31 March 2023, the Trust employed 1,508 whole time equivalents (WTEs) valuation of staff, 27 WTEs higher than last year.

The table below provides a breakdown by staff group.

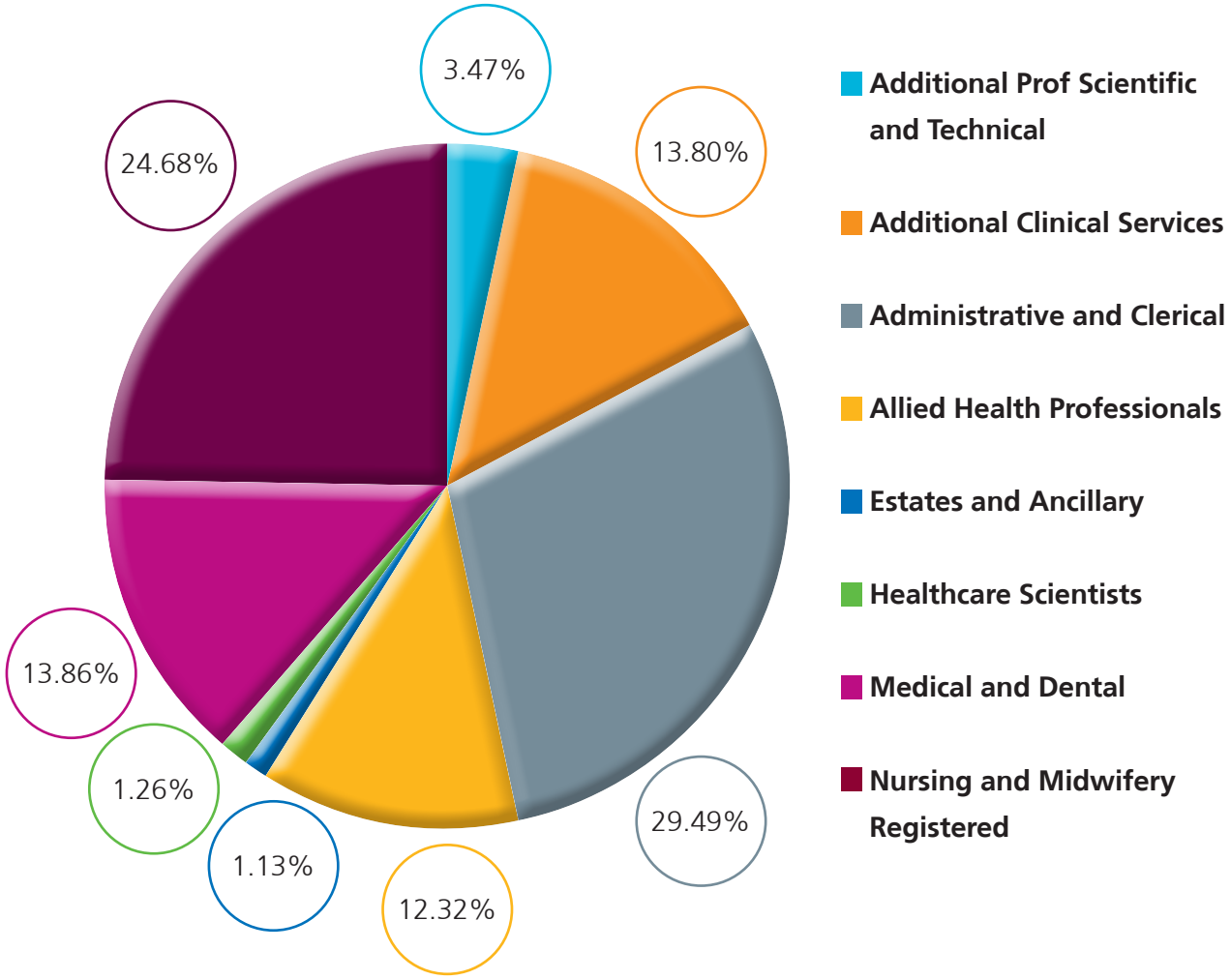
RNOH Staff WTE and Headcount as at 31 March 2023

Staff Group	Headcount	WTE	% Breakdown of WTE in Trust by staff group
Additional Prof Scientific and Technical	57	52	3.47%
Additional Clinical Services	220	208	13.80%
Administrative and Clerical	486	445	29.49%
Allied Health Professionals	209	186	12.32%
Estates and Ancillary	17	17	1.13%
Healthcare Scientists	20	19	1.26%
Medical and Dental	221	209	13.86%
Nursing and Midwifery Registered	406	372	24.68%
Grand Total	**1636**	**1508**	**100.00%**





% Breakdown of WTE in Trust by staff group



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	8	34	91	16	18	9	1	995	1172
Male	4	93	22	11	14	5	6	309	464
Total	**12**	**127**	**113**	**27**	**32**	**14**	**7**	**1304**	**1636**

	2022/23 (Average WTE)	2022/23 Permanently Employed (Average WTE)	2022/23 Other (Average WTE)	2022/23 Total Employee Costs (£000s)	2022/23 Permanent Employee Costs (£000s)	2022/23 Other Employee Costs (£000s)
Medical and dental	216	211	5	27,956	27,350	606
Ambulance staff	0	0	0	0	0	0
Administration and estates	489	464	25	27,082	25,638	1,444
Healthcare assisstants and other support staff	168	143	25	6,016	5,164	852
Nursing, midwifery and health visiting staff	421	375	46	25,645	22,853	2,792
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	328	311	17	19,401	18,066	1,335
Healthcare science staff	2	2	0	139	139	0
Social care staff	5	5	0	335	335	0
Other	1	1	0	29	29	0
Total average numbers	**1,630**	**1,512**	**118**	**106,603**	**99,573**	**7,030**
Of which:						
Numbers of employees engaged on capital projects	23	14	7	0	779	298

Staff Sickness absence

The figures shown below are presented as calendar year figures for the last available full calendar year (2022), in line with the Department of Health and Social Care Group Accounting Manual requirement.

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2022	Average FTE days lost to Cabinet Office definitions	FTE – Days Available	FTE – Days Lost to Sickness Absence	Average Sick Days per FTE
1,503	13,317	548,709	21,603	8.9

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse
Period covered: January to December 2022

Equality and diversity (including equal opportunities and disability)

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.

This year there were a number of key achievements around Inclusion, including; refreshing of the Equality Impact Assessment and process; development of recruitment training with a focus on fairness and inclusion of recruitment practices; the implementation of accountable decision making and; the delivery of a number of listening events for staff which have contributed to the 2022/23 Inclusion Plan.

Staff Wellbeing

The Trust continues to focus on staff wellbeing. This year the Trust opened the Wellbeing Hub. The Hub is composed of two sections, a 'silent reflection' space and a 'social refresh' space. The silent reflection space provides a quiet, darker space for staff to relax, read, and listen to personal devices and to make use of the massage chair. The social refresh space allows staff to meet, eat together and chat. The Trust has been able to use this space to facilitate additional initiatives such as the pop-up Wingman's where staff were served refreshments, the clothing swap and our London Community Kitchen surplus food provision.

There has also been a focus on cost of living interventions. Our Wellbeing lead reviewed a large number of financial wellbeing initiatives against benefit and harm to our staff over the short, medium and long term. The Trust was able to provide a suite of additional solutions that would support staff facing financial difficulty or concerns including new solutions such as the London Capital Credit Union, and the additional promotion of existing solutions such as our Venable Loans.

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.

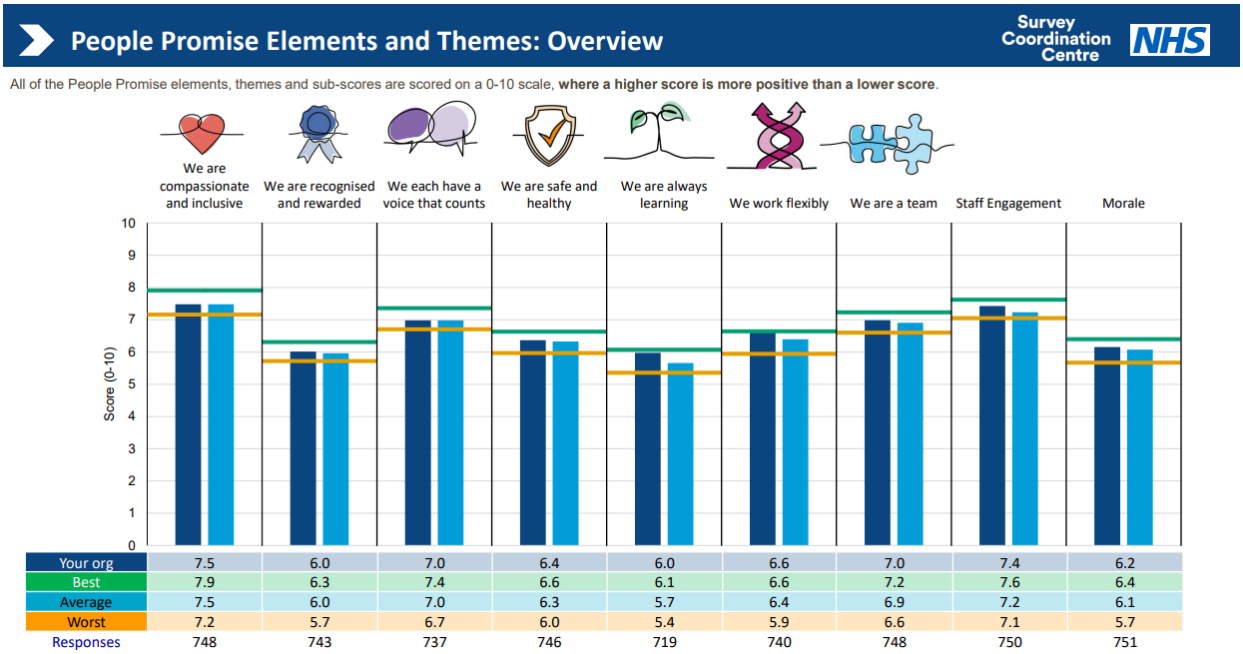
Staff Experience – Staff Survey Results

This year the national NHS Staff Survey report was aligned to the NHS People Promises, plus two additional themes, Staff Engagement and Morale. The chart below shows the Trusts performance, benchmarked against other acute specialist Trusts in the NHS.

Despite another challenging year in the NHS, we were pleased to see that we maintained a strong performance on our staff survey results. Some of the key highlights were:

- Achieved the best score amongst Acute Specialist Trusts for 'We work flexibly'
- On all themes the Trust was average or better
- RNOH was better than average on six elements or themes, in addition to 'We work flexibly'
  - We are safe and healthy
  - We are always learning
  - We are a team
  - Staff Engagement
  - Morale

The Trust has also performed very well when compared to other London Trusts.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.5	6.0	7.0	6.4	6.0	6.6	7.0	7.4	6.2
Best	7.9	6.3	7.4	6.6	6.1	6.6	7.2	7.6	6.4
Average	7.5	6.0	7.0	6.3	5.7	6.4	6.9	7.2	6.1
Worst	7.2	5.7	6.7	6.0	5.4	5.9	6.6	7.1	5.7
Responses	748	743	737	746	719	740	748	750	751

Element/Theme	National Average	RNOH	London Trusts	NCL Trusts	London AST
Staff engagement	6.8	7.4	1	1	1
Morale	6.8	7.4	1	1	1
We are inclusive and compassionate	7.2	7.5	=4	1	=1
We are recognised and rewarded	5.8	6	=8	=3	1
We each have a voice that counts	6.7	7	=4	1	1
We are safe and healthy	5.9	6.4	1	1	1
We are learning	5.4	6	=2	1	1
We work flexibly	6.1	6.6	4	1	1
We are a team	6.7	7	=5	=1	1

*Please note, each trust type is adjusted to a standard trust workforce profile for a typical trust of that type. As a result comparisons between different trust types have limitations, however, as the RNOH has a more similar workforce profile to other London trusts in relation to ethnicity profile, it is very useful for us to understand our standing in this group.

- RNOH achieved the highest score on all elements/themes of any Acute Specialist Trust in London
- The Trust had the highest score on all but one elements/themes within the NCL ICB
- The Trust placed top 5 on eight of the nine elements/themes in London

Some key interventions this year were:

- Continued celebration of events that are important to our staff such as Black History Month, Diwali etc, The Trust also participate in Pride in London for the first time in 2022, and will be participating in Pride in London 2023
- Investment in Leadership Development including continued provision of our Leading through Compassionate Conversations Training which has received excellent reviews, and a bespoke Leadership Programme provided by the Tavistock Institute for our Ward and team managers in nursing and AHPs

- The opening of our Wellbeing Hub as a place for staff to unwind and relax, and the provision of 'pop-up wingman' where staff were served refreshments
- The implementation of our surplus food provision with the partnership of London Community Kitchen
- Quarterly clothes swap
- Communications campaign around cost of living support provided by the Trust
- The launch of our EDI Strategy – we achieved an outstanding on our WRES/WDES action plan
- Provision of tea trollies for staff to celebrate our Trust acheivements and to thank staff

Expenditure on Consultancies

During the year 2022/23, consultancy expenditure amounted to £2,743,764 (2021/22 £2,415,910).

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

Table 1 lists all off-payroll engagements as of 31 March 2023, for more than £245 per day:

	Number
Number of existing engagement as of 31 March 2023	**12**
The number that have existed for less than 1 year at the time of reporting	**9**
The number that have existed between 1 and 2 years at the time of reporting	**2**
The number that have existed between 2 and 3 years at the time of reporting	**1**
The number that have existed 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 details all off-payroll engagements between 1 April 2022 and 31 March 2023, for more than £245 per day.

	Number
Number of temporary off-payroll workers engaged between 1 April 2022 and 31 March 2023	**13**
Of which:	
Number not subject to off-payroll legislation	**0**
Number subject to off-payroll legislation and determined as in scope of IR35	**1**
Number subject to off-payroll legislation and determined as out of scope of IR35	**12**
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 2022 and 31 March 2023:

	Number
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	**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	**14**

Table 4: Severance Payments

The tables are subject to audit

Reporting of compensation schemes – exit packages 2022/23

	Number of compulsory redundances Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	1
£10,000 – £25,000	3	-	3
£25,001 – £50,000	1	-	1
£50,001 – £100,000	-	-	-
£100,001 – £150,000*	-	-	-
£150,001 – £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**4**	**1**	**5**
Total cost (£)	£70,000	£6,000	£76,000

Reporting of compensation schemes – exit packages 2021/22

	Number of compulsory redundances Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	1
£10,000 – £25,000	1	1	2
£25,001 – £50,000	3	2	5
£50,001 – £100,000	-	2	2
£100,001 – £150,000*	1	-	1
£150,001 – £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**5**	**6**	**11**
Total cost (£)	£252,000	£191,000	£443,000

Exit packages: other (non-compulsory) departures payments

	2022/23		2021/22	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	**5**	**185**
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	**1**	**6**
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	**1**	**6**	-	-
Total number of exit packages by type	-	-	**6**	**191**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-
Exit packages: other (non-compulsory) departure payments				

Glossary and abbreviated terms

AHP	Allied Healthcare Professionals
AMR	Antimicrobial Resistance
APS	Acute Pain Service
BAF	Board Assurance Framework
BESS	British Elbow and Shoulder Society
CAUTI	Catheter Urinary Tract Infection
CCG	Clinical Commissioning Group
CD	Controlled Drugs
C.diff	Clostridium difficile
CEO	Chief Executive Officer
CHDU	Children's High Dependency Unit
CMP	Case Mix Programme
CNS	Clinical Nurse Specialist
CoPAT	Complex Oral Outpatient Antimicrobial Therapy
COSHH	Control of Substances Hazardous to Health
COVID-19	Coronavirus Disease 2019
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSP	Chartered Society of Physiotherapy
CT	Computerised Tomography
DOB	Date of Birth
DLT	Divisional Leadership Teams
DNA	Did not attend
DPST	Data Protection Security Toolkit
DTC	Drugs and Therapeutic Committee
ECOG	Eastern Cooperative Oncology Group
EMIS	Egton Medical Information Systems
ePMA	Electronic Prescribing and Medicines Administration
EPRR	Emergency Preparedness Resilience and Response
EQ-5D Index	Standardised patient reported outcome measure in knee and hip operations
EQ-VAS	Standardised patient reported outcome measure in knee and hip operations
EU	European Union
FFT	Friends and Family Test
FTSUG	Freedom to Speak Up Guardian
GDPR	General Data Protection Regulation
HFE	Human Factors and Ergonomics
HMMC	Hertfordshire Medicines Management Committee
HMS	Homecare Medicines Service
HOHA	Hospital Onset Healthcare Associated
HTA	Human Tissue Act
HQIP	Healthcare Quality Improvement Partnership
ICNARC	Intensive Care National Audit and Research Centre
ICU	Intensive Care Unit

IG	Information Governance
IP	Independent prescribing
IPC	Infection Prevention and Control
IRG	Incident Review Group
ISS	Facilities support services company
IT	Information Technology
IV	Intravenous
LfE	Learning from Excellence
MAGEC Rod	Magnetic Expansion Control Rod (Surgical Scoliosis Treatment)
MHRA	Medicines and Healthcare products Regulatory Agency
MRI	Magnetic Resonance Imaging
MDT	Multidisciplinary Team
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCL	North Central London
NCL JFC	North Central London Joint Formulary Committee
NEIAA	National Early Inflammatory Arthritis Audit
NHS	National Health Service
NHSE	NHS England
NHSEI	NHS England and Improvement
NHSI	NHS Improvement
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
OPAT	Outpatient Parenteral Antibiotic Therapy Service
OPD	Outpatient Department
OSC	Overview and Scrutiny Committee
OT	Occupational Therapy/Therapist
OVIVA	Oral vs. IV Antibiotic
PALS	Patient Advice Liaison Service
PAT	Pets as Therapy
PCA	Pain Controlled Analgesia
PDS	Personal Demographics Service
PIR	Post Infection Review
PNI	Peripheral Nerve Injury
POA	Pre-Operative Assessment
PROMs	Patient Reported Outcome Measures
PSI	Patient Specific Instruments
PT	Physiotherapist/Physiotherapy
PQIP	Perioperative Quality Improvement Programme
PU	Pressure Ulcer
QI	Quality Improvement
RAG	Red Amber Green

RBF	Rate based enteral feeding
RCA	Root Cause Analysis
RCN	Royal College of Nursing
REC	Research Ethics Committee
RNOH	Royal National Orthopaedic Hospital NHS Trust
RPS	Royal Pharmaceutical Society
SAFE Patient Care	Stanmore Accreditation for Excellence in Patient Care
SD	Satellite Dispensed
SEU	Shoulder and Elbow Unit
SHOT	Serious Hazards of Transfusion
SI	Serious Incident
SOP	Standard Operating Procedure
SSI	Surgical Site Infection
SUS	Secondary Uses Service
THR	Total Hip Replacement
TSB	The Stanmore Building
TTA	To take away medicines
UK	United Kingdom
VAL-YOU	Internal campaign to make RNOH the best place to work in the NHS
VBF	Volume based enteral feeding
VTE	Venous Thromboembolism
WHO	World Health Organization
XLH	X-linked Hypophosphataemia
XR	X-Ray

Part 6:

Accounts for the year ended 31 March 2023

Statement of Comprehensive Income

	Note	2022/23 £000	2021/22 £000
Operating income from patient care activities	3	181,517	176,441
Other operating income	4	8,828	11,993
Operating expenses	6, 8	(186,106)	(173,950)
Operating surplus from continuing operations		**4,239**	**14,484**
Finance income	10	1,070	25
Finance expenses	11	(67)	(103)
PDC dividends payable		(3,643)	(3,233)
Net finance costs		**(2,640)**	**(3,311)**
Other losses	12	(25)	(93)
Surplus for the year		**1,574**	**11,080**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	15	5,771	3,969
Total comprehensive income for the period		**7,345**	**15,049**

Statement of Financial Position

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Intangible assets	13	2,935	1,540
Property, plant and equipment	14	139,039	120,555
Right of use assets	16	9,195	
Receivables	18	1,869	1,541
Total non-current assets		**153,038**	**123,636**
Current assets			
Inventories	17	2,590	2,435
Receivables	18	12,529	8,392
Cash and cash equivalents	19	54,184	50,526
Total current assets		**69,303**	**61,353**
Current liabilities			
Trade and other payables	20	(30,401)	(21,572)
Borrowings	21	(1,184)	(71)
Provisions	23	(87)	(1,485)
Other liabilities	21	(6,140)	(6,142)
Total current liabilities		**(37,812)**	**(29,270)**
Total assets less current liabilities		**184,529**	**155,719**
Non-current liabilities			
Borrowings	21	(10,417)	(1,156)
Provisions	23	(719)	(813)
Total non-current liabilities		**(11,136)**	**(1,969)**
Total assets employed		**173,393**	**153,750**
Financed by			
Public dividend capital		167,223	155,457
Revaluation reserve		44,598	38,827
Income and expenditure reserve		(38,428)	(40,534)
Total taxpayers' equity		**173,393**	**153,750**

The notes on pages 8 to 59 form part of these accounts.

Name
Position
Date

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	To
	£000	£000	£000	£0
Taxpayers' and others' equity at 1 April 2022 - brought forward	**155,457**	**38,827**	**(40,534)**	**153,7**
Implementation of IFRS 16 on 1 April 2022	**-**	**-**	**532**	**5**
Surplus for the year	-	-	1,574	**1,5**
Revaluations	-	5,771	-	**5,7**
Public dividend capital received	11,766	-	-	**11,7**
Taxpayers' and others' equity at 31 March 2023	**167,223**	**44,598**	**(38,428)**	**173,3**

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	To
	£000	£000	£000	£0
Taxpayers' and others' equity at 1 April 2021 - brought forward	**153,738**	**34,858**	**(51,614)**	**136,9**
Surplus for the year	-	-	11,080	**11,0**
Revaluations	-	3,969	-	**3,9**
Public dividend capital received	1,719	-	-	**1,7**
Taxpayers' and others' equity at 31 March 2022	**155,457**	**38,827**	**(40,534)**	**153,7**


Reception

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.




11:52
Private Care
PRIVATE CARE
Private Care
PATIENTS NURSING FOLDER

Statement of Cash Flows

	Note	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus		4,239	14,484
Non-cash income and expense:			
Depreciation and amortisation	6	7,825	5,807
Net impairments	7	3,052	643
Income recognised in respect of capital donations	4	(132)	(283)
(Increase) / decrease in receivables and other assets		(4,428)	751
(Increase) / decrease in inventories		(155)	488
Increase / (decrease) in payables and other liabilities		8,312	(173)
Increase / (decrease) in provisions		(1,419)	1,165
Net cash flows from operating activities		**17,294**	**22,882**
Cash flows from investing activities			
Interest received		1,070	25
Purchase of intangible assets		(964)	(272)
Purchase of PPE and investment property		(20,914)	(9,530)
Receipt of cash donations to purchase assets		131	283
Net cash flows used in investing activities		**(20,677)**	**(9,494)**
Cash flows from financing activities			
Public dividend capital received		11,766	1,719
Movement on loans from DHSC		(68)	(68)
Capital element of lease liability repayments		(904)	-
Interest on loans		(27)	(28)
Interest element of lease liability repayments		(114)	-
PDC dividend paid		(3,612)	(3,178)
Net cash flows from / (used in) financing activities		**7,041**	**(1,555)**
Increase in cash and cash equivalents		**3,658**	**11,833**
Cash and cash equivalents at 1 April - brought forward		**50,526**	**38,693**
Cash and cash equivalents at 31 March	19	**54,184**	**50,526**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 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, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 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 main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments ('block contracts') to fund an agreed level of activity.

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets.

Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

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 the 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.

Note 1.4 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 is 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 1.5 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.

Pension costs

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 1.6 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 1.7 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.8 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 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.

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, 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 and, where capitalised in accordance with IAS 23, borrowings costs. 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, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating 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.

This includes assets donated to the Trust by the Department of Health and Social Care or NHS England 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:

	Min life Years	Max life Years
Buildings, excluding dwellings	1	51
Dwellings	14	28
Plant & machinery	1	15
Information technology	5	10
Furniture & fittings	7	50

Note 1.9 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, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

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

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

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 the table below:

	Min life Years	Max life Years
Software licences	5	10

Note 1.10 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.

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 1.11 Cash and cash equivalents

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

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

Note 1.12 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, ie, 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 lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust recognises the expected allowance for credit losses for the following classes of income:

NHS injury cost recovery scheme
The Trust estimates the expected credit loss allowances that is not expected to be recoverable in accordance with the GAM guidance. The compensation recovery unit (CRU) of the Department of Work and Pensions (DWP) advises a percentage probability of not receiving the income. The percentage probability for the Financial Year 2022/23 is 24.86% (23.76% in 2021/22).

Other Non-NHS debtor categories
The Trust estimates the debt allowances of non-NHS debt by firstly establishing the collection ratio for the different types of debt. The estimation of the allowances is then enhanced through further assessments of debt with significant values and/or specific risk characteristics. This assessment also takes into account recommendations from the Trust's external specialist debt collectors.
There is no recognition of credit loss allowances for NHS receivables as credit notes should be raised to cancel invalid receivables with NHS counterparties.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

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

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic 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.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

Note 1.14 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 from 31 March 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.27%	0.47%
Medium-term	After 5 years up to 10 years	3.20%	0.70%
Long-term	After 10 years up to 40 years	3.51%	0.95%
Very long-term	Exceeding 40 years	3.00%	0.66%

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 from 31 March 2023:

	Inflation rate	Prior year rate
Year 1	7.40%	4.00%
Year 2	0.60%	2.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (prior year: minus 1.30%).

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 24 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 1.15 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 25 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 25, 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 or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 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 1.17 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 1.18 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

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 service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

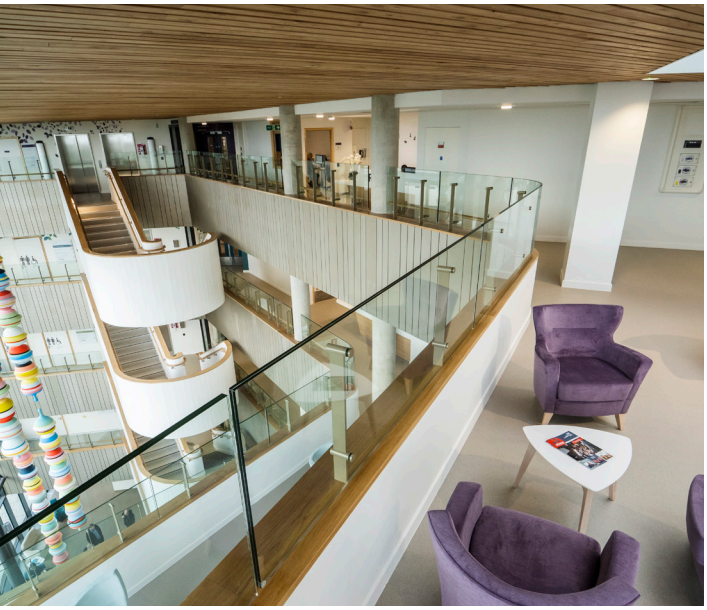
Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

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

IFRS 17 Insurance Contracts is to be implemented in 2016/17 for NHS Trusts. The HM Treasury Financial Reporting Manual (FReM) is yet be updated to incorporate this standard. The impact of this standard on the Trust's financial statements has therefore not been assessed pending the update in the FReM and subsequently the DHSC GAM.







Note 1.23 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 January - March 2023 with a valuation date of 31 March 2023. The valuation report was issued on 25th April 2023. The Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards (January 2022) has been applied as a basis for the valuation.

The carrying values of owned land and buildings as at 31 March 2023 are: buildings £89,097,000 and land £16,937,000.

The sensitivity of the Net Book Value of land and building to changes to the cost indices applied to the valuation is illustrated below.

If the Land and Buildings Cost Indices provided by the Royal Institute of Chartered Surveyors were 10% lower this would have the following impact in note 14.1 :

* A reduction in the Buildings Book Value of £8.9m
* A reduction in the Land Net Book Value of £1.7m

If the Land and Buildings Cost indices provided by the Royal Institute of Chartered Surveyors were 10% higher this would have the following impact in note 14.1 :

* An increase in the Buildings Book Value of £8.9m
* An increase in the Land Net Book Value of £1.7m

Note 2 Operating Segments

The Trust manages all services and functions as a unified and fully integrated healthcare provider and, as such, operates one segment.







Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2022/23 £000	2021/22 £000
Income from commissioners under block contracts*	155,244	149,639
High cost drugs income from commissioners (excluding pass-through costs)	8,136	8,751
Other NHS clinical income	1,802	3,073
Private patient income	8,424	6,505
Elective recovery fund	-	4,148
Agenda for change pay award central funding*	3,011	-
Additional pension contribution central funding**	4,099	3,955
Other clinical income	801	370
Total income from activities	**181,517**	**176,441**

* In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2022/23 £000	2021/22 £000
NHS England	80,517	66,872
Clinical commissioning groups	22,014	99,621
Integrated care boards*	67,932	-
Department of Health and Social Care	-	4
Other NHS providers	27	(12)
Non-NHS: private patients	8,424	6,505
Injury cost recovery scheme	801	370
Non NHS: other	1,802	3,081
Total income from activities	**181,517**	**176,441**
Of which:		
Related to continuing operations	181,517	176,441
Related to discontinued operations	-	-

* Integrated Care Boards were formed in 2022/23 therefore the comparative value for 2021/22 is absent.


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Note 4 Other operating income

	2022/23		
	Contract income	Non-contract income	Total
	£000	£000	£000
Research and development	1,094	-	**1,094**
Education and training	2,316	141	**2,457**
Non-patient care services to other bodies	1,079	-	**1,079**
Reimbursement and top up funding	293	-	**293**
Receipt of capital grants and donations and peppercorn leases	-	132	**132**
Charitable and other contributions to expenditure	-	210	**210**
Other income	3,563	-	**3,563**
Total other operating income	**8,345**	**483**	**8,828**
Of which:			
Related to continuing operations			8,828
Related to discontinued operations			-

2021/22		
Contract income	**Non-contract income**	**Total**
£000	**£000**	**£000**
1,230	-	**1,230**
2,249	181	**2,430**
586	-	**586**
647	-	**647**
-	283	**283**
-	454	**454**
6,363	-	**6,363**
11,075	**918**	**11,993**

11,993
-

Note 5 Other operating income

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2022/23 £000	2021/22 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,019	441
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 6 Operating expenses

Note 6.1 Operating expenses by type of expense

	2022/23	2021/22
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	477	453
Purchase of healthcare from non-NHS and non-DHSC bodies	1,044	1,601
Staff and executive directors costs	104,289	97,984
Remuneration of non-executive directors	109	112
Supplies and services - clinical (excluding drugs costs)	31,171	29,420
Supplies and services - general	7,765	7,589
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,809	5,774
Inventories written down	4	203
Consultancy costs	2,744	2,416
Establishment	1,475	1,432
Premises	8,038	6,419
Transport (including patient travel)	4,879	3,700
Depreciation on property, plant and equipment and right of use assets	7,395	5,340
Amortisation on intangible assets	430	467
Net impairments	3,052	643
Movement in credit loss allowance: contract receivables / contract assets	1,144	340
Movement in credit loss allowance: all other receivables and investments	116	(249)
Increase/(decrease) in other provisions	(1,250)	1,356
Change in provisions discount rate(s)	(97)	8
Fees payable to the external auditor		
*Fees payable to the external auditor - statutory audit service	105	78
other auditor remuneration (external auditor only)	-	-
Internal audit costs	49	48
Clinical negligence	3,483	3,296
Legal fees	116	557
Research and development	1,446	1,315
Education and training	1,841	1,857
Operating lease expenditure (comparative only)	-	1,128
Redundancy	71	254
Hospitality	22	57
Other	379	352
Total	**186,106**	**173,950**
Of which:		
Related to continuing operations	186,106	173,950
Related to discontinued operations	-	-

* operating expenses on statutory external audit fees includes VAT

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2.0 million (2021/22: £2.0 million).

Note 7 Impairment of assets

	2022/23	2021/22
	£000	£000
Net impairments charged to operating surplus resulting from:		
Loss or damage from normal operations	1,631	10
Abandonment of assets in course of construction	-	190
Unforeseen obsolescence	-	-
Changes in market price	1,421	443
Total net impairments charged to operating surplus	**3,052**	**643**

Note 8 Employee benefits

	2022/23 Total £000	2021/22 Total £000
Salaries and wages	82,190	76,733
Social security costs	9,288	8,195
Apprenticeship levy	395	369
Employer's contributions to NHS pensions	13,447	12,973
Pension cost - other	6	4
Termination benefits	74	446
Temporary staff (including agency)	2,245	2,481
Total gross staff costs	**107,645**	**101,201**
Recoveries in respect of seconded staff	-	-
Total staff costs	**107,645**	**101,201**
Of which		
Costs capitalised as part of assets	1,077	1,069

Note 9 Pension costs

Note 9.1 NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 9.2 Other Pension Schemes

The Trust also makes pension contributions towards a small number of the Trust's employees (19 employees in 2022/23, 11 employees in 2021/22) who are members of the National Employment Savings Trust. The Trust's contribution to this scheme was £5,888 in 2022/23 (£4,116 in 2021/22).

Note 10 Finance income

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

	2022/23	2021/22
	£000	£000
Interest on bank accounts*	1,070	25
Total finance income	**1,070**	**25**

* The increase in interest income on bank accounts in 2022/23 compared to 2021/22 is due to higher interest rates on cash balances held with the Government Banking Service.

Note 11 Finance expenditure

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

	2022/23	2021/22
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	26	28
Interest on lease obligations	114	-
Total interest expense	**140**	**28**
HMRC financing charge on VAT liability*	(73)	75
Total finance costs	**67**	**103**

* A formal assessment was received in November 2021 from HMRC which required the Trust to repay VAT on the basis that VAT had been incorrectly reclaimed as well as pay £0.075m interest. HMRC withdrew the assessment in July 2022.

Note 12 Other gains / (losses)

	2022/23	2021/22
	£000	£000
Losses on disposal of assets	(25)	(93)
Total losses on disposal of assets	**(25)**	**(93)**

Note 13 Intangible assets

Note 13.1 Intangible assets - 2022/23

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**8,087**	**-**	**8,087**
Additions	964	-	**964**
Reclassifications	818	43	**861**
Valuation / gross cost at 31 March 2023	**9,869**	**43**	**9,912**
Amortisation at 1 April 2022 - brought forward	**6,547**	**-**	**6,547**
Provided during the year	430	-	**430**
Amortisation at 31 March 2023	**6,977**	**-**	**6,977**
Net book value at 31 March 2023	**2,892**	**43**	**2,935**
Net book value at 1 April 2022	**1,540**	**-**	**1,540**

Note 13.2 Intangible assets - 2021/22

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021 - as previously stated	**9,191**	**-**	**9,191**
Additions	-	272	**272**
Reclassifications	272	(272)	**-**
Disposals / derecognition	(1,376)	-	**(1,376)**
Valuation / gross cost at 31 March 2022	**8,087**	**-**	**8,087**
Amortisation at 1 April 2021 - as previously stated	**7,446**	**-**	**7,446**
Provided during the year	467	-	**467**
Impairments	10	-	**10**
Disposals / derecognition	(1,376)	-	**(1,376)**
Amortisation at 31 March 2022	**6,547**	**-**	**6,547**
Net book value at 31 March 2022	**1,540**	**-**	**1,540**
Net book value at 1 April 2021	**1,745**	**-**	**1,745**

Note 14 Property, plant and equipment

Note 14.1 Property, plant and equipment - 2022/23

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000
Valuation/gross cost at 1 April 2022 - brought forward	**18,817**	**79,496**	**2,212**	**7,976**	**31,639**
Additions*	-	-	-	21,282	131
Revaluations	(1,880)	4,509	136	-	-
Reclassifications	-	2,380	450	(9,255)	2,640
Disposals / derecognition	-	-	-	-	(393)
Valuation/gross cost at 31 March 2023	**16,937**	**86,385**	**2,798**	**20,003**	**34,017**
Accumulated depreciation at 1 April 2022 - brought forward	**-**	**69**	**-**	**-**	**23,633**
Provided during the year	-	2,840	114	-	1,903
Impairments	-	69	-	1,631	-
Revaluations	-	(2,892)	(114)	-	-
Reclassifications	-	-	-	94	(94)
Disposals / derecognition	-	-	-	-	(318)
Accumulated depreciation at 31 March 2023	**-**	**86**	**-**	**1,725**	**25,124**
Net book value at 31 March 2023	**16,937**	**86,299**	**2,798**	**18,278**	**8,893**
Net book value at 1 April 2022	**18,817**	**79,427**	**2,212**	**7,976**	**8,006**

* Additions in 2022/23 are significantly higher compared to 2021/22 which is primarily because of capital expenditure on the construction of four operating the NHS England. The total capital expenditure on these operating theatres is £11.2m in 2022/23. The scheme is expected to be completed in September 2023 a as at 31st March 2023. Additions also included £2.1m on clinical equipment, £4.6m on investment in digital and £3.5m on other enhancements to buildings.

Information technology £000	Furniture & fittings £000	Total £000
5,616	**1,533**	**147,289**
-	-	**21,413**
-	-	**2,765**
2,924	-	**(861)**
-	-	**(393)**
8,540	**1,533**	**170,213**
2,326	**706**	**26,734**
1,019	188	**6,064**
-	-	**1,700**
-	-	**(3,006)**
-	-	**-**
-	-	**(318)**
3,345	**894**	**31,174**
5,195	**639**	**139,039**
3,290	**827**	**120,555**

atres. This capital scheme is mainly centrally funded by and is therefore treated within assets under construction

Note 14.2 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - as previously stated	**17,247**	**76,787**	**2,224**	**6,305**	**29,074**
Prior period adjustments	-	-	-	-	-
Valuation / gross cost at 1 April 2021 - restated	**17,247**	**76,787**	**2,224**	**6,305**	**29,074**
Transfers by absorption	-	-	-	-	-
Additions	-	-	-	9,384	-
Revaluations	1,570	(847)	(35)	-	-
Reclassifications	-	3,556	23	(7,523)	2,915
Disposals / derecognition	-	-	-	(190)	(350)
Valuation/gross cost at 31 March 2022	**18,817**	**79,496**	**2,212**	**7,976**	**31,639**
Accumulated depreciation at 1 April 2021 - as previously stated	**-**	**54**	**-**	**-**	**22,423**
Prior period adjustments	-	-	-	-	-
Accumulated depreciation at 1 April 2021 - restated	**-**	**54**	**-**	**-**	**22,423**
Transfers by absorption	-	-	-	-	-
Provided during the year	-	2,744	109	-	1,467
Impairments	-	633	-	-	-
Revaluations	-	(3,172)	(109)	-	-
Reclassifications	-	(190)	-	190	-
Disposals / derecognition	-	-	-	(190)	(257)
Accumulated depreciation at 31 March 2022	**-**	**69**	**-**	**-**	**23,633**
Net book value at 31 March 2022	**18,817**	**79,427**	**2,212**	**7,976**	**8,006**
Net book value at 1 April 2021	**17,247**	**76,733**	**2,224**	**6,305**	**6,651**

Information technology	Furniture & fittings	Total
£000	£000	£000
11,025	**1,533**	**144,195**
-	-	**-**
11,025	**1,533**	**144,195**
-	-	**-**
-	-	**9,384**
-	-	**688**
1,029	-	**-**
(6,438)	-	**(6,978)**
5,616	**1,533**	**147,289**
7,932	**518**	**30,927**
-	**-**	**-**
7,932	**518**	**30,927**
-	-	**-**
832	188	**5,340**
-	-	**633**
-	-	**(3,281)**
-	-	**-**
(6,438)	-	**(6,885)**
2,326	**706**	**26,734**
3,290	**827**	**120,555**
3,093	**1,015**	**113,268**

Note 14.3 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Infor tech
	£000	£000	£000	£000	£000	
Owned - purchased	16,937	83,344	2,798	18,278	8,657	
Owned - donated/granted	-	2,955	-	-	236	
Total net book value at 31 March 2023	**16,937**	**86,299**	**2,798**	**18,278**	**8,893**	

Note 14.4 Property, plant and equipment financing - 31 March 2022

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Infor tech
	£000	£000	£000	£000	£000	
Owned - purchased	18,817	76,667	2,212	7,748	7,659	
Owned - donated/granted	-	2,760	-	228	347	
Total net book value at 31 March 2022	**18,817**	**79,427**	**2,212**	**7,976**	**8,006**	

Note 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Infor tech
	£000	£000	£000	£000	£000	
Subject to an operating lease	-	-	-	-	-	
Not subject to an operating lease	16,937	86,299	2,798	18,278	8,893	
Total net book value at 31 March 2023	**16,937**	**86,299**	**2,798**	**18,278**	**8,893**	

mation nology	Furniture & fittings	Total
£000	£000	£000
5,195	431	**135,640**
-	208	**3,399**
5,195	**639**	**139,039**

mation nology	Furniture & fittings	Total
£000	£000	£000
3,289	543	**116,935**
1	284	**3,620**
3,290	**827**	**120,555**

mation nology	Furniture & fittings	Total
£000	£000	£000
-	-	**-**
5,195	639	**139,039**
5,195	**639**	**139,039**

Note 15 Revaluations of property, plant and equipment

Property

During 2022/23, 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 2023. The firm had previously undertaken the valuation of land and buildings as at 31 March 2022. The partner in charge of the valuation was Mr Richard Ayres MRICS. The valuation as at 31st March 2023 applied a desk-top approach incorporating updates for cost indices and investment in buildings in 2022/23 which was supplemented with a targeted site inspection. The valuation as at 31st March 2021 was based on a full site inspection (the benchmark frequency for full site inspections is one year in every 5 years).

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 16 Leases - Royal National Orthopaedic Hospital NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust has one material right-of-use asset which is for the provision of accommodation at Bolsover St. in Central London. This accommodation is a healthcare facility and is principally used for out-patients and diagnostic imaging. The Trust also has 3 other leases as at 31st March 2023 - 2 leases for medical equipment and one other lease for accommodation for the provision of healthcare.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.





Note 16.1 Right of use assets - 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Total £000	Of w leased DHSC g bo
IFRS 16 implementation - adjustments for existing operating leases / subleases	11,446	131	**11,577**	1
Additions	-	301	**301**	
Impairments	(2,119)	-	**(2,119)**	
Valuation/gross cost at 31 March 2023	**9,327**	**432**	**9,759**	**1**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	**-**	
Provided during the year	1,144	187	**1,331**	
Impairments	(767)	-	**(767)**	
Accumulated depreciation at 31 March 2023	**377**	**187**	**564**	
Net book value at 31 March 2023	**8,950**	**245**	**9,195**	**1**
Net book value of right of use assets leased from other NHS providers	-	-	-	
Net book value of right of use assets leased from other DHSC group bodies	1357	-	1357	1

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377
-
377

,357

-
,357





Note 16.2 Revaluations of right of use assets

During 2022/23, the Trust engaged Gerald Eve LLP, an independent firm of Chartered Surveyors, to undertake a valuation of the one material right-of-use asset which is the accommodation in Bolsover Street, Central London. The partner in charge of the valuation was Mr Richard Ayres MRICS. The valuation as at 31st March 2023 was based on a site inspection by the valuers.

Note 16.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 21.2.

	2022/23
	£000
Carrying value at 31 March 2022	**-**
IFRS 16 implementation - adjustments for existing operating leases	11,045
Lease additions	301
Interest charge arising in year	114
Lease payments (cash outflows)	(1,018)
Carrying value at 31 March 2023	**10,442**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.
These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.4 Maturity analysis of future lease payments at 31 March 2023

	Total	Of which leased from DHSC group bodies:
	31 March 2023	31 March 2023
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	1,114	177
- later than one year and not later than five years;	4,422	1,065
- later than five years.	5,441	-
Total gross future lease payments	**10,977**	**1,242**
Finance charges allocated to future periods	(535)	(19)
Net lease liabilities at 31 March 2023	**10,442**	**1,223**
Of which:		
Leased from other NHS providers	-	-
Leased from other DHSC group bodies	-	1,223

Note 16.5 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The Trust had no obligations under leases the Trust previously determined to be finance leases under IAS 17 at 31 March 2022.

Note 16.6 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	2021/22 £000
Operating lease expense	
Minimum lease payments	1,128
Total	**1,128**

	31 March 2022 £000
Future minimum lease payments due:	
- not later than one year;	1,127
- later than one year and not later than five years;	5,526
- later than five years.	7,429
Total	**14,082**
Future minimum sublease payments to be received	-

Note 16.7 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 13.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022
	£000
Operating lease commitments under IAS 17 at 31 March 2022	**14,082**
Impact of discounting at the incremental borrowing rate	
IAS 17 operating lease commitment discounted at incremental borrowing rate	**13,328**
Less:	
Irrecoverable VAT previously included in IAS 17 commitment	(2,347)
Other adjustments:	
Other adjustments	64
Total lease liabilities under IFRS 16 as at 1 April 2022	**11,045**

Note 17 Inventories

	31 March 2023 £000	31 March 2022 £000
Drugs	303	227
Consumables	2,166	2,087
Energy	51	51
Other	70	70
Total inventories	**2,590**	**2,435**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £20,356k (2021/22: £19,998k). Write-down of inventories recognised as expenses for the year were £4k (2021/22: £203k).

See note 29 (Losses and Special Payments) which outlines a write-off of inventory in 2022/23. The write-down of inventory incorporates the stock write-off and also the utilisation of the previously recognised inventory impairment balance.

Note 18 Receivables

Note 18.1 Current and Non-current Receivables

	31 March 2023 £000	31 March 2022 £000
Current		
Contract receivables	11,888	7,619
Allowance for impaired contract receivables / assets	(2,743)	(1,599)
Allowance for other impaired receivables	(528)	(412)
Prepayments (non-PFI)	3,318	2,061
PDC dividend receivable	-	15
VAT receivable	665	728
Other receivables	(71)	(20)
Total current receivables	**12,529**	**8,392**
Non-current		
Contract receivables	1,540	1,188
Other receivables	329	353
Total non-current receivables	**1,869**	**1,541**
Of which receivable from NHS and DHSC group bodies:		
Current	5,201	2,130
Non-current	329	353

Note 18.2 Allowances for credit losses

	2022/23		2021/22	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,599**	**412**	**1,259**	**661**
New allowances arising	1,280	116	-	-
Changes in existing allowances	-	-	435	(249)
Reversals of allowances	(136)	-	(95)	-
Allowances as at 31 Mar 2023	**2,743**	**528**	**1,599**	**412**

Note 19 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.

	2022/23	2021/22
	£000	£000
At 1 April	**50,526**	**38,693**
Net change in year	3,658	11,833
At 31 March	**54,184**	**50,526**
Broken down into:		
Cash at commercial banks and in hand	6	47
Cash with the Government Banking Service	54,178	50,479
Total cash and cash equivalents as in SoFP and SoCF	**54,184**	**50,526**

Note 20 Trade and other payables

	31 March 2023 £000	31 March 2022 £000
Current		
Trade payables	2,722	1,233
Capital payables	2,274	1,775
Accruals	20,873	14,423
Social security costs	1,603	1,247
Other taxes payable	1,173	1,171
PDC dividend payable	16	-
Pension contributions payable	1,368	1,333
Other payables	372	390
Total current trade and other payables	**30,401**	**21,572**
Of which payables from NHS and DHSC group bodies:		
Current	3,122	5,047

Note 21 Other liabilities

Note 21.1 Deferred income

	31 March 2023 £000	31 March 2022 £000
Current		
Deferred income: contract liabilities	6,140	6,142
Total other current liabilities	**6,140**	**6,142**

Note 21.2 Borrowings

	31 March 2023 £000	31 March 2022 £000
Current		
Loans from DHSC	71	71
Lease liabilities*	1,113	-
Total current borrowings	**1,184**	**71**
Non-current		
Loans from DHSC	1,088	1,156
Lease liabilities*	9,329	-
Total non-current borrowings	**10,417**	**1,156**

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 16.

Note 22 Reconciliation of liabilities arising from financing activities

Note 22.1 Reconciliation of liabilities arising from financing activities - 2022/23

	Loans from DHSC	Other loans	Lease Liability	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2022	**1,227**	**-**	**-**	**-**	**1,227**
Cash movements:					
Financing cash flows - payments and receipts of principal	(68)	-	(904)	-	**(972)**
Financing cash flows - payments of interest	(27)	-	(114)	-	**(141)**
Non-cash movements:					
Impact of implementing IFRS 16 on 1 April 2022	-	-	11,045	-	**11,045**
Additions	-	-	301	-	**301**
Lease liability remeasurements	-	-	-	-	**-**
Application of effective interest rate	27	-	114	-	**141**
Carrying value at 31 March 2023	**1,159**	**-**	**10,442**	**-**	**11,601**

Note 22.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Lease Liability	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2021	**1,295**	**-**	**-**	**-**	**1,295**
Cash movements:					
Financing cash flows - payments and receipts of principal	(68)	-	-	-	**(68)**
Financing cash flows - payments of interest	(28)	-	-	-	**(28)**
Non-cash movements:					
Application of effective interest rate	28	-	-	-	**28**
Carrying value at 31 March 2022	**1,227**	**-**	**-**	**-**	**1,227**

Note 23 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2022	**523**	**17**	**1,758**	**2,298**
Change in the discount rate	(97)	-	(294)	**(391)**
Arising during the year	75	8	263	**346**
Utilised during the year	(47)	(7)	(38)	**(92)**
Reversed unused*	-	-	(1,362)	**(1,362)**
Unwinding of discount	-	-	7	**7**
At 31 March 2023	**454**	**18**	**334**	**806**
Expected timing of cash flows:				
- not later than one year;	64	18	5	**87**
- later than one year and not later than five years;	256	-	12	**268**
- later than five years.	134	-	317	**451**
Total	**454**	**18**	**334**	**806**

* A formal assessment was received in November 2021 from HMRC which required the Trust to repay VAT on the basis that VAT had been incorrectly reclaimed and an interest charge was also levied. HMRC withdrew the assessment in July 2022 which resulted in unused provisions of £1.362m.

Note 24 Clinical negligence liabilities

At 31 March 2023, £34,380k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal National Orthopaedic Hospital NHS Trust (31 March 2022: £54,535k).

Note 25 Contingent assets and liabilities

	31 March 2023 £000	31 March 2022 £000
Value of contingent liabilities		
NHS Resolution legal claims	(8)	(2)
Gross value of contingent liabilities	**(8)**	**(2)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(8)**	**(2)**
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.

Note 26 Contractual capital commitments

	31 March 2023 £000	31 March 2022 £000
Property, plant and equipment	5,593	285
Intangible assets	-	28
Total	**5,593**	**313**

Note 27 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 2023 £000	31 March 2022 £000
not later than 1 year	18,316	18,696
after 1 year and not later than 5 years	32,218	29,001
paid thereafter	-	-
Total	**50,534**	**47,697**

Note 28 Financial instruments

Note 28.1 Financial risk management

Note 28.2 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, Clinical Commissioning Groups and Integrated care Boards, 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 2022/23 the Trust has not drawn any revenue support loans or revenue support PDC (no revenue support loans or revenue support PDC drawn on 2021/22). There is a reasonable level of assurance that access to adequate DHSC revenue support funding will be available in 2022/23 (NHS England has issued guidance in April 2023 on how revenue support can be accessed by NHS Trusts in 2023/24). The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	10,486	**10,486**
Cash and cash equivalents	54,184	**54,184**
Total at 31 March 2023	**64,670**	**64,670**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	7,143	**7,143**
Cash and cash equivalents	50,526	**50,526**
Total at 31 March 2022	**57,669**	**57,669**

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,159	**1,159**
Obligations under leases	10,442	**10,442**
Trade and other payables excluding non financial liabilities	25,531	**25,531**
Total at 31 March 2023	**37,132**	**37,132**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	1,227	**1,227**
Trade and other payables excluding non financial liabilities	17,164	**17,164**
Total at 31 March 2022	**18,391**	**18,391**

Note 28.4 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 2023 £000	31 March 2022 £000
In one year or less	26,737	17,801
In more than one year but not more than five years	4,871	340
In more than five years	6,368	884
Total	**37,976**	**19,025**

Note 28.5 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 29 Losses and special payments

	2022/23		2021/22	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	1	-
Damage to clinical consumables*	-	-	3	71
Total losses	**1**	**1,203**	**4**	**71**
Special payments				
Ex-gratia payments	18	7	13	22
Total special payments	**19**	**13**	**13**	**22**
Total losses and special payments	**20**	**1,216**	**17**	**93**
Compensation payments received				

* The losses in 2022/23 relate to a write-off of prostheses stocks which were not suitable to be implanted. These prostheses are manufactured to reflect the morphology of each patient and are therefore unique to each patient and cannot be used for other patients. The factors which led to the write-off include delays in the expected date of the operation where a change in the patient's morphology means the implant is no longer suitable and disease progression since the prostheses specification was made known to the manufacturer which may lead to the prostheses becoming unsuitable for implanting. The write-off reflects the accumulation of such implants in inventory since 2013/14. Stock impairment balances in the SoFP have been recognised in previous years to reflect the build up of prostheses stocks which are not suitable to be implanted.

Note 30 Related parties

The Department of Health and Social Care (DHSC) is the parent department of the Trust. During 2022/23 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 2022/23 or have receivables or payables balances greater than £1.0m as at 31 March 2023 are set out below:

St George's University Hospitals NHS Foundation Trust
NHS Bedfordshire, Luton and Milton Keynes ICB
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
NHS Hertfordshire and West Essex ICB
NHS Kent and Medway ICB
NHS Mid and South Essex ICB
NHS North Central London ICB
NHS North East London ICB
NHS North West London ICB
NHS South East London ICB
NHS South West London ICB
NHS Suffolk and North East Essex ICB
NHS Sussex ICB
NHS Herts Valleys CCG (demised 01/07/22)
NHS North Central London CCG (demised 01/07/22)
NHS North East London CCG (Y04) (demised 01/07/22)
NHS North West London CCG (Y05) (demised 01/07/22)
NHS England
Health Education England
NHS Resolution
The Department of Health and Social Care

During 2022/23 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. The Charity reimbursed the Trust £23,430 in 2022/23 (£46,540 in 2021/22) for financial and other administrative services undertaken on behalf of the Charity by the Trust. This arrangement with the RNOH Charity ceased in September 2022.

Note 31 Better Payment Practice code

Non-NHS Payables	2022/23 Number	2022/23 £000	2021/22 Number	2021/22 £000
Total non-NHS trade invoices paid in the year	25,493	115,690	26,316	103,002
Total non-NHS trade invoices paid within target	23,857	107,588	20,475	82,726
Percentage of non-NHS trade invoices paid within target	93.6%	93.0%	77.8%	80.3%
NHS Payables				
Total NHS trade invoices paid in the year	732	10,293	922	11,044
Total NHS trade invoices paid within target	599	8,392	437	5,552
Percentage of NHS trade invoices paid within target	81.8%	81.5%	47.4%	50.3%

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 32 External financing limit

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

	2022/23 £000	2021/22 £000
Cash flow financing	7,136	(10,182)
External financing requirement	**7,136**	**(10,182)**
External financing limit (EFL)	7,182	(10,182)
Under spend against EFL	**46**	**-**

Note 33 Capital Resource Limit

	2022/23 £000	2021/22 £000
Gross capital expenditure	22,678	9,656
Less: Disposals	(75)	(93)
Less: Donated and granted capital additions	(131)	(283)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	93
Charge against Capital Resource Limit	**22,472**	**9,373**
Capital Resource Limit	22,518	9,969
Under spend against CRL	**46**	**596**

Note 34 Breakeven duty financial performance

	2022/23 £000	2021/22 £000
Adjusted financial performance surplus (control total basis)	3,240	11,931
Remove impairments scoring to Departmental Expenditure Limit	1,631	200
Breakeven duty financial performance surplus	**4,871**	**12,131**

Note 35 Adjusted financial performance (control total basis):

	2022/23	2021/22
	£000	£000
Surplus for the period	1,574	11,080
Remove net impairments not scoring to the Departmental expenditure limit	1,421	443
Remove I&E impact of capital grants /capital donations/peppercorn leases	236	(23)
Remove loss recognised on return of COVID assets to DHSC	-	93
Remove net impact of inventories received from DHSC group bodies for COVID response	9	338
Adjusted financial performance surplus	**3,240**	**11,931**

Note 36 Compliance with the Control Total set by NHS England

	2021/22	2020/21
	£000	£000
Adjusted financial performance surplus on a Control Total basis (see note 35)	3,240	11,931
Adjusted surplus/(deficit) Control Total set by NHS Improvement	(1,150)	1,077
Underspend against Control Total set by NHS England	**4,390**	**10,854**





Note 37 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012
	£000	£000	£000	£000	£
Breakeven duty in-year financial performance		1,026	(911)	1,102	2,0
Breakeven duty cumulative position	(2,954)	(1,928)	(2,839)	(1,737)	3
Operating income		94,370	102,469	111,762	120,8
Cumulative breakeven position as a percentage of operating income		(2.0%)	(2.8%)	(1.6%)	0.

	2016/17	2017/18	2018/19	2019
	£000	£000	£000	£
Breakeven duty in-year financial performance	(6,796)	(11,807)	(12,634)	(10,7
Breakeven duty cumulative position	(6,384)	(18,191)	(30,825)	(41,5
Operating income	140,587	143,653	155,126	169,6
Cumulative breakeven position as a percentage of operating income	(4.5%)	(12.7%)	(19.9%)	(24.5

2/13	2013/14	2014/15	2015/16
000	£000	£000	£000
078	5,912	235	(6,076)
341	6,253	6,488	412
302	132,331	130,490	131,628
.3%	4.7%	5.0%	0.3%

9/20	2020/21	2021/22	2022/23
000	£000	£000	£000
721)	1,846	12,131	4,871
546)	(39,700)	(27,569)	(22,698)
696	182,053	188,434	190,345
5%)	(21.8%)	(14.6%)	(11.9%)

Independent auditor's report to the directors of 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 Royal National Orthopaedic Hospital NHS Trust (the 'Trust') for the year ended 31 March 2023, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the 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 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended; and
- 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 2022-23; 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 2022-23 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 2022) 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.

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.

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.

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

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the 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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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 England, or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements, 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
- 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 27 June 2023 we referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 in relation to

the Trust reporting a breach of its breakeven duty for the year ending 31 March 2023 and planning to breach its breakeven duty for the year ending 31 March 2024.

Responsibilities of directors

As explained more fully in the Statement of directors' responsibilities in respect of the accounts set out on page 59, the directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions and 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.

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. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2022-23).
- 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, 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 risk of fraudulent income and expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries that altered the Trust's financial performance for the year
  - incomplete recognition of year-end non-pay operating expenditure;
  - the recognition of patient care and other income not principally derived from contracts that are at a fixed price; and
  - accounting estimates made in respect of manual expenditure accruals.
- 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 focus on material manual journals posted close to year end, material manual accrual journals posted at year end, any journals posted by unauthorised users and journals posted by senior management;
  - reviewing cash payments and invoices received in March, April and May 2023;
  - sample testing of patient care and other income not principally derived from contracts that are at a fixed price;
  - challenging assumptions and judgements made by management in its accounting estimates for manual 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. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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 communicated with management and the Audit Committee in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to valuation of land and buildings and right of use assets and liabilities included within the accounts.
- Our 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 England'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.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements –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 2023.

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, they will be reported by exception in a further auditor's report. 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 2023.

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust set out on page 60, 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(2A)(c) 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 January 2023. 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 Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2023 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.

Jackson Murray

Jackson Murray, Key Audit Partner

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

Bristol

30 June 2023

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

In our auditor's report issued on 30 June 2023, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2023, 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 2023 issued on 30 June 2023 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 2023 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 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since 30 June 2023 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 2023.

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(2A)(c) 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 January 2023. 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 Royal National Orthopaedic Hospital NHS Trust for the year ended 31 March 2023 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.

Jackson Murray

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

Bristol

29 September 2023