NHS
The Rotherham
NHS Foundation Trust

The Rotherham NHS Foundation Trust

Annual Report and Accounts

2021/22

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Together

The Rotherham NHS Foundation Trust

Annual Report and Accounts 2021/22

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paragraph 25 (4) (a) of the National Health Service Act 2006


NHS

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Welcome from the Chairman

In the first instance, I would like to say 'thank you' to everyone who has worked extremely hard over the last year; staff have shown tremendous dedication and resilience during 2021/2022 as we continued to be challenged due to the ongoing implications of the Covid-19 pandemic. This document, The Rotherham NHS Foundation Trust's Annual Report and Accounts for 2021/22, sets out how the Trust has performed over the year, including some key achievements, as well as some reflections about the ongoing challenges we face.

After initially starting with the Trust in February 2020, we extended Dr Richard Jenkins' secondment as our Interim Chief Executive twice during 2021/22, in September and March, with discussions ongoing about longer term arrangements. We also welcomed Steve Hackett as Director of Finance in July and Angela Wendzicha as Director of Corporate Affairs in September, with Helen Dobson becoming our Interim Chief Nurse in October and substantive Chief Nurse from April 2022.

The year continued to be dominated by Covid-19, which has had a massive impact on our services, colleagues, patients and the community we serve. While the changing needs of the pandemic challenged our services and colleagues, we adapted and were able to make progress on our recovery plans. This could not have been achieved without the continued hard work and dedication of our colleagues in our hospital and community locations.

Our Rotherham Hospital and Community Charity continued to receive support from our local community, and with grants from NHS Charities Together as a result of Captain Tom's fundraising efforts. We used the grants to invest in outdoor areas to benefit the wellbeing of our colleagues and patients. In July 2021, we opened our charity funded Wellbeing Garden for staff, which was shortly followed by our new Woodland Walk. These joined the Snowdrop Memorial Garden which was partfunded by the charity 4Louis.

The pandemic has had a significant impact on our colleagues and their health and wellbeing is pivotal in us being able to provide safe and effective care. We have therefore put great emphasis on the wellbeing of our staff. In addition to the charity-funded projects, we have also provided psychological support and visits from 'Thunder', a therapy husky which have proved extremely popular. We have also set up a new healthy lifestyle course for staff - 'Healthy eating, healthy mind, healthy body'.

We continue to collaborate as a key partner in the Rotherham Place Plan, working effectively with colleagues at the Clinical Commissioning Group (CCG), Rotherham Metropolitan Borough Council (RMBC), Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) who provide local mental health services and the voluntary sector.

The Trust is a partner in the South Yorkshire and Bassetlaw Integrated Care System (ICS) which continues to develop and system working is becoming increasingly important.

Recognising the contribution our colleagues make remains extremely important, especially given the ongoing challenges of the Covid-19 pandemic. For the second time, we held our annual Proud Awards ceremony virtually in November, live-streamed on our YouTube channel.

Our Trust continued to play an important role in the national vaccination programme, efficiently vaccinating our colleagues, health and care staff across Rotherham and members of the local community. Our Family Health division also rolled out the Covid-19 vaccination to school children across the borough.

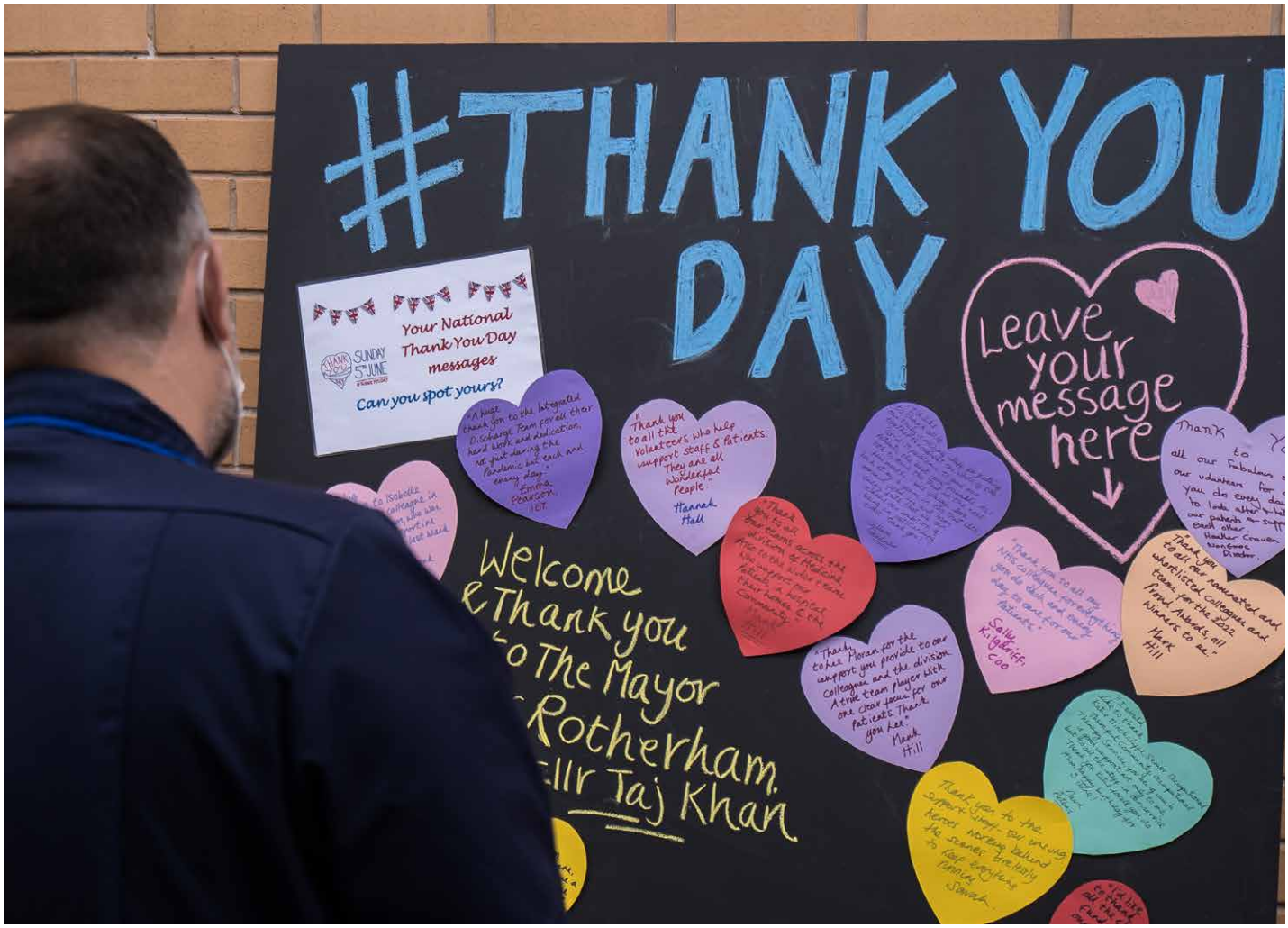
In December, we launched our new five year strategy, titled 'Our new journey, together' which sets out our priorities and takes into account the changes and learning as a result of rapid changes to the NHS due to the pandemic. While this year has continued to be extremely challenging, our new strategy provides a new direction as the country returns to a sense of normality.

We could not have achieved so much during the year if it wasn't for our hardworking, dedicated colleagues working across the community and hospital services. They have continued to care for our patients and we are very proud of them.

Best wishes,

Martin Havenhand
Chairman


GRATINO'S


#THANK YOU DAY
Your National Thank You Day messages
Can you spot yours?
SUNDAY 5TH JUNE
Leave your message here
Welcome
Thank you
To The Mayor
Rotherham
Cllr Taj Khan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Part 1: Performance Report

Overview of Performance: Statement from the Interim Chief Executive

In the first instance, I would like to say 'thank you' to everyone who has worked extremely hard over the last year; staff have shown tremendous dedication and resilience during 2021/2022 as we continued to be challenged due to the ongoing implications of the Covid-19 pandemic. This document, The Rotherham NHS Foundation Trust's Annual Report and Accounts for 2021/22, sets out how the Trust has performed over the year, including some key achievements, as well as some reflections about the ongoing challenges we face.

As stated above, the last 12 months have been exceptionally difficult for the NHS as a whole with the challenges we faced from the new Omicron variant of COVID-19. Nevertheless, we have faced these challenges as a team at the Trust and by working collectively we have delivered some incredible achievements.

There are a number of areas where the Trust is performing very well; we have strong and productive partnerships with a range of organisations across the system which we have invested time in developing over the last year.

We have seen an increase in our waiting lists as referrals began to increase back to pre-Covid levels. Elective activity has been reduced for the majority of the reporting period due predominantly to the ongoing challenges relating to the pandemic. Treatment for cancer has been an important focus for the Trust during the last year with a reduction seen in the backlog of patients waiting over 62 days.

The recognition that we have received nationally as the only place in the area to receive digital aspirant funding, our elective recovery seen to be performing as one of the top ten Trusts in the country in addition to our return to a financially balanced position all speak for themselves.

However, we do recognise that we have a number of challenges that we must overcome. During May and June 2021 we welcomed Inspectors from the Care Quality Commission as part of their routine Inspection cycle. The Inspection encompassed four core service areas (Urgent and Emergency Care, Medical Care (including care of the older person), Maternity, and services for Children and Young People. A separate Well-Led Inspection was also carried out.

We were disappointed that the Trust overall rating remained 'Requires Improvement' and I am committed to ensuring the Trust builds on the improvements already made to ensure we offer and deliver exceptional care to our patients and service users.

As our Chairman stated, our new Strategy looks to the future and builds upon what we have already achieved. We acknowledge that our people are our most valuable commodity in ensuring our continuing success and we are committed to ensuring we have the right people with the right skills to deliver high quality services is our strength and foundation for the future.

Staff engagement continues to be one of our key priorities and the Trust had a higher response rate to previous years, and higher than the national average. Out of 117 questions, 92 were scored positively. Our aggregate scores brought the Trust out as second best of the four South Yorkshire acute Trusts, and fourth out of the 12 acute Trusts across Yorkshire and the Humber.

Throughout the year, we have continued to change and adapt to new ways of working so that we can continue to provide safe and effective care for our patients. Patient safety and the quality of care we provide remain top priorities for the Trust and are at the heart of everything we do.

We have also made investments in our estate to help improve the patient experience. In 2021, we opened our new Discharge Lounge providing modern clinical facilities.

In April 2021, we created a new Division of Therapies, Dietetics and Community Care, enabling greater visibility of their fantastic services and colleagues that deliver them.

My thanks go out to all our committed and driven workforce, our Governors and members who all contributed to ensuring we continued to deliver the best care to our patients and their families. We could not have achieved what we have without the support of our volunteers who have worked hard to provide practical support to our patients at critical time when they have not been able to receive visitors due to national restrictions around visiting.

I would also like to thank our Charity which has been instrumental in supporting staff and patients with wellbeing packages throughout the year.

A brief history and statutory background

The Rotherham NHS Foundation Trust was established on 01 June 2005 pursuant to Section 6 of the Health and Social Care (Community Health and Social Care) Act 2003. We are regulated by NHS Improvement/England, are membership-based and a public benefit corporation and the Care Quality Commission (CQC) regulates the quality of the services the Trust provides. Prior to 2005, the Trust was known as Rotherham General Hospitals NHS Trust.

In 2011, Rotherham Community Health Services was acquired by the Trust resulting in a combined Trust providing both acute and community services across Rotherham, Doncaster and Barnsley.

Activities of The Rotherham NHS Foundation Trust

The Trust is registered with the Care Quality Commission to carry out the following legally regulated services:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures
- Maternity and midwifery services
- Termination of pregnancies
- Family planning services
- Assessment of medical treatment for persons detained under the Mental Health Act 1983

We deliver our care across multiple sites. The majority of our acute services are provided at the Trust's Moorgate Road site, however, the Trust also provides services at Breathing Space, Park Rehabilitation Centre, Rotherham Community Health Centre, Rotherham Intermediate Care Centre, New Street Health Centre in Barnsley and at The Flying Scotsman Centre in Doncaster.

As at 31 March 2022, the Trust had 4 400 dedicated members of staff working across an Acute and Community model of care serving a population of approximately 265,411 across the South Yorkshire and Bassetlaw region. The Trust has a Divisional management structure in order to co-ordinate and deliver healthcare services through the following structure:

- Medicine
- Surgery
- Urgent and Emergency Care Centre
- Community
- Family Health
- Clinical Support Services

The Trust has additional support services comprising Informatics, Estates and Facilities, Strategy, Planning and Performance Workforce and Finance, all of which are led by an Executive Director.

Throughout the last year, we have further developed and strengthened our partnership with Barnsley through the Barnsley and Rotherham Integrated Laboratory Services (BRILS) which provides an integrated pathology service across the two Trusts. In addition, we continue to have a joint ENT on call rota with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust covering emergency care across the region. We have also seen the Integrated Discharge Team which we run in collaboration with Rotherham Metropolitan Borough Council become further embedded within our organisation to support and facilitation discharges of our patient in a timely manner.

Over the last year, we have played an increasingly active role within the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) which in itself has continued to develop at pace. In addition, we have continued to play a leading role in Place-based working with partners across the Rotherham Integrated Care Partnership.

The Trust has an active Council of Governors with a statutory duty to hold our Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

Our Purpose

Overview of the Trust's Strategy

During the course of the last financial year the Board committed to and subsequently reviewed and refreshed our next 5 Year Strategy taking into consideration that the future will be more about system working and less about individual organisations.

The development of our new 5 Year Strategy has been very much engagementled with approximately 500 engagement sessions taking place with colleagues, patients in addition to partners across Rotherham all of which provided us with insight into what mattered to our stakeholders.

Key Issues, Opportunities and Risks

It is essential that we continue to focus on maintaining a high standard of quality care. The Board Assurance Framework is one of the tools the Board can assure itself on the delivery of the achievement of the Trust Ambitions within the new 5 Year Strategy. The Board Assurance Framework has been revised to align with the new Strategy with the new style presented to the Board in February 2022.

The key risks identified in year are described within the Annual Governance Statement at page 63.

The risks relevant for the end of the financial year and going forward as future risks relate to the following:

- Not embedded quality care due to lack of resource, capacity and capability
- Insufficient influence at PLACE will mean that we will not establish ourselves as leaders in improving the lives of the population we serve
- A lack of appetite for developing strong working relationships and mature governance processes will not progress a robust service configuration
- Insufficient resource and lack of compassionate leadership risks not developing and maintaining a positive culture leading to our inability to recruit and retain staff
- Insufficient resources (both financial and human resource) risks non delivery of safe and excellent care which will impact on our patient waiting lists and ability to deliver emergency care
- If we do not deliver on our financial plan for 2022-23 we will not be able to deliver our services

Estates Improvements

The 2021/22 capital programme builds on last years' successful delivery of multiple fast track construction developments in maintaining accessibility to services during the COVID-19 Pandemic. This years' schemes further improve
accessibility to services and assist in the Trusts return to business, post Pandemic and include:

- Implementation of the AccessAble web-based platform, improving accessibility to all services for all service users.
- Refurbishment of Kepple Ward.
- High risk backlog infrastructure replacement of aging High Voltage electrical infrastructure, thereby improving organisational resilience.
- Replacement of 350 windows, improving patient and staff comfort and experience, front of house appearance and reduction in energy demand.
- Staff wellbeing developments and refurbishments of grounds and gardens, staff rest rooms and wellbeing facilities.

Environmental Sustainability and Net Zero

The Rotherham NHS Foundation Trust's Green Plan sets out how the Trust will address Sir Simon Stevens Net Zero challenge, for the NHS to reduce the environmental impact arising from carbon emissions with a view to achieving 80% net zero by 2032 and totally emissions free on site by 2040.

Our Green Plan intends to exceed the current NHS commitments towards environmental sustainability, by:

- Achieving at least an 80% reduction in emissions from on-site sources by 2032
- Achieving a further 5% reduction in general waste, based on 2020's levels
- Reducing patient service mileage by 25% based on 2020 by 2032, by delivering care closer to home and in the community settings
- Ceasing use of all single use plastics
- Reducing water consumption by 10% by 2025

In 2021 we made significant progress in reducing our carbon footprint through the successful completion of an £11m capital investment through a range of energy savings projects, including the replacement of our Combined Heat and Power Plant and primary heating boilers at The Rotherham Hospital and widescale replacement of lighting with LED fittings across our sites.

The Trust was successfully awarded £2.5m grant funding from the Public Sector Decarbonisation Fund, which is being invested in a Heat Pump to replace the inefficient gas boiler at Old Greenoaks Wellbeing Centre, along with building insulation and window upgrades across the Trusts buildings.

We pledge to adhere to the NHS CO2 reduction targets to eliminate our CO2 footprint through this plan, as approved by our Board of Directors. By working collaboratively with our peer organisations within the Integrated Care System in South Yorkshire and as an Anchor organisation within our community, we will uphold our corporate and social responsibilities. We will minimise our environmental impact and work to provide sustainable healthcare services, in

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid, verified invoice, whichever is later. As can be seen in the table below, during 2021/22 the Trust paid **88.94%** by number and **83.67%** by value of all of its total bills within the 30-day target.

	Number	Value £000's
NON NHS		
Total Bills Paid in Year	47,728	112,953
Total Bills Paid Within Target	42,692	95,655
Percentage of Bills Paid in Target	**89.45%**	**84.69%**
NHS		
Total Bills Paid in Year	2,010	12,052
Total Bills Paid Within Target	1,547	8,931
Percentage of Bills Paid in Target	**76.97%**	**84.69%**
Total		
Total Bills Paid in Year	49,738	125,005
Total Bills Paid Within Target	44,239	104,586
Percentage of Bills Paid in Target	**88.94%**	**83.67%**

Performance has slightly increased compared to the figures report for the end of the 2020/21 financial year (88.42% by number and 82.14% by value).
The total amount of liability to pay interest which accrued by virtue of the Trust failing to pay invoices within the 30-day period, and the total amount of interest actually paid in discharge of such liability by the Trust during 2021/22 was £35.

Information on fees and charging

The Trust has nothing to disclose in relation to any individual service having full costs exceeding £1 million.

Income disclosures as required by section 43(2A) of the NHS Act 2006

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Rotherham NHS Foundation Trust meets this requirement.

As required by section 43(3A) of the NHS Act 2006, an NHS Foundation Trust must provide information on the impact that other income it has received has had on its provision of goods and services for the purposes of the health service in England. The Rotherham NHS Foundation Trust has not received any income which was not for the purposes of the health service in England during 2021/22.


NHS
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Performance Analysis
Emergency Access

The Rotherham NHS Foundation Trust continues to take part in the field test of the proposed new national urgent care metrics, which the Trust is reporting separately to NHS England. As such, information about the field test is available from NHS England directly. 2021/22 was the second consecutive year where there were no patients who waited for longer than 12 hours following a decision to admit into the hospital.

The organisation's journey of development this year has been to continue to embed effective discharge planning by ward teams with the new national 'right to reside' indicators now in place across all areas.

Through 2022/23 we will maintain our focus on the importance of improving flow through the wards and Assessment Units to support the Urgent and Emergency Care Centre, as this has continued to be a challenge in 2021/22. This work will include continued attention on identifying planned discharges, increasing the proportion of morning discharges and standardising the number of discharges across all seven days of the week. The relaxation of infection, prevention and control measures relating to COVID-19 from late April 2022 should enable us to simplify emergency patient pathways.

COVID-19 continued to add significant pressures on the Trust across the year, and it was necessary for us to respond quickly and decisively to the changing pandemic situation. The Trust was one of the worst affected nationally during each of the peaks of the two major COVID-19 waves in 2021/22 in terms of the proportion of our beds which were occupied by patients with COVID-19, reducing available capacity for other patients. The Trust therefore placed significant focus on the challenges posed by the pandemic, working closely with partner organisations. The operational, medical and nursing teams coped admirably and we mitigated the acute pressures, and balanced the need for a continued response to COVID-19 with the need to deliver wider healthcare services to the population.

As in previous years, the Trust worked with Place partners to develop a Winter Plan. This consisted of modelling of the anticipated demand that would be placed upon critical care and the acute and community services and the actions that needed to be taken to meet this demand. All partners across the borough were engaged with the plan and contributed to key actions. This resulted in the use of flexible COVID-19 and non-COVID-19 beds across the acute and community bed bases. The organisation continues to work closely with health and social care partners in Rotherham to reduce avoidable hospital admissions and avoid unnecessarily prolonged hospital stays throughout the year.

Given the pressures on the health service during further COVID-19 waves in 2021/22, the Trust's elective care activity was reduced during the busiest periods, in order to support COVID-19 capacity for emergency admissions. Despite this, the South Yorkshire and Bassetlaw Integrated Care System took part in the national Accelerator Programme in Quarter two 2021/22, where systems were tasked with delivering as much elective activity compared to pre-pandemic as possible. The national team tasked all participating systems with an ambition to deliver 120% of 2019/20 activity. The Trust delivered increased levels of elective activity as a result of the programme, due to the additional investment that was available for expanding capacity.

Cancer Waiting Times

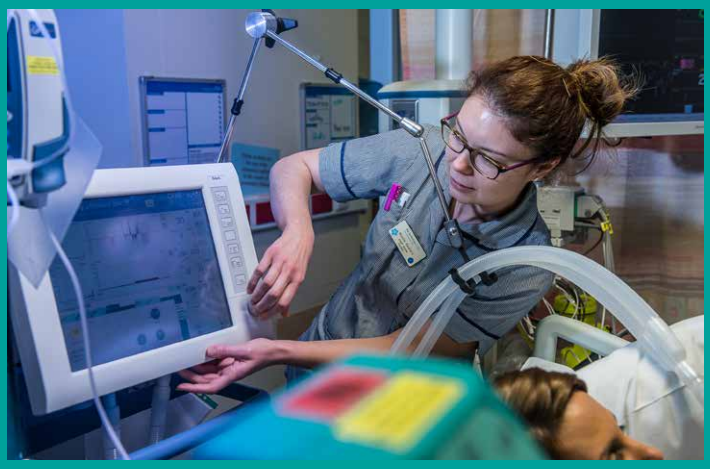
Timely management of patients referred onto the cancer pathway is an important focus for the Trust. Following the significant reduction in some key cancer activity in 2020/21 based on national guidance, in 2021/22, our focus was on reducing the backlogs of patients waiting for care and returning to pre-pandemic levels of activity.

The Trust was identified nationally as one of the top performers in responding to the increased number of cancer referrals in 2021/22, although the Trust remained noncompliant with the 62-day standard of patients being treated following urgent referral from their GP.

The Trust monitored performance against the new national 28-day cancer faster diagnosis standard, due for implementation in 2022, throughout the year. This new standard requires patients to be given a confirmed diagnosis within 28 days of referral, in order to ensure more patients with and without cancer receive this confirmed diagnosis much faster.

Diagnostic Waiting Times

The national standard requires that no more than 1% of patients should wait longer than six weeks, which the Trust delivered consistently in 2019-20. However, due to the impact of the pandemic (including the backlog of patients waiting and the infection, prevention and control measures that led to a reduction in capacity), this standard was not delivered during 2021-22, although the Trust saw a significant improvement on 2020-21 performance.



Other Performance Indicators

Community services continued to see increased activity across adult and children's services. This reflects the ongoing drive to provide care closer to home and away from the acute hospital setting despite the pressures this increased demand brings, community teams continue to respond positively, and in a number of areas have implemented new ways of working.

Within children's services, the teams continue to work with partners and on the implementation of the 0-19 service model, and the development of new roles to support this. The children's teams saw new and different pressures on services in 2021/22, particularly due to a shortage of Tier 4 Children's and Adolescent Mental Health beds both locally and nationally. These challenges led to a number of patients staying on our acute paediatric ward who would normally be treated in different, specialist NHS facilities.

Looking ahead to 2022/23

The Trust has made significant progress against our objectives in 2021/22, but there are still a number of core dimensions where our performance needs to improve. As more normal operations resume within the NHS in 2022/23, it will be a year for resetting and re-doubling our efforts to return to pre-pandemic delivery of services and performance.

Our key areas of focus include launching a Quality Improvement (QI) approach in the organisation, in order to start embedding a QI approach into our day-to-day work. Additionally, we will be redesigning some of our quality governance structures and processes in order to ensure we are set up in a way that enables us to learn from what we do, particularly where we do not deliver as well as we would like.

Whilst the Trust is not currently reporting on the national emergency access standards, we know that each day, too many patients are waiting too long in our Urgent and Emergency Care Centre (UECC). Given the new national focus on the number of patients waiting 12-hours in department, there is a need for us to improve our performance against this metric, whilst also continuing to work to the national field test standards. We will continue to focus on how we manage flow through the organisation to do this. The Trust has launched a much broader and significant programme of work to sit around this, which includes a focus on clinical leadership, emergency pathways and our internal ways of working.

How we exit the COVID-19 pandemic will also be a key focus area for the Trust. It is essential that we continue to support the health and wellbeing of our colleagues who have experienced the most challenging and traumatic working conditions in the history of the NHS over the last two years. It is also critical that our recovery of elective activity continues, especially now some of the constraints from operating through enhanced infection, prevention and control measures have now been removed.

Summary of performance against key healthcare targets

Performance of the Trust during the year has been severely affected by the pandemic and national reporting requirements have changed, as have our local and national expectations.

Emergency Access

The Rotherham NHS Foundation Trust has continued to be a field test site for the proposed Urgent Care Metrics throughout 2021/22, and as such we are unable to report against our performance within the Urgent and Emergency Care Centre (UECC) for many of the standard metrics, such as the 4-hour standard.

Implementing the proposed new field test standards has now been underway for almost 3 years. The new standards require a different approach to managing patients in the UECC in particular, with patients requiring a different approach to care to that of a department operating under a 4-hour target. That will naturally have an impact on our performance figures when considered against more traditional metrics therefore.

Our operational improvement journey has continued, with a focus on effective ward rounds and discharge planning by ward teams. These pieces of work continue to be supported by the Integrated Discharge Team with staff from the Trust and Rotherham Metropolitan Borough Council (RMBC) coming together to form a single point of access for all complex discharges. Through 2021/22 there has been a ontinued focus on the importance of improving flow through the organisation to support the Urgent and Emergency Care Centre (UECC). This includes continued attention on identifying planned discharges, increasing discharges and standardising the number of discharges across all seven days of the week.

The Trust participated in the development of a Winter Plan in partnership with the Place (Rotherham) system. This consisted of modelling of the anticipated demand that would be placed upon the acute and community services and the actions that needed to be taken to meet this demand. All partners across the borough were engaged with the plan and contributed to specific actions. This resulted in additional acute and community capacity being brought on stream from the autumn. Additional beds were provided by RMBC and the Clinical Commissioning Group (CCG) within the care and nursing home sector.

The Trust placed significant focus on the challenges posed by COVID-19 and the winter, and colleagues worked closely with partner organisations in particular to improve the quality and timeliness of the transfer of patients from acute settings once they were medically fit to do so. The recording of a patient's Right to Reside (RtR) status when they are in an acute bed is now embedded within daily ward rounds and within the relevant areas of the Electronic Patient Record. This is to ensure we can maintain daily oversight of our position regarding patients who are medically fit to be discharged out of the Trust.

18 Week Referral to Treatment Waiting Times

Following a significant drop off in the Trust's waiting list size in 2020/21 due to reduced referral volumes, in 2021/22 the organisation saw waiting list numbers increasing significantly (by just over 70%) as referrals bounced back to pre-Covid levels, but capacity remained constrained. However, at least a third of this increase was due to the Trust amending its reporting processes to ensure the most recent guidance around Appointment Slot Issues (ASIs) was being followed, with these patients now counted as part of the Trust's total waiting list.

The Trust's elective care activity was reduced for most of the year due to some of the challenges posed by the pandemic, including significant increased staff sickness levels, and the necessary infection, prevention and control measures. Elective capacity was further reduced in November 2021 and then for most of the fourth quarter of the year, as the emergency pressures required us to utilise these beds for our non-elective patients. During these periods, the Trust was only able to continue with inpatient treatments that were urgent or for patients on cancer pathways.

Despite these challenges, the Trust reduced the numbers of patients waiting over 52 weeks from approximately 600 at the end of 2020/21 to fewer than 100 by the end of 2021/22, although this was a slight increase from a low of just over 30 just before the Christmas period.

From a performance perspective, following a steady improvement in delivery of the Referral to Treatment standard up to a peak of 85.1% in July 2021, waiting times were then affected by the pressures seen over the autumn and winter, with 74.8% of patients waiting under 18 weeks by the end of the year. There were particular challenges in some of our specialties with a small medical workforce due to the ongoing impact of the COVID-19 pandemic on staff sickness levels, as well as those specialties that are more reliant on theatre and elective bed capacity.

Capacity pressures and requirements to manage the pandemic will continue to be monitored in 2022/23, as the Trust continues to mitigate the current challenges and aims to return to pre-COVID-19 levels of activity as soon as possible.

Cancer waiting times

The timely management of patients referred onto a cancer pathway is an important focus for the Trust. During the first year of the pandemic the Trust had to limit and reduce access to some diagnostics and treatment within cancer pathways due to the national guidance at the time. This was implemented in a clinically-appropriate way, with all urgent cancer patients treated appropriately and the Trust recommencing diagnostic services as soon as it was safe to do so. With NHS services re-opened throughout 2021/22, the Trust saw referral volumes increase to pre-Covid levels. Teams managed these within the capacity available, with the Trust reducing the backlog of patients waiting over 62 days to within the trajectory set at the start of the year, and supporting the wider Cancer Alliance area to deliver to plan.

As well as a clear focus on ensuring fewer patients were waiting over 62 days on cancer pathways, the Trust also prepared for the introduction of the Faster Diagnosis Standard in 2022/23. This included a review of the front end of pathways within those specialties where performance is well below the standard and benchmarks poorly compared to other trusts, including Lower Gastrointestinal tumour sites. The reintroduction of the straight-to-test diagnostic pathway made a significant difference and supported a ten percentage point improvement in performance, from under 65% to above the 75% standard by March 2022.

The Trust failed to deliver the constitutional 62-day standard throughout the year, due to some of the pressures described above. Re-setting expectations around cancer performance and delivery will be a priority in 2022/23, with a particular focus on our Prostate pathway. Despite this, the Trust was recognised nationally as one of the most effective in terms of recovery of cancer performance, especially given our management of the increase referral volumes we've experienced.

Mortality

Mortality performance continued to be a key area of focus during 2021/22, following the establishment of the Mortality Improvement Group the year before, chaired by the Interim Chief Executive. The work of the group has now delivered the impact anticipated at the start of the programme, with the HSMR now within the 'as expected' range, and continuing to fall. The latest HSMR 12-month rolling figure is 102.6, based on the latest available data to December 2021.

This Group, supported by a new Mortality Analytics Group and the outputs of the Trust's Safe & Sound Mortality Group, have continued to identify key actions required around themes and trends and to drive improvements around the '3C's' (quality of care; case mix; and coding). Furthermore, 'deep dive' reviews of deaths involving some key mortality alerts, in particular around pneumonia, chronic obstructive airways disease (COPD), and intestinal obstruction without hernia, have taken place. Alerts within these three disease groups are no longer showing on the HSMR data for the Trust, which demonstrates the value this work has delivered.

Despite this significant improvement in our core mortality metrics, it is recognised that there is still progress to be made around improving the Trust's learning from deaths across all levels of the organisation. As above, a programme of work focussed on our Quality Governance structures and processes, will support this goal. Alongside this improvement work, the Medical Director and Chief Nurse continue to lead weekly Harm Free Care meetings, where any quality of care issues arising that week are discussed and appropriate actions taken where required.

Other Performance Indicators

Community services continued to see increased activity across adult and children's services. District Nursing provided support and care for patients in need again within the restrictions placed on everyone as a result of the pandemic. The team ensured patients in need were seen as soon and as safely as practicable, and in a number of areas have continued to implement new ways of working.

The Trust has continued to increase activity within diagnostic services in a safe and appropriate manner, and has remained the top trust nationally for delivery of the DM01 standard in Endoscopy throughout the 2021/22 year.

Other diagnostic modalities continue to experience capacity constraints and challenges in eliminating the COVID-19 backlogs, although the arrival of a second MRI scanner for the Trust at the end of the 2021/22 year will support our longer-term needs in this particular area.

Going Concern Disclosure

After making enquiries, the Directors have a reasonable expectation that the services provide by the Rotherham NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Conclusion

In summary, 2021-22 continued to be an extremely busy year for the Trust and I would like to reiterate how proud I am of all our staff who worked tremendously hard through difficult circumstances to ensure out patients received high-quality care.
Performance Report signed by the Interim Chief Executive in the capacity as Accounting Officer.

R. Jenkins

Dr Richard Jenkins
Interim Chief Executive
Dated: 20 June 2022

Part 2: Accountability Report

Director's Report

The Board of Directors: Roles and Responsibilities

The Trust Board operates as a unitary Board with collective accountability for all aspects of the Trust's performance ranging from clinical, quality, to sustainability and financial performance.

The Board is led by Mr Martin Havenhand, Chair and the Executive Team is led by Dr Richard Jenkins, Interim Chief Executive. The Board sets the strategic direction having regard to priorities set by the NHS in addition to monitoring the performance against the Trust's objectives and Operational Plan.

The Board of Directors considers that it has the necessary range of skills, knowledge and experience to address the current challenges facing the organisation.

The Board also ensures that the Trust delivers safe and effective clinical care in addition to ensuring the Trust maintains high standards within both clinical and corporate governance. The Board of Directors is jointly and severally responsible for scrutinising and challenging the performance of the Trust to ensure that the Trust delivers on our Strategy and continues to improve to deliver high quality care to all our patients and staff.

The Board of Directors are collectively responsible for exercising the powers of the but has the ability and authority to delegate some of these powers to Board Committees and senior management. The Board has a number of Assurance Committees supporting the Board in seeking assurance on all matters relating to quality, finance, performance, people and risk. The aforementioned Assurance Committees are Audit Committee, Finance and Performance, People, and the Quality Committee. The Remuneration Committee and Nominations Committee are both statutory committees.

The day to day management of the organisation is delegated form the Board of Directors through the Interim Chief Executive to the Executive Directors. To ensure that the organisation is managed effectively, efficiently and to the highest standards in accordance with its values, clear objectives are set and progress towards their achievement is monitored on a monthly and quarterly basis.

In addition, the Board has an agreed Scheme of Delegation, Standing Financial Instructions which articulate where Board approval is required in relation to any decision and where decisions can be made by the Executive Team.

Composition of the Board

The Board of Directors comprises eight Non-Executive Directors (including a Non- Executive Chair) and seven Executive Directors. The following illustrates the experience and expertise that each of the Directors bring to the Trust.

Non-Executive Directors are appointed by the Council of Governors and collectively they bring a broad range of business, clinical, financial and commercial experience and expertise to the Trust.

All Non-Executive Directors are considered to be independent in character and they are free from material business relationships that may interfere with their judgement.

The performance of the Board as a whole is reviewed on an annual basis through a self-assessment facilitated via an on-line survey through our Internal Auditors.

Non-Executive Directors

Name and Position	Background	Total Number of Board Meetings attended
Martin Havenhand **Chair**	Martin is a very experienced Chair and Non-Executive Director within both the private and public sectors. Martin is particularly skilled and experienced in developing appropriate strategies and plans that achieve positive results. Martin joined the Trust as Chair in February 2014 and is passionate about improving health services in addition to addressing health inequalities and remains committed to improving the health and wellbeing of our staff. Martin is Chair of the Trust Board, Nominations Committee, Council of Governors in addition to the Governor Nominations Committee. Terms of office 01.01.2014 to 31.01.2017 01.02.2017 to 31.01.2020 01.02.2020 to 31.02.2023	15/17
Lynn Hagger **Non-Executive Director** **and Vice-Chair**	Lynn joined the Trust as a Non-Executive Director on 1 October 2013 for a three year term of office. Lynn has over 35 years' experience within the NHS as a Non-Executive Director of acute hospitals including as Chair of Sheffield Children's Hospital and Non-Executive Director of Leeds Teaching NHS Foundation Trust. Lynn has a background in social work and legal practice following which she became a legal academic with lectureships at the Universities of Manchester, Liverpool and Sheffield. She has taught administrative/public law, contract, environmental and European law before specialising in healthcare law and ethics at undergraduate and post graduate level. Terms of office Lynn has been re-appointed by the Council of Governors during the following periods: 01.10.2016 – 30.09.2019 01.10.2019 – 30.09.2021 01.10.2021 – 30.09.2022 Lynn has remained as Vice-Chair and Chairs the Trusts' People Committee. Lynn is Vice Chair of the Nominations Committee and is a member of the Charitable Funds Committee.	16/17
Nicola Bancroft **Non-Executive Director**	Nicola joined the Trust as a Non-Executive Director on 1 October 2016. Nicola has over 30 years commercial experience within the retail sector having worked for Walgreens Boots Alliance in a number of senior finance and strategy leadership roles and for DFS where Nicola was Group Finance Officer. Nicola has worked extensively on the implementation of various customer focused strategies and transformation programmes in both businesses. Nicola has a first class honours degree in accounting and finance and is a fellow of the Chartered Institute of Management Accountants. Nicola is passionate about coaching and developing leaders and their teams to be the best they can be. Nicola has been the Chair of the Finance and Performance Committee since August 2020 is a member of the Audit Committee, Vice Chair of the Remuneration Committee and member of the Charitable Funds Committee. Terms of office 01.10.2019 to 30.09.2022	16/17

Name and Position	Background	Total Number of Board Meetings attended
Heather Craven Non-Executive Director	Heather joined the Trust as a Non-Executive Director in February 2017. Heather is a Chartered Accountant and has spent he majority of her career working in the private sector as Finance Director for FTSE and AIM listed companies across a wide spectrum of industries both in the UK and overseas. Since 2006, Heather has helped a number of organisations via interim and consultancy roles to identify operational, commercial and financial issues and weaknesses delivering solutions to resolve. Heather is a member of the Quality Committee, Chair of the Remuneration Committee and Vice Chair of the Charitable Funds Committee. Terms of office 17.02.2017 to 16.02.2020 17.02.2020 to 28.02.2023	14/17
Rumit Shah Non-Executive Director	Rumit joined the Trust as a Non-Executive Director in January 2020 for a two year term of office. The Council of Governors approved a further three year term of office from January 2022. Rumit is currently a full-time practicing General Practitioner in Hatfield, Doncaster. Rumit is a graduate of the University of Sheffield and his commitment to the NHS spans over 38 years during which time he has been engaged in various capacities including the Local Medical committees (LMC), Primary Care Groups, Primary Care Trusts in addition to being a Clinical Director of East Doncaster Primary Care Network. Rumit is the Chair of the Doncaster LMC. Rumit has been a GP Appraiser, sat on the National Clinical Assessment Service (NCAS) assessing General Practice, a GP member on the Area Prescribing Committee and the Scheduled Drug Monitoring Sub- Committee of Doncaster. is a passionate advocate for excellent quality of care delivered in a timely manner and from August 2020 he has been the Chair of the Quality Committee. Rumit is Chair of the Quality Committee, Vice Chair of the Finance and Performance Committee and a member of the Nominations Committee. Terms of office 01.01.2020 to 31.12.2021 01.01.2022 to 31.12.2024	14/17
Michael Smith Non-Executive Director	Michael joined the Trust as a Non-Executive Director in April 2019. Michael is an experienced Non-Executive Director and also serves on the Board at Humber Teaching NHS Foundation Trust. Michael has an Honours Degree in Law and a Master's in Business Administration in addition to a Master's in Mental Health Law. He has extensive experience within both the public and private sectors and has been the President of the Rotherham Chamber of Commerce. Michael is a volunteer director/trustee of the Magna Science Adventure Centre and is an enterprise adviser to a local Special School. Michael serves as Chair on the Charitable Funds Committee. Michael is Chair of the Charitable Funds Committee, Vice Chair of the People Committee, Vice Chair of the Audit Committee and a member of the Remuneration Committee. Terms of office 01.04.2019 to 31.03.2020 31.03.2022 to 30.09.2022	12/17
Mark Edgell Non-Executive Director	Mark joined the Trust on 01 June 2012 and served as the Chair of the Quality Committee and was a member of the Audit Committee and the Nominations Committee. Mark left the Trust on 31 May 2021	3/3

Michael Killick Non-Executive Director	Michael joined the Trust from 01 April 2021 as a Non-Executive Director and left September 2021.	5/10
Joanna Bibby Non-Executive Director	Jo Bibby joined the Trust as a Non-Executive Director on 01 June 2021 for a three year term of office until 31 May 2024. Jo has worked in health and healthcare throughout her career, at both national and local level. During ten years at the Department of Health, she was responsible for a range of policy areas including research and development and finance and performance. Jo has led development of approaches to improve the safety and quality of health care, many of which are now applied routinely across the NHS. Jo works at the Health Foundation, an independent charity and 'think tank' where she is responsible for a nationally recognised strategy to improve health and reduce health inequalities. Jo is a member of the People Committee, Vice Chair of the Quality Committee and a member of the Nominations Committee.	10/15
Kamran Malik Non-Executive Director	Kamran Malik joined the Trust as an Associate NED in April 2021 and was subsequently appointed as a substantive NED from 11 September 2021 until 10 September 2024. Kamran is a finance professional focusing on business transformation through a coaching approach to people and culture change. He qualified as a Chartered Accountant with KPMG, worked overseas with TNT in senior finance roles, was a Finance Director for a start-up before joining the Royal Mail. During his 20 years at the Royal Mail, he further expanded his business acumen by undertaking various senior leadership roles and professional qualifications including Risk Management, Regulatory Compliance, Procurement, Business and Personal Coaching and as a Director of Cost Transformation. Kamran is Chair of the Audit Committee, a member of the Finance and Performance Committee and a member of the Remuneration Committee.	16/17

Executive Directors

Name and Position	Background	Total Number of Board Meetings attended
Dr Richard Jenkins, Interim Chief Executive	Richard joined the Trust on 10 February 2020 as Interim Chief Executive on a joint basis with Barnsley Hospital NHS Foundation Trust where he serves as the Chief Executive. He has previously been the Medical Director for two NHS provider organisations. He has practised medicine for over 28 years since graduating from the University of Sheffield in 1991with an intercalated degree in virology in addition to his medical degree. Richard was a trainee doctor in South Yorkshire before he became a Consultant in 2002, specialising in diabetes and endocrinology.	16/17
Michael Wright, Deputy Chief Executive	Michael joined the Trust initially as Interim Deputy Chief Executive in February 2020 becoming substantive from November 2020. Michael has extensive experience across both the NHS and Department for Work and Pensions. He has been a Turnaround Director at Liverpool University Hospitals NHS Foundation Trust and the Director of Finance at Barnsley Hospital NHS Foundation Trust.	17/17
George Briggs, Chief Operating Officer	George has worked in the NHS for over 40 years working within a variety of organisations. He has extensive experience as a general manager and Associate Director in a number of specialities including cardiothoracic, intensive care, surgery and medicine.	11/17
Steve Hackett, Director of Finance	Steve joined the Trust as Director of Finance in July 2021. He has worked in the NHS since 1990 having previously worked for local acute Trusts, NHS England and Primary Care Trusts in the area. Steve qualified as a Certified Accountant in 1997 and has worked as a Director of Finance in the NHS since 2001, with recent roles at Chesterfield Royal Hospital NHS Foundation Trust and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).	12/12
Dr Callum Gardner, Medical Director	Callum joined the Trust in September 2018 as Interim Medical Director before being appointed to the substantive post in November 2019 and continues to hold joint responsibility for quality and clinical governance with the Chief Nurse. Callum is a Consultant in acute medicine with a sub-speciality interest in respiratory medicine. Callum was previously the Divisional Director for the Emergency and Medicine Division at North West Anglia NHS Foundation Trust. He has also held a number of key roles including Deputy Medical Director, Associate Medical Director: Patient Experience. Callum was a doctor in the Royal Navy for almost 18 years.	16/17
Angela Wood, Chief Nurse	Angela joined the Trust in 2018 as the Interim Chief Nurse before being appointed into the substantive post in February 2019. Angela has over 33 years nursing experience and joined the Trust from her role as Deputy Director of Nursing for Lancashire and South Cumbria at NHS England. Angela left the Trust for a secondment opportunity in October 2021.	9/11
Helen Dobson, Interim Chief Nurse October 2021 **Chief Nurse from December 2021**	Helen was appointed as Interim Chief Nurse in October 2021 and subsequently appointed to the substantive Chief Nurse role. Helen previously worked at Sheffield Children's NHS Foundation Trust specialising in Paediatric Critical Care and has a significant educational background, including being a Lecturer/ Practitioner at the University of Sheffield and leading national educational groups. Helen joined The Rotherham NHS Foundation Trust in November 2015 as Head of Nursing for our Surgical Division and was appointed Deputy Chief Nurse in February 2017.	9/11

Directors' Register of Interests

All Board members are required to declare any company directorships and any other significant interests which may conflict with their management responsibilities. Any such declarations are reviewed and published on the Trust website and has been completed for the relevant reporting period.

Registers are available from the Director of Corporate Affairs (Company Secretary) at the address below:

Ms Angela Wendzicha
Director of Corporate Affairs (Company Secretary)
Trust Headquarters
Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

Committees of the Board

Audit Committee (Statutory Committee)

The Trust Audit Committee is a Statutory Committee formally constituted by as a Committee of the Board and comprises three Non-Executive Directors.

The Audit
Committee is chaired by Kamran Malik and membership comprises two additional Non-Executive Directors, Nicola Bancroft and Michael Smith. Standing attendees to the Audit Committee include the Director of Finance, Chief Nurse and Director of Corporate Affairs. Representatives from both Internal and External Audit are also in attendance.

The Audit Committee has a key role in ensuring the adequacy and effectiveness of systems, governance, risk management and internal control (both financial and nonfinancial), all of which support the Trust's priorities. In carrying out its function, the Audit Committee predominantly utilises the work of Internal and External Audit. During the last financial year, Trust did not use External Audit or Internal Audit for any non-audit related services.

The Committee is responsible for providing the Board with advice and recommendations on all matters which include the effectiveness of the framework of controls in the Trust, the adequacy of the arrangements for managing risk and the adequacy of the performance of our auditors.

During the last financial year, the Audit Committee met seven times and met its key responsibilities by considering the following matters;

- Approved the Internal Audit Plan for 2021-22
- Approved the Anti-Fraud Annual Work Plan for 2021-22
- Reviewed the ongoing development of the Board Assurance Framework
- Monitored responses by management to the recommendations made by Internal Audit through associated reviews
- Received assurance in relation to the improvement plan to strengthen the Trust's processes for managing litigation and inquests in addition to actions as a result of litigation
- Maintained oversight of the Trust's schedule of outstanding debt and the schedule of losses and compensations
- Maintained oversight of the Tender Waivers
- Reviewed the work of External Audit
- Reviewed the work and findings from Anti-Fraud
- Reviewed the 2021-22 Financial Statements seeking assurance they are appropriately compiled on a going concern basis
- Reviewed the Trust's Standing Financial Instructions and Standing Orders in addition to Scheme of Delegation and Matters Reserved for the Board
- Received assurance in relation to cyber security
- Received the Register of Interests
- Reviewed the Annual Report and Accounts (2020-21)
- Received the Annual Review of Standards of Business Conduct
- Received the Annual Report from the Freedom to Speak Up Guardian
- Reviewed the position in relation to Risk Management and the Trust's Risk Register.

Nominations Committee (Statutory)

The Trust has two Nominations Committees. Responsibility for the appointment of Executive Directors lies with the Board of Director's Nominations Committee.

Responsibility for the appointment of Non-Executive Directors lies with the Council of Governor's Nominations Committee. Both are chaired by the Trust Chair.

Remuneration Committee (Statutory)

The Remuneration Committee is Chaired by Heather Craven, Non-Executive Director and comprises three other Non-Executive Directors. Nicola Bancroft is Vice Chair and Kamran Malik and Mike Smith the remaining Non-Executive Director members of the Remuneration Committee. The Chief Executive, Director of Workforce and Director of Corporate Affairs are in attendance at the Remuneration Committee. The structure of the remuneration of Executive Directors was considered and approved during the reporting period and details of the remuneration of board members can be found in the remuneration section of the annual report.

The Remuneration Committee has met on five occasions during the last financial year with attendance as follows:

Heather Craven	5/5
Nicola Bancroft	4/5
Mike Smith	4/5
Kamran Malik	2/2
Michael Killick	3/4

Board and Committee Effectiveness

During the last financial year, the Board and Assurance Committees undertook a survey assessment survey on the effectiveness of the Board and Committees. The scores and comments were reviewed by each respective committee during April and May 2022. The survey results recognised that the Finance and Performance Committee and Audit Committee were operating well there was scope to strengthen the Quality Committee and People Committee through planned development work in early 2022-23.

Remuneration Report

Annual Statement from the Chair of The Rotherham NHS Foundation Trust Remuneration Committee.

In accordance with the requirements of the HM Treasury Financial Reporting Manual (FReM) and NHS Improvement, the remuneration report is divided into the following:

- Annual Statement on Remuneration
- Director's Remuneration Policy sets out the Trust's senior manager's remuneration policy and
- The Annual Remuneration Report

I am pleased to present the Remuneration Report for the financial year 2021-22 on behalf of The Rotherham NHS Foundation Trust Remuneration Committee. As delegated by the Board of Directors, the Remuneration Committee has primary regard to the remuneration and terms of service of Executive Directors. The remuneration of Non-Executive Directors is dealt with by the Remuneration Committee established by the Council of Governors.

Major decisions taken on senior managers' remuneration 2021-22

The definition of 'senior manager' as contained in the FReM has been applied and refers to Executive and Non-Executive Directors only, that is those who influence the decisions of the Trust as a whole.

During 2021-22, the Remuneration Committee continued to utilise annual benchmarked data, including that provided by NHS Providers as the pay and reward framework upon which to base Executive salary awards.

For the period 2021-22, the Remuneration Committee took into account the Executive Remuneration Framework whilst being mindful to ensure that levels of remuneration were sufficient to attract, retain and motivate directors with the skills and experience required by the Trust. The Trust was mindful not to pay more than necessary for this.

In addition, guidance from NHSI/E, specifically 'Established pay rates for acute NHS Trusts and Foundation Trusts' was reviewed and taken into consideration during deliberations on pay awards.

In line with additional guidance from NHSI/E, the Executive Directors were awarded a 2% non-consolidated award on salaries in place as at 31 March 2021.

H A Craven

Heather Craven
Chair of the Trust's Remuneration Committee
20 June 2022

Senior Managers Remuneration Policy

The Remuneration Policy for Executive Directors was updated during 2019-20 and remained in place for the period 2021-22. The aims of the pay and reward framework remaining in place are to:

1. Facilitate the recruitment and retention of high quality senior staff;
2. Ensure that remuneration reflects the extent of the role and responsibilities of individual posts and their contribution to the Trust;
3. Ensure that the remuneration is justifiable and provides good value for money; and
4. Provide a transparent framework for determining senior level remuneration

Directors' Remuneration Report and Pension Entitlements

A) Salaries and Allowances – Subject to Audit of Part 3 of Schedule 8 to the Regulations, or where required by the NHS FT Code of Governance. These disclosures outline the remuneration figures for Senior Managers made up of a single remuneration figure for each senior manager who served during the year in tabular form as shown below. This Single Total Figure table reports salary and benefits related to the period in office.

Single Total Figure Table	d 01/04/21 to 31/03/22						Period 01/04/20 to 31/03/21					
	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension–Related Benefits (bands of £2500)	Total (bands of £5000)	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension–Related Benefits (bands of £2500)	Total (bands of £5000)
Mr M Havenhand, Chairman	50 - 55	0	0	0	0	50 - 55	50 - 55	0	0	0	0	50 - 55
Mrs N Bancroft, Non Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr M Edgell, Non-Executive Director (in office until 31/05/2021)	0 - 5	0	0	0	0	0 - 5	10 - 15	0	0	0	0	10 - 15
Mrs L Hagger, Non-Executive Director & Vice Chair	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mrs H Craven, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Dr R Shah, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr M Smith, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Dr J Bibby (in office from 01/06/2021)	10 - 15	0	0	0	0	10 - 15						
Mr K Malik, Non-Executive Director (in office from 11/09/2021, and as an Associate Non-Executive Director between 01/04/2021 and 10/09/2021)	10 - 15	0	0	0	0	10 - 15						
Dr R Jenkins, Interim Chief Executive	115 - 120	3	0	0	60 - 62.5	175 - 180	110 - 115	0	0	0	52.5 - 55	165 -170
Mr M Wright, Deputy Chief Executive	145 - 150	5	0	0	22.5 - 25	170 - 175	145 - 150	0	0	0	35 - 37.5	180 - 185
Mr S Ned, Joint Director of Workforce	65 - 70	0	0	0	30 - 32.5	100 - 105	65 - 70	0	0	0	35 - 37.5	100 - 105
Mr S Hackett, Director of Finance (in office from 01/07/2021)	105 - 110	3	0	0	0	105 - 110	40 - 45	0	0	0	0	40 - 45
Mr S Diggles, Interim Director of Finance (in office to 09/07/2021)	50 - 55	0	0	15 - 20	0	70 - 75	55 - 60	0	0	0	0	55 - 60
Dr C Gardner, Medical Director	185 - 190	0	0	0	45 - 47.5	230 - 235	180 - 185	0	0	0	42.5 - 45.0	225 - 230
Mrs A Wood, Chief Nurse (in office to 31/10/2021)	70 - 75	0	0	0	47.5 - 50	120 - 125	120 - 125	0	0	0	30.0 - 32.5	155 - 160
Mrs H Dobson, Interim Chief Nurse (in office from 12/10/2021)	55 - 60	0	0	0	575 - 577.5	630 - 635						
Mr G Briggs, Chief Operating Officer	130 - 135	0	0	0	12.5 - 15	140 - 145	125 - 130	0	0	0	20.0 - 22.5	145 - 150

Dr R Jenkins is seconded to Rotherham FT from Barnsley FT on an interim basis as the Chief Executive. Dr Jenkins worked for the Trust on a 0.45 Full Time Equivalent (that is 2.25 days per week) between the period 1 April 2021 and 30 September 2021, and 0.5 Full Time Equivalent (2.5 days per week) between 1 October 2021 and 31 March 2022. Based on his full remuneration across both Trusts, his salary and fees would fall within the band of £245K to £250K.

Mr S Ned is employed part time by both Rotherham FT, and Barnsley FT. Mr S Ned works for Rotherham FT on a 0.5 Full Time Equivalent (that is, 2.5 days per week). Based on his full remuneration across both Trusts, his salary and fees would fall within the band of £135K to £149K.

During the financial year Mr S Hackett and Mr S Diggles chose not to be covered by the pension arrangements

Taxable benefits shown in the above table relate to lease car schemes.

Mr S Diggles was employed with the Trust as Interim Director of Finance between the period of 11 November 2020 and 9 July 2021. Part of the remuneration package offered to Mr Diggles included a performance related bonus payable upon completion of his contract with the Trust, subject to achieving specific performance objectives, as summarised in the table below.

No weighting was applied to the performance objectives in that payment was based on all objectives being met. A report was presented to the Remuneration Committee by the Interim Deputy Chief Executive held in July 2021, which supported the decision to pay the bonus based on each of the objectives deemed as being met.

Performance Objective	Outcome
Delivery of the 2020/21 year-end financial position against plan	Objective delivered, evidenced by the audited accounts plus scrutiny at the Trust's Finance and Performance Committee
Delivery of the 2020/21 capital programme	Objective delivered, evidenced by the audited accounts plus scrutiny at the Trust's Finance and Performance Committee
Set a deliverable financial plan for 2021/22	Objective delivered, a financial plan for the first half of 2021/22 was approved by Board in line with reporting requirements of NHS England and NHS Improvement
Ensure an effective handover to the new substantive Director of Finance	Objective achieved, based on feedback from key persons
Manage the relationship with NHSEI with regard to financial recovery	Objective achieved, based on feedback from key persons
Support effective working arrangements within the finance team	Objective achieved, based on feedback from key persons
Delivery of the financial governance improvement plan	Objective achieved, based on feedback from key persons
Revision of the Trust Standard Financial Instructions (SFIs).	Objective achieved, the SFIs were drafted in readiness for the new Director of Finance to review and present to Executive Team

Directors and Governors Expenses

Per section 156 (1) of the Health and Social Care Act 2012, which amended paragraph 26 of Schedule 7 to the NHS Act 2006, the following information is required.

	Number in office		Number receiving expenses	
	2021/22	2020/21	**2021/22**	2020/21
Governors	**23**	26	**0**	0
Directors (including the Chair and Non-Executives)	**18**	17	**1**	4

	2021/22	**2020/21**
Expenses shown in hundreds £00s	£00	£00
Aggregate sum of expenses paid to Governors	0	0
Aggregate sum of expenses paid to Directors	47	31
Total	**47**	**31**

B) Pension Benefits – Subject to Audit

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

This table outlines the real increase during the reporting year of pension benefit, related lump sum and cash equivalent transfer values (CETV) at pension age and the value of accrued pension, lump sum and CETV at the end of the year, specifically related to the period in office.

Name and title	Real increase during the reporting year in pension at pension age (bands of £2,500) £000	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at 31 March 2022* (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Cash Equivalent Transfer Value at 31 March 2022 £000	Real increase in Cash Equivalent Transfer Value (for period in post) £000	Employer's contribution to stakeholder pension £000
Dr R Jenkins, Interim Chief Executive	2.5 - 5.0	0.0 - 2.5	85.0 - 90.0	165.0 - 170.0	1,553	1,661	68	NA
Mr M Wright, Deputy Chief Executive	0.0 - 2.5	0.0 - 2.5	30.0 - 35.0	0.0 - 5.0	417	456	17	NA
Mr S Ned, Joint Director of Workforce	2.5 - 5.0	0.0 - 2.5	65.0 - 70.0	145.0 - 150.0	1,255	1,325	44	NA
Dr C Gardner, Medical Director	2.5 - 5.0	0.0 - 2.5	20.0 - 25.0	0.0 - 5.0	217	264	19	NA
Mrs A Wood, Chief Nurse (in office to 31/10/2021)	0.0 - 2.5	0.0 - 2.5	25.0 - 30.0	35.0 - 40.0	415	469	20	NA
Mrs H Dobson, Interim Chief Nurse (in office from 12/10/2021)	10.0 - 12.5	30.0 - 32.5	60.0 - 65.0	155.0 - 160.0	674	1,211	242	NA
Mr G Briggs, Chief Operating Officer	0.0 - 2.5	2.5 - 5.0	50.0 - 55.0	150.0 - 155.0	1,202	1,288	62	NA

Cash Equivalent Transfer Values (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. It is the amount available to transfer to an alternative plan in exchange for giving up rights under the scheme. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. The accrued benefits derived from the member's purchase of added years of service and any 'transferred-in' service must be included in these pension disclosures.

The method used to calculate CETVS changed, to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8th August 2019. If the individual concerned was entitled to GMP, this will affect the calculation of the real increase in CETV. This is more likely to affect the 1995 Section and the 2008 Section.

This does not affect the calculation of the real increase in pension benefits, column (a) and (b) of this Pensions Table, nor the Single total figure table, column (e) of the Salaries table.

The real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.


NHS

Off-payroll arrangements

As part of the Review of Tax arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, NHS Foundations Trusts are required to present data in respect of off-payroll arrangements.

Table 1: Highly paid off-payroll workers engagement as at 31 March 2022 earning £245 per day or greater

Number of existing engagements as of 31 March 2022	**0**
Of which;	
Number that have existed for less than one year at time of reporting	0
Number that have existed between one and two years at time of reporting	0
Number that have existed between two and three years at time of reporting	0
Number that have existed between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater.

Number of off-payroll workers engaged during the year ended 31 March 2022	**0**
Of which;	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	0
Subject to off-payroll legislation and determined as out-of-scope of IR35*	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
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 the review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022.

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	**0**
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements*	**9**

* There are 7 Board member posts. In year there have been two Directors of Finance and two Chief Nurses

Staff costs – Subject to Audit

	2021/22			2020/21		
	Permanent	**Other***	**Total**	**Permanent**	**Other***	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages**	160,112	6,484	**166,596**	158,750	6,629	**165,379**
Social security costs	16,915		**16,915**	15,532		**15,532**
Apprenticeship levy	829		**829**	767		**767**
Employer's contributions to NHS pensions***	27,918		**27,918**	26,255		**26,255**
Pension cost - other	97		**97**	87		**87**
Termination benefits						
Temporary Staff - External Bank		9,756	**9,756**		8,158	**8,158**
Temporary staff - agency/contract**		6,274	**6,274**		4,480	**4,480**
Total gross staff costs	**205,871**	**22,514**	**228,385**	**201,391**	**19,267**	**220,658**
Of which:						
Costs capitalised as part of assets	***83***	***369***	***452***	*148*	*73*	*221*

** 'Other' staff includes secondments in, and trainee medial staff employed by the local lead unit, but training within The Rotherham NHS FT on rotation.*

*** The Salaries, Social Security, Apprenticeship levy, Employers contributions and other Pension costs associated with staff employed via a Secondary Contracted Payroll are included in those lines, and not classed as Agency staff as these staff have zero hours permanent contracts direct with the Trust.*

**** Employers pension contributions increased by 6.3% in both 2021/22 and 2020/21.*

Staff Exit Packages – Subject to Audit

The table below summarises the total number of exit packages agreed during the year. Included within these are compulsory redundancies and other schemes including MARS (Mutually Agreed Resignation Scheme) applications. The note shows packages agreed in year, irrespective of the actual date of accrual or payment.

This table excludes Payment in Lieu of Notice (PILON) payments made as part of standard contractual terms, and not part of a wider exit package.

Exit costs in this note are the full costs of departures agreed in the year. Where The Rotherham NHS FT has agreed early retirements, the additional costs are met by The Rotherham NHS FT and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21
<£10,000	**1**	0	**0**	0	**1**	0
£10,000 - £25,000	**1**	0	**0**	0	**1**	0
£25,001 - £50,000	**1**	0	**0**	0	**1**	0
£50,001 - £55,000	**0**	0	**0**	0	**0**	0
£55,001 - £60,000	**0**	**0**	**1**	0	**1**	0
Total number of exit packages by type	**3**	**0**	**1**	0	**4**	0
Total resource cost £000s	**53**	**0**	**60**	0	**113**	0

Analysis of non-compulsory departure payments

In 2021/22 there was one other agreed departure, and therefore £60k payments made (nil during the 2020/21 financial year). This note reflects packages agreed in year, irrespective of the actual date of accrual or payment.

The table below discloses non-compulsory departures and values of associated payments by individual type. The note shows packages agreed in year, irrespective of the actual date of accrual or payment. As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number below will not necessarily match the total numbers in Exit Packages note above which will be the number of individuals.

	Number of agreements		Total value of agreements £000s	
	2021/22	2020/21	**2021/22**	2020/21
Voluntary redundancies including early retirement contractual costs	**0**	0	**0**	0
Mutually agreed resignations (MARS) contractual	**0**	0	**0**	0
Early retirements in the efficiency of the service contractual costs	**0**	0	**0**	0
Contractual payments in lieu of notice*	**0**	0	**0**	0
Exit payments following employment tribunals or court orders	**1**	0	**60**	0
Non-contractual payments requiring HMT approval**	**0**	0	**0**	0
Total	**1**	0	**60**	0
of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	***0***	*0*	***0***	*0*

** Any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" above.*

*** Includes any non-contractual severance payment made following judicial mediation and amounts relating to non- contractual payments in lieu of notice.*

The Remuneration Report includes exit payments payable to individuals named in that Report where applicable. Those exit payments would also be included in this table above.

This note excludes PILON payments made as part of standard contractual terms, and not part of a wider exit package.

Average number of people employed (whole time equivalent basis) – Subject to Audit

	2021/22			2020/21		
	Permanent No.	**Other* No.**	**Total No.**	Permanent No.	Other* No.	Total No.
Medical and dental	473	74	**547**	438	108	**546**
Administration and estates	1,091	10	**1,101**	1,075	10	**1,085**
Healthcare assistants and other support staff	939	4	**943**	907	1	**908**
Nursing, midwifery and health visiting staff	1,216	33	**1,249**	1,182	38	**1,220**
Scientific, therapeutic and technical staff	460	14	**474**	446	11	**457**
Healthcare Science Staff	109	2	**111**	104	2	**106**
	4,288	**137**	**4,425**	4,152	170	4,322
Of which:						
Number of employees engaged on Capital projects	**2**	**4**	**6**	**3**	**1**	**4**

*'Other' staff includes secondments in, and trainee medial staff employed by the local lead unit, but training within The Rotherham NHS FT on rotation.

The Hutton disclosure – Subject to Audit

The Trust is required to disclose the relationship between the remuneration of the highest-paid director in the organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2021/22 was £182,500 (2020/21, £182,500). This is a change between years of 0%.

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

For employees of the Trust as a whole, the range of remuneration in 2021/22 was from £9,406 to mid-point band £247,500 (2020/21 £8,115 to mid-point band £247,500). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 5.67%. This is based on the average salary in 2021/22 being £34,887 (2020/21 £33,015). 5 employees received remuneration in excess of the highest-paid director in 2021/22.

Of the five individuals who received remuneration in excess of the highest-paid director in 2021/22, one is our Interim Chief Executive who works under a shared arrangement for both the Trust and for Barnsley Hospital NHS Foundation Trust. The definition of the highest paid director under the Fair Play disclosure is defined as the salary paid by the Trust alone.
Therefore this person is not classed as the highest paid director because the cost to the Trust is lower than this person's total remuneration.

The other four individuals who received remuneration in excess of the highest-paid director in 2021/22 are secondary payroll staff, and are doctors with specialist skills which are in high demand due to limited availability.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

	2021/22	2020/21
Mid-point of £5k band of highest paid director's total remuneration (£000)	**182.5**	**182.5**
The percentage change from the previous financial year in respect of the highest paid director	**0%**	
Average annualised salary and allowances over all employees (excluding the highest paid director) (£000)	**34.9**	**33.0**
The percentage change from the previous financial year in respect of the average annualised salary and allowances	**6%**	

2021/22	25th percentile	Median	75th percentile
Salary component of pay	21.8	31.5	39.0
Total pay and benefits excluding pension benefits	21.8	31.5	39.0
Pay and benefits excluding pension: pay ratio for highest paid director	8.37:1	5.79:1	4.68:1

Comparative figures, 2020/21	25th percentile	Median	75th percentile
Salary component of pay	19.7	27.4	37.9
Total pay and benefits excluding pension benefits	19.7	27.4	37.9
Pay and benefits excluding pension: pay ratio for highest paid director	9.26:1	6.66:1	4.82:1

Remuneration Report signed by the Interim Chief Executive

R. Jenkins

Dr Richard Jenkins

Interim Chief Executive

20 June 2022

Staff Report

Analysis of Staff Costs – Subject to Audit

Staff Costs	2021/22			2020/21		
	Permanent	Other*	Total	Permanent	Other*	Total
	£000	£000	£000	£000	£000	£000
Salaries & wages**	160,112	6,484	150,632	139,880	5,261	145,141
Social security costs	16,915	-	16,915	15,532	-	15,532
Apprenticeship levy	829	-	829	767	-	767
Employer's contributions to NHS pensions***	27,918	-	27,918	26,255	-	26,255
Pension cost - other	97	-	97	87	-	87
Termination benefits	-	-	-	-	-	-
Temporary Staff - External Bank****	-	9,756	9,756	-	8,131	8,131
Temporary staff - agency/contract**	-	6,274	6,274	-	4,621	4,621
TOTAL GROSS STAFF COSTS	**205,871**	**22,514**	**228,385**	**201,277**	**19,381**	**220,658**
Of which: Costs capitalised as part of assets	83	369	452	148	73	221

*'Other' staff includes secondments in, and trainee medical staff employed by the local lead unit, but training within The Rotherham NHS FT on rotation.

Analysis of Staff – Gender

As at end March 2022 the breakdown of Trust employed staff by Gender was as follows:

Currently 1 Chief Nurse and 1 Interim Chief Nurse in ESR. Chief Nurse on External Secondment

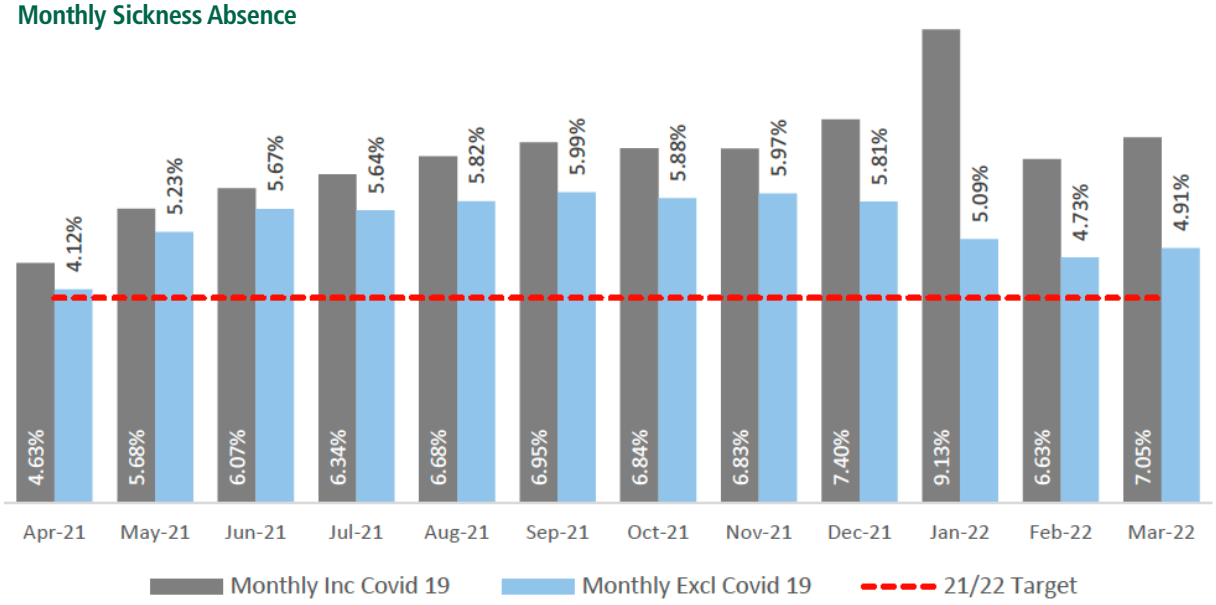
	Male	Female	Total
Executive Directors	6	2	8
Non-Executive Directors	4	4	8
Employees	903	4130	5033
Total	913	4136	5049

Sickness Absence Data

Below data is extracted from ESR (Electronic Staff Record) and uses the following parameters
Employee Catergories - Fixed Term & Permanent

Month	Long Term	Short Term	Monthly Excl Covid 19	Rolling 12mth Excl Covid 19	Monthly Inc Covid 19	Rolling 12mth Inc Covid 19	21/22 Target	Long Term 21/22	Short Term 21/22	Monthly 21/22	Rolling 21/22	Long Term 20/21	Short Term 20/21	Monthly 20/21	Rolling 20/21	RTW Disc 20/21
Apr-21	3.06%	1.57%	4.12%	3.89%	4.63%	5.09%	3.95%	3.06%	1.57%	4.63%	5.09%	3.18%	0.96%	4.13%	4.80%	76.78%
May-21	4.10%	1.57%	5.23%	4.04%	5.68%	5.05%	3.95%	4.10%	1.57%	5.68%	5.05%	2.83%	0.78%	3.61%	4.69%	75.70%
Jun-21	4.49%	1.58%	5.67%	4.21%	6.07%	5.13%	3.95%	4.49%	1.58%	6.07%	5.13%	2.59%	0.82%	3.41%	4.59%	75.71%
Jul-21	4.38%	1.96%	5.64%	4.40%	6.34%	5.31%	3.95%	4.38%	1.96%	6.34%	5.31%	2.36%	0.92%	3.28%	4.50%	77.95%
Aug-21	4.67%	2.01%	5.82%	4.61%	6.68%	5.54%	3.95%	4.67%	2.01%	6.68%	5.54%	2.44%	1.07%	3.51%	4.42%	76.26%
Sep-21	4.91%	2.04%	5.99%	4.76%	6.95%	5.74%	3.95%	4.91%	2.04%	3.95%	5.74%	3.01%	1.01%	4.02%	4.35%	75.44%
Oct-21	4.47%	2.36%	5.88%	4.90%	6.84%	5.86%	3.95%	4.47%	2.36%	6.84%	5.86%	3.19%	1.19%	4.38%	4.28%	75.15%
Nov-21	4.31%	2.52%	5.97%	5.04%	6.83%	5.91%	3.95%	4.31%	2.52%	6.83%	5.91%	3.10%	1.36%	4.46%	4.23%	73.35%
Dec-21	4.57%	2.84%	5.81%	5.18%	7.40%	6.05%	3.95%	4.57%	2.84%	7.40%	6.05%	3.16%	1.09%	4.25%	4.12%	69.85%
Jan-22	4.40%	4.73%	5.09%	5.26%	9.13%	6.37%	3.95%	4.40%	4.73%	9.13%	6.37%	2.72%	1.15%	3.86%	3.98%	67.25%
Feb-22	3.93%	2.70%	4.73%	5.28%	6.63%	6.46%	3.95%	3.93%	2.70%	6.63%	6.46%	3.02%	1.32%	4.34%	3.93%	64.64%
Mar-22	3.89%	3.16%	4.91%	5.36%	7.05%	6.66%	3.95%	3.89%	3.16%	7.05%	6.66%	2.68%	1.14%	3.82%	3.86%	62.76%

Monthly Sickness Absence



Data relating to the sickness absence for the Trust is published by NHS Digital and can be accessed here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff policies and actions applied during the financial year

The Trust has a suite of policies, procedures and initiatives in relation to the workforce in order to support and develop colleagues in their roles. Some of the key policies and actions are detailed below.

The Trust is an accredited Disability Confident (level 2) Employer, and as such the organisation's policy in respect of disabled applicants who indicate that they wish to be considered for a post under the 'Disability Confident Scheme' is that they will be shortlisted and invited for interview where they meet the essential requirements for the post.

Managers at the Trust, with the help of the Occupational Health service provider and Human Resources, regularly make workplace modifications for staff that are reasonable and ensure that disabled colleagues can not only continue in their role with the Trust but also seek promotion opportunities. Work is undertaken on a proactive basis, where applicable, with outside agencies to help support the continued employment and promotion of colleagues. The Trust has a disability passport scheme to facilitate reasonable adjustments. During the last year, the Trust has undertaken a rigorous tendering exercise in respect of Occupational Health, and engaged a new provider as a result. Colleagues from the Trust's Disability Staff Network were involved in designing the service specification, and the Trust's Head of Equality, Diversity and Inclusion was part of the scoring panel, in order to ensure that the needs of disabled employees and candidates were taken fully into account as part of the process.

The Learning and Development department acts as a contact point for all colleagues booking onto training provided by the Trust and supports colleagues who require reasonable adjustments or special arrangements to access training. In this way the organisation ensures that reasonable adjustments are made to support colleagues who disclose a disability which may mean they require extra support with their learning and development.

Alongside Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), the Trust continues to use the Equality Delivery System (EDS2) to assist in discussions with local partners including local populations and review and improve services and the experience of employment for people with characteristics protected by the Equality Act 2010.

Modern slavery is addressed under the umbrella of safeguarding at the Trust, all safeguarding training has been updated to include modem slavery and it is included in the Adult Safeguarding policy. All staff are required to undertake safeguarding training to ensure they understand how to raise a concern.

Throughout 2021/22, the Trust's Diversity and Inclusion Group has met regularly to review and drive progress against the Trust's equality, diversity and inclusion (EDI) action plan and has provided regular updates to the Board and relevant committees.

All colleagues have access to local workforce development programmes and training courses; colleagues discuss their training needs with their line manager during their annual appraisal, at one-toone meetings or at other times, as arranged locally.

The Trust continues to strive for continuous improvement and to prioritise engagement with colleagues, setting high standards, learning from colleague experience, and strengthening partnership working.

Ensuring active colleague involvement in the management and direction of services at all levels is achieved through valuing colleagues, listening and responding to their views and monitoring quality workforce indicators. Equally, the organisation acknowledges that its colleagues should have confidence that their input is valued and that the Trust is responsive to their views in the decisions it takes, building on that positive relationship. This was demonstrated when developing the Trust's new 5 Tear Strategy where a large number of engagement and stakeholder sessions were held across the organisation to enable maximum input and engagement with the development of the Strategy.

There are a number of mechanisms through which information is communicated to employees. These include weekly all user e-mails and bulletins, monthly Team Brief, departmental meetings, monthly senior leader meeting, ad hoc briefings, Twitter and Facebook accounts, personal letters, and electronic pay slip messages and attachments. There is also a direct communication facility available to enable colleagues to ask questions of the Interim Chief Executive (anonymously if desired). The method(s) used will be the most appropriate for the particular information to be conveyed but one or more methods will be used for all matters of importance.

There is a colleague intranet (The Hub) which provides information regarding the latest changes and developments as well as routine information. Not all clinical and support colleagues use electronic communication methods and consequently, managers are asked to make all colleagues aware of information communicated by electronic means.

The weekly all user e-mails, the intranet and monthly Team Briefs are all used as a means of conveying official information, as appropriate, which is of benefit to colleagues in a social, personal and developmental way. Examples include reporting on the achievements of colleagues, benefits and services available, activities and events taking place, health related information and offers. There are separate pages on the intranet for colleague health, benefits and wellbeing offering an extensive range of discounts and contacts as well as sources for support, development and training.

Colleagues are actively engaged with and their feedback obtained on matters being communicated. This occurs through the 'Team Brief' process, Colleague Forums and through the regular meetings of the Joint Partnership Forum and Local Negotiating Committee where Trade Unions and professional association representatives meet with senior managers to discuss issues affecting staff and local conditions of service.

A sub group of the Joint Partnership Forum, the Joint Policy Group, agrees and updates Human Resources (HR) policies in line with current employment law and ensures they have broad agreement within the organisation. The Local Negotiating Committee is the forum for medical and dental staff.

All Trust policies are available on the intranet for colleagues, including the extensive range of HR policies, many of which are about services available directly in support of colleagues. Examples include: Special Leave, Flexible Working, Managing Attendance, Reservist, Health and Wellbeing policies, Freedom to Speak Up (Raising Concerns), Shared Parental Leave, Adoption Leave and Dying at Work charter.

The Trust recognises the challenges that the pandemic has placed on all of our colleagues over the last two years; therefore the key priority for the organisation during 2021/22 was to ensure that all our colleagues felt supported and had every opportunity to access any health and wellbeing support or service they may require now or in the future. The Trust updated "Our People Pack" which is a one stop shop document that contains helpful hints and tips about looking after yourself, your team and others at this difficult time. It includes links to a variety of wellbeing support available at local, regional and national level.

Despite the challenges placed on the organisation by the pandemic, the Trust recognised that valuing and celebrating the achievements of the workforce is essential to enable the future growth and development of the organisation and the individuals who are part of it. This was visibly demonstrated when specific events were arranged for colleagues during November 2021 as part of 'Proud Week' during which a Recognition of Learning event and the Long Service Award ceremony were held. The week culminated in a virtual awards ceremony for colleagues held on 19 November 2021 which involved a large number of celebrities thanking our staff for the contribution they had made during the year.

Health & Safety and Occupational Health

During 2021/22 an eighth consecutive gold award was received by the Trust for preventing accidents on its hospital and community sites from the Royal Society for the Prevention of Accidents (RoSPA), as part of their RoSPA Occupational Health and Safety Awards. Only organisations able to maintain continued high standards in health and safety achieve the gold award.

During 2021/22 the Trust retendered for its occupational health contract, Sheffield Teaching Hospital were successful following an extensive procurement exercise and were awarded the contract which commenced on 01 March 2022.

The Trust's occupational health service is located discreetly behind the main Woodside building, offering professional specialist nurse, counselling and proactive occupational health services. As part of the occupational health provision the Trust can access the Employee Assistance Programme (EAP), which provides confidential support by qualified counsellors 24 hours a day to colleagues. The occupational health service continued to deliver high quality interventions to employees, supporting a healthier, fitter workforce and supporting the Trust's objective to reduce sickness absence.

Supporting the health and wellbeing of all colleagues at the Trust has been a key driver during the pandemic; the organisation has strived to ensure that all its workers were both protected and supported during the most difficult few years in NHS history. To support managers and colleagues the Trust launched 'Our People Pack' in 2020 with an updated version being produced in 2021. This document provided health and wellbeing hints and tips for all colleagues at an individual level, team level and at organisational level; as well as providing a one stop shop containing all the local, regional and national health and wellbeing offers and services available for colleagues to access should they require support.

Countering Fraud, Bribery and Corruption

Effective from 1 April 2021 the NHS Counter Fraud Authority (NHSCFA) implemented the Government Functional Standard 013: Counter Fraud ('the Functional Standard') within the NHS. During the year, the NHSCFA have developed their requirements in relation to the Functional Standard.

All NHS funded services are required to comply with the Functional Standard. Progress against the requirements of the Functional Standard is overseen by the Trust's Director of Finance and Audit Committee.

The Trust is required to self-assess against the requirements of the Functional Standard annually by completing and submitting the Trust's Counter Fraud Functional Standard Return (CFFSR). This requires prior sign off by the Trust's Director of Finance and the Audit Committee chair. Further detail of the Trust's submission can be found in the Counter Fraud Annual Report.

The Trust's Interim Chief Executive and Director of Finance are jointly responsible for ensuring adherence to the NHS Counter Fraud Authority (NHSCFA) Anti- Crime Strategy for countering fraud, bribery and corruption. The NHSCFA is responsible for ensuring the quality of measures to counter fraud, bribery and corruption within NHS Foundation Trusts.

Service condition 24.2 of the NHS Standard Contract 2021 to 2022 sets out The Trust's obligations, to safeguard NHS funds and resources through compliance with 23 standards for countering fraud, bribery and corruption as follows:

Strategic Governance (7 standards). Covers standards in relation to The Trust's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

Inform and Involve (4 standards). Covers requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of fraud, bribery and corruption against the NHS.

Prevent and Deter (6 standards). Covers the requirements in relation to discouraging individuals who may be tempted to commit fraud against the NHS and ensuring that opportunities for crime to occur are minimised.

Hold to Account (6 standards). Sets out the requirements in relation to detecting and investigating economic crime, obtaining sanctions and seeking redress.

In order to demonstrate compliance with the standards, the Trust is required to complete and submit an annual Self Review Tool (SRT) assessment rating compliance against a red/amber/green scale. An SRT against these standards was completed which demonstrated an overall 'Green' rating.

The Trust has a nominated Counter Fraud Specialist (CFS) in place provided by 360 Assurance. The CFS is responsible for carrying out a range of activities in compliance with the above standards that are overseen by the Director of Finance and the Audit Committee. The CFS undertakes fraud, bribery and corruption risk assessments throughout the year which are used to inform the annual programme of activities that are undertaken within the above areas.

During the reporting year, counter fraud activity has focussed on activities to ensure compliance with NHSCFA standards and to address areas of heightened risk.

The Trust has a Fraud, Bribery and Corruption policy which outlines the Trust's zero tolerance approach to fraud, bribery and corruption and sends a clear message that all available sanctions will be pursued in respect of those caught committing offences against the Trust. Clear reporting procedures are included within the policy and the policy is signposted to staff within all training delivered by the CFS.

Where fraud is identified or reported it is formally investigated in accordance with the Trust's Fraud, Bribery and Corruption policy. During 2020/2021 two referrals of suspected fraud, bribery or corruption were made to the CFS, demonstrating a good awareness and understanding of the Fraud, Bribery and Corruption policy.

The Trust has three staff inclusion networks (BAME, Disability and LGBT+[1]).

The Trust's Equality Objectives, Annual Equality and Diversity report, Gender Pay Gap report and WRES and WDES reports (including action plans) can all be viewed at:
www.therotherhamft.nhs.uk/Equality_and_Diversity/Equality_and_diversity_monitoring_data/

All colleagues are required to undertake the national Equality, Diversity and Human Rights e-learning module every three years (for colleagues who do not use computers, an equivalent face to face training package is provided). As at March 2022, compliance with this training requirement is 94.79%, significantly above the Trust's 85% target. Additionally, a range of training relating to equality, diversity and inclusion is available to colleagues.

[1] Pertaining collectively to people who identify as lesbian, gay, bisexual, or transgender, including nonbinary, intersex, and others including those questioning their gender identity or sexual orientation.

Analysis of Staff: Ethnicity of Staff

As at end March 2022 the breakdown of Trust employed staff by ethnicity was as follows:

Ethnicity Group	Headcount	% Headcount
BME	674	13.35%
Not Stated	86	1.70%
White	4289	84.95%
Grand Total	**5049**	**100.00%**

Ethnic Origin	Headcount	% of Workforce
A White - British	4165	82.49%
B White - Irish	22	0.44%
C White - Any other White background	68	1.35%
C3 White Unspecified	1	0.02%
CA White English	9	0.18%
CB White Scottish	3	0.06%
CC White Welsh	1	0.02%
CP White Polish	1	0.02%
CQ White ex-USSR	1	0.02%
CU White Croatian	3	0.06%
CX White Mixed	3	0.06%
CY White Other European	12	0.24%
D Mixed - White & Black Caribbean	15	0.30%
E Mixed - White & Black African	9	0.18%
F Mixed - White & Asian	22	0.44%
G Mixed - Any other mixed background	21	0.42%
GC Mixed - Black & White	1	0.02%
H Asian or Asian British - Indian	231	4.58%
J Asian or Asian British - Pakistani	146	2.89%
K Asian or Asian British - Bangladeshi	11	0.22%
L Asian or Asian British - Any other Asian background	50	0.99%
LF Asian Tamil	1	0.02%
LH Asian British	2	0.04%
M Black or Black British - Caribbean	10	0.20%
N Black or Black British - African	84	1.66%
P Black or Black British - Any other Black background	5	0.10%
PC Black Nigerian	1	0.02%
R Chinese	14	0.28%
S Any Other Ethnic Group	47	0.93%
SC Filipino	2	0.04%
SE Other Specified	2	0.04%
Z Not Stated	86	1.70%
Grand Total	**5049**	**100.00%**

Information on staff turnover

Information relating to staff turnover can be found as part of the NHS workforce statistics provided by NHS Digital by following this web link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff Experience and Engagement

2021 National Staff Survey Results - People Promise element and theme results

The NHS staff survey is conducted annually. The table below provides a high-level overview of the National Staff Survey results; this year saw significant change in the analysis and format of the data. This was to ensure that there was alignment with the new seven elements of the NHS People Promise. The remaining two domains, staff engagement and morale continue to be benchmarked. Despite the ongoing challenges faced by all NHS organisations including TRFT; the Trust maintained its position amongst peer organisations. The Trust recognises that in order to drive continuous improvements for the benefit of both patients and staff, further work to engage with colleagues and build on the progress made in relation to the NHS People Promises will remain a key priority throughout 2022-23.

	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
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.2	5.9	6.7	6.0	5.3	6.0	6.7	6.7	5.8
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,735	2,754	2,675	2,686	2,597	2,727	2,728	2,761	2,753

Previous Comparisons from the NSS (2019 and 2020 results)

	Trust	Benchmark	Trust	Benchmark
Theme	2020		2019	
Equality, diversity & inclusion	9.3	9.1	9.2	9.2
Health & wellbeing	6.1	6.1	5.8	6.0
Immediate managers	7.8	6.8	6.8	6.9
Morale	6.3	6.2	6.0	6.2
Quality of care	7.4	7.5	7.2	7.5
Safe environment (bullying & harassment)	8.4	8.1	8.2	8.2
Safe environment (violence)	9.5	9.5	9.5	9.5
Safety culture	6.7	6.8	6.6	6.8
Staff engagement	6.9	7.0	6.7	7.1
Team working	6.6	6.5	6.5	6.7

The results from the national staff survey 2021 reflect the good progress which the Trust has made during a very challenging period for the whole of the NHS.

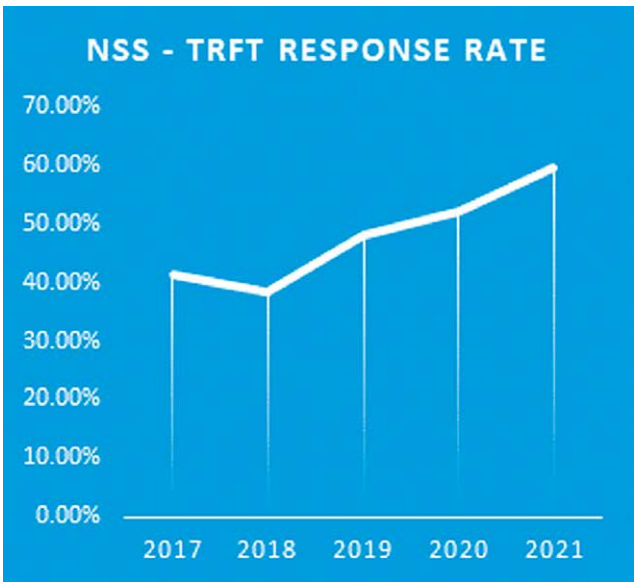
For the 2021 NHS Staff Survey the response rate was 60% (compared to an average of 52% and a Trust score of 52% for 2020). A total of 117 questions were asked in the 2021 survey, of these 92 can be positively scored.

Although this was a very good performance, there were challenges that managers and colleagues faced in ensuring that team members received hard copy surveys on time. As part of the Trust's review, colleagues were asked to feedback on the overall distribution process, what worked, what caused issues, and opportunities for improvement in 2022.

Survey Response Rate

The Trust changed its approach for the distribution of the staff survey during 2020 (moved to hard copy) and achieved an improved response rate; a similar approach was adopted for 2021 and the Trust achieved its highest response level in the last 5 years.

	2017	2018	2019	2020	2021
Best	72.6%	71.6%	76.0%	79.8%	79.4%
TRFT	41.5%	38.5%	48.0%	52.2%	59.7%
Median	43.9%	43.6%	46.9%	45.4%	51.1%
Worst	27.3%	24.6%	27.2%	28.1%	36.5%



Our ambition to maximise our staff voice and engagement across the organisation has been reflected in the significant participation and feedback received through the staff survey. The table below highlights the improvement journey from 2017 to date.

Areas of improvement

Top 5 scores vs Picker Average	Trust	Picker Avg
q19a. Received appraisal in the past 12 months	90%	82%
q9b. Immediate manager gives clear feedback on my work	65%	61%
q14c. Not experienced harassment, bullying or abuse from other colleagues	85%	82%
q4c. Satisfied with level of pay	35%	32%
q15. Organisation acts fairly: career progression	59%	56%

Most improved scores	Trust 2021	Trust 2020
q13d. Last experience of physical violence reported	69%	62%
q14d. Last experience of harassment/bullying/abuse reported	48%	45%
q17a. Would feel secure raising concerns about unsafe clinical practice	75%	72%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	47%	44%
q9b. Immediate manager gives clear feedback on my work	65%	62%

Key areas for improvement and future priorities

Bottom 5 scores vs Picker Average	Trust	Picker Avg
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	52%	66%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	34%	45%
q21a. Care of patients/service users is organisation's top priority	68%	76%
q21c. Would recommend organisation as place to work	54%	59%
q21b. Organisation acts on concerns raised by patients/service users	68%	71%

Most declined scores	Trust 2021	Trust 2020
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	52%	63%
q21c. Would recommend organisation as place to work	54%	64%
q22c. I am not planning on leaving this organisation	58%	66%
q22b. I am unlikely to look for a job at a new organisation in the next 12 months	52%	59%
q22a. I don't often think about leaving this organisation	42%	49%

As the Trust moves towards recovery from the pandemic the key areas of focus and priority for 2022-23 will be:

Continue to prioritise staff wellbeing and recovery through meaningful engagement and health management e.g. new Occupational Health provision, enhanced Employee Assistance Programmes, develop fast track internal support mechanisms to maintain good health

- Enhance our appraisal process from a qualitative perspective to better understand the challenges of our workforce and to inform our improvement strategies in making TRFT a better place to work.
- Be an employer of choice recognising the talent across Rotherham whilst supporting staff and the wider population develop career pathways in healthcare.

Monitoring arrangements - future priorities and how they will be measured

The Board of Directors will agree key milestones and delivery targets for the Trust; however, workforce related performance and people objectives will be monitored through the governance structures in place including the Operational Workforce Group, People Committee, the Executive Team and ultimately the Board of Directors.

Locally each Division will develop improvement plans using key information from the national staff survey results, CQC feedback, People Pulse survey and other key Trust metrics. These will be managed through a monthly divisional performance meeting and dashboards, providing assurance to the Executive Team and Board of Directors.

The wider workforce and engagement activities will be monitored through the Operational Workforce Group chaired by the Director of Workforce. The actions of this group and any associated work plans will provide the appropriate levels of assurance to the People Committee.

Trade Union Facility Time disclosures

Engaging, communicating and consulting with our employees in partnership with our trade unions and professional bodies has always been core to our service delivery, and this became even more important alongside the additional challenges brought by the pandemic during the last 2 years. We are committed to developing communication with all employees and maximising the benefits of staff involvement by ensuring that we have robust mechanisms in place with our union colleagues. We recognise that employee involvement and partnership working must take place throughout the organisation, regardless of professional, service or functional boundaries.

We are committed to maximising staff involvement by:

- Developing and implementing effective communication processes within the Trust
- Developing a culture of staff involvement and participation where mechanisms are in place for all staff to be able to contribute to the decision making processes that affect their working lives and the delivery of health care, whilst feeling confident that their contribution makes a difference and is valued; and
- Effective change management delivered through partnership working

We recognise that good employment relations are an important factor in achieving our objectives and delivering high quality patient care. Cooperation and communication are important features of the relationship between us, our unions and our employees. In partnership with our union colleagues, we recognise our common interests and are committed to maintaining and improving employment relations and engagement in the Trust and dealing with, and resolving, any issues at an early stage, as speedily as possible and in line with jointly agreed policies and procedures.

Our Trade Union Recognition and Facilities Agreement is our system for agreeing access to paid time and development for our union colleagues. We will review this this agreement during 2022/23 to ensure that the Trust enables our union colleagues to give the best possible support to their members and to the organisation. Throughout the year we engage through many formal and informal, planned and ad hoc fora in the pursuit of achieving our common interests for our employees, and ultimately our patients.

Table 1: Relevant union officials
What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
20	Between 1501 and 5000

Table 2: Percentage of time spent on facility time
How many of your employees who were relevant union officials employed during the relevant period spent
a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	6
1-50%	14
51%-99%	0
100%	0

Table 3: Percentage of pay bill spent on facility time
Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£88,220
Provide the total pay bill	£205,871,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.043

Table 4: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours	10.36

(Total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

Expenditure on Consultancy

Consultancy costs during 2021/22 were £24k compared to £199 during 2020/2021. The consultancy work undertaken during 2021/22 was across various functions of the Trust.

Off-payroll engagements

The decision to appoint Board members or senior officials with significant financial responsibility through an off-payroll arrangement is made at a very senior level and for exceptional operational reasons. During 2021/22 zero off-payroll engagements were entered into.

Table 1. Highly paid off-payroll worker engagements as at 31 March 2022, earning £245 per day or greater	
Number of existing engagements as of 31 March 2022	0
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed between one and two years at time of reporting	0

Table 2. All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2022	0
Of which:	
Not subject of off-payroll legislation*	0
Subject to off payroll legislation and determined as in-scope of IR35	0
Subject to off payroll legislation and determined as out-of-scope of IR35	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0
Number that have existed between two and three years at time of reporting	0
Number that have existed between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Table 3. For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	0

Staff Exit Packages

The table below summarises the total number of exit packages agreed during the year. Included within these are compulsory redundancies and other schemes including MARS (Mutually Agreed Resignation Scheme) applications. The note shows packages agreed in year, irrespective of the actual date of accrual or payment. This table excludes Payment in Lieu of Notice (PILON) payments made as part of standard contractual terms, and not part of a wider exit package.

Exit costs in this note are the full costs of departures agreed in the year. Where The Rotherham NHS FT has agreed early retirements, the additional costs are met by The Rotherham NHS FT and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

	Number of compulsory redundancies		Number of other non-compulsory departures agreed		Total number of exit packages by cost band	
	2021/22	2020/21	2021/22	2020/21	2021/22	2020/21
Total number of exit packages by type	3	0	1	0	4	0
Total resource cost £000s	53	0	60	0	113	0

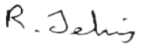
Analysis of non-compulsory departure payments

In 2021/22 there was one non-compulsory departure payment amounting to £60k, this note reflects packages agreed in year, irrespective of the actual date of accrual or payment.

This note excludes PILON payments made as part of standard contractual terms, and not part of a wider exit package.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	4	1
£10,000 – £25,000	1	113	1
£25,001 – £50,000	1		1
£50,001 – £100,000			1
£100,000 – £150,000			
£150,001 – £200,000			
etc.			
Total number of exit packages by type	3	1	4
Total resource cost	53k	60k	113k

Accountability Report signed by the Interim Chief Executive as Accounting Officer



Dr Richard Jenkins
Interim Chief Executive
20 June 2022


NHS

Council of Governors

The Council of Governors is responsible for making decisions regarding the appointment or removal of the Chairman, the Non-Executive Directors and the Trust's auditors; and the terms and conditions of office of the Non-Executive Directors in addition to approving the appointment of the Chief Executive. The Council of Governors is also consulted by the Board of Directors and its views taken into consideration when formulating the Trust's forward plans.

The Council also considers the Trust's annual accounts and the external auditor's report on them as well as representing the interests of members and partnership organisations in the governance of the Trust. Regularly feeding back information about the Trust to the constituency it represents.

Other statutory duties of the Council of Governors include providing their views to the Board of Directors on the Trust's strategy, to respond to the Board of Directors when consulted and to undertake functions as requested by the Board of Directors, and to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

Should any disagreements between the Board of Directors and the Council of Governors arise the manner in which these will be resolved is described in Annex 6 of the Trust's Constitution which is available on the Trust's internet site.

The Council of Governors comprises of 16 elected Public Governors, 5 elected Staff Governors and 7 appointed Partner Governors.

All Governors, both elected and appointed, hold office for a term of three years. They are eligible for re-election or re-appointment at the end of that period and serve a maximum of three terms (nine years in total). The Trust Constitution outlines that a Governor may, in exceptional circumstances, serve longer than nine years. However, this will be subject to annual re-election.

All elections for public and staff governor positions are conducted under the auspices of Civica, in accordance with the requirements of the Trust's Constitution.

The restrictions implemented in 2020 in response to the COVID 19 pandemic in terms of face to face meetings continued into 2021/22, with the Council of Governors meetings and any of its sub committees, continued to be held virtually. The Council of Governors met four times as scheduled.

Although members of the public were excluded from the meeting due to the restrictions, the agenda and meeting papers for the Council of Governors were made available prior to the meeting on the Trust's website, with arrangements made for any questions from the public to be submitted in advance of the meeting.

The annual elections to the Council of Governors were held in quarter one of 2021/22.

Detailed on the following page are members of the Council of Governors during 2021/22, the constituency each represent, their term of office and meeting attendance record:

Constituency	Name	Term of Office	Meeting attendance
Wentworth North (Covering the electoral wards of Hoober, Swinton, Wath)	Tania McGee	01.11.2020 to 31.05.2023 **Resigned 06.12.2021**	2 of 3
	Vacancy x1	01.04.2021 to 31.03.2022	-
Wentworth South (Covering the electoral wards of Rawmarsh, Silverwood, Valley)	Robert McPherson	Re-elected 01.06.2020 to 31.05.2023	1 of 4
	Neil Redfern	01.11.2020 to 31.05.2023	4 of 4
Wentworth Valley (Covering the electoral wards of Hellaby, Maltby, Wickersley)	Andrew Ball	01.11.2020 to 31.05.2023	3 of 4
	Keith Stringer	01.11.2020 to 31.05.2023 Resigned 11.08.2021	1 of 1
Rotherham South (Covering the electoral wards of Boston Castle, Rotherham East, Sitwell)	Marilyn Gambles	01.06.2019 to 31.05.2022	4 of 4
	A A Zaidi	01.06.2019 to 31.05.2022	4 of 4
Rotherham North (Covering the electoral wards of Keppel, Rotherham West, Wingfield)	Anthony Stephan Lowe	01.11.2020 to 31.05.2023	3 of 4
	Vacancy x1	01.04.2021 to 31.03.2022	-
Rother Valley South (Covering the electoral wards of Anston & Woodsetts, Dinnington, Wales)	Gavin Rimmer (Lead Governor)	Re-elected 01.06.2020 to 31.05.2023	4 of 4
	Ian Cocks	01.06.2021 to 31.05.2024	2 of 3
Rother Valley West (Covering the electoral wards of Brinsworth & Catcliffe, Holderness, Rother Vale)	Dennis Moore	Re-elected 01.06.2021 to 31.05.2024 Resigned 30.06.2021	0 of 1
	Vacancy x1	01.04.2021 to 31.03.2022	-
Rest of England (Covering those who live outside the borough)	Frank Kler	01.11.2020 to 31.05.2023	2 of 4
	Geoffrey Berry	01.11.2020 to 31.05.2023	4 of 4
Staff Governors (elected x5):	Christopher Bott	01.06.2019 to 31.05.2022 Resigned 22.09.2021	1 of 2
	James Cooper	01.11.2020 to 31.05.2023	3 of 4
	Clare Denning	01.11.2020 to 31.05.2023	3 of 4
	Owen Dickinson	01.06.2019 to 31.05.2022	2 of 3
	Dr Julian McDonough	01.06.2019 to 31.05.2022	3 of 4
Partner Governor Organisations (nominated/appointed):			
Sheffield Hallam University	Dr Joanne Lidster	17.05.2019 to 16.05.2022	2 of 4
Sheffield University	Vacancy	01.04.2021 to 31.03.2022	-
Rotherham Partnership	Vacancy	01.04.2021 to 31.03.2022	-
Voluntary Action Rotherham	Jean Flanagan	01.09.2020 to 31.08.2023	4 of 4
Rotherham Metropolitan Borough Council	Cllr Patricia Jarvis	06.02.2020 to 05.02.2023 Stood down 06.05.2021	0 of 0
	Cllr Eve Rose Keenan	21.06.2021 to 20.06.2024	3 of 3
Barnsley and Rotherham Chamber of Commerce	Tricia Smith	20.01.2020 to 19.01.2023	3 of 4
Rotherham Ethnic Minority Alliance	Shakoor Adalat	12.02.2019 to 11.02.2022	0 of 4
	Vacancy	12.02.2022	

Members of the Board of Directors (Executive and Non-Executive Directors) have routinely attended the scheduled Council of Governors meetings to ensure that they develop an understanding of the view of Governors and Members. Their attendance during 2021/22 was as follows:

Current Director/Non-Executive Director	Number of meetings attended (out of 4)
Martin Havenhand, Chairman	3
Nicola Bancroft, Non-Executive Director	4
Joanna Bibby, Non-Executive Director	1
George Briggs, Chief Operating Officer	3
Heather Craven, Non-Executive Director	3
Stuart Diggles, Interim Director of Finance	1
Helen Dobson, Interim Chief Nurse	2
Mark Edgell, Non-Executive Director	1
Callum Gardner, Executive Medical Director	4
Steven Hackett, Director of Finance	2
Lynn Hagger, Non-Executive Director	4
Richard Jenkins, Interim Chief Executive	1
Michael Killick, Non-Executive Director	1
Kamran Malik, , Non-Executive Director	2
Steven Ned, Director of Workforce	0
Rumit Shah, Non-Executive Director	4
Michael Smith, Non-Executive Director	4
Angela Wood, Chief Nurse	1
Michael Wright, Deputy Chief Executive	2

All governors are required to comply with the Trust's Code of Conduct and Constitution and declare any interests that may result in a conflict of interest in their role as governors. At each meeting of the Council of Governors a standing agenda item also requires all governors to make known any interest in relation to the agenda and any changes to their declared interests. An annual review is also undertaken of the register.

The register of governor's interests is available to view on the Trust's website (www.therotherhamft.nhs.uk) or by requesting a copy from the Company Secretary.

Ms Angela Wendzicha, Director of Corporate Affairs
General Management Department
Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

Members who wishes to communicate with the Governors can do so by sending an email to rghtr.public.governors@nhs.net .

Alternatively they may write to the Governor at the following address:

Name of Governor
C/O Ms Angela Wendzicha, Director of Corporate Affairs
General Management Department
Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham
S60 2UD

The Foundation Trust Membership

"The Rotherham NHS Foundation Trust Public Governors have an important role in representing the public voice and diversity of the local community and influencing the continual improvement of health services for the people of Rotherham".

The Trust has two membership constituencies:
A 'public constituency'
A 'staff constituency

To become a Public Member, the person must be at least 16 years of age and live within the Trust's constituency area (consisting of seven local electoral wards and Rest of England constituency), not be a Member of the staff constituency and have made an application for membership to the Trust.

The Rotherham NHS Foundation Trust public constituency boundaries are:

To become a Staff Member, the person must be at least 16 years of age, be employed by the Trust with a permanent contract or have worked at the Trust for at least 12 months. Staff have to opt in for Trust Membership.

At the end of 2021/22 there were over 14,395 Members of The Rotherham NHS Foundation Trust (TRFT) as detailed below:

Public	
Rother Valley South	907
Rother Valley West	1,160
Rotherham South	1,335
Rotherham North	1,786
Wentworth South	1,054
Wentworth North	1,475
Wentworth Valley	1,486
Rest of England	1,412
Staff	
Total number of Staff Members	3,780
Total Membership:	14,395

The Trust values the continued support and engagement of its Membership and recognises the importance of a diverse membership that is representative of all the communities it serves. Detailed below is a breakdown of a number of metrics pertaining to our membership.

	Public	Staff	Total
Age NHSI	**10,615**	**3,780**	**14,395**
0-16	0	0	0
17-21	0	6	6
22+	9,452	3,768	13,220
Not stated	1,163	6	1,169
Age	**9,452**	**3,768**	**13,220**
22-29	190	284	474
30-39	1,274	889	2,163
40-49	1,309	897	2,206
50-59	1,796	1,136	2,932
60-74	2,693	546	3,239
75+	2,190	16	2,206
Gender	**10,615**	**3,780**	**14,395**
Unspecified	3	3	6
Male	4,152	571	4,723
Female	6,460	3,206	9,666
Transgender	0	0	0
Ethnicity	**10,615**	**3,780**	**14,395**
White - English, Welsh, Scottish, Northern Irish, British	3,670	2,509	6,179
White - Irish	15	8	23
White - Gypsy or Irish Traveller	0	0	0
White - Other	13	27	40
Mixed - White and Black Caribbean	2	5	7
Mixed - White and Black African	1	3	4
Mixed - White and Asian	1	10	11
Mixed - Other Mixed	10	4	14
Asian or Asian British - Indian	32	51	83
Asian or Asian British - Pakistani	163	26	189
Asian or Asian British - Bangladeshi	3	2	5
Asian or Asian British - Chinese	5	6	11
Asian or Asian British - Other Asian	22	18	40
Black or Black British - African	24	19	43
Black or Black British - Caribbean	5	6	11
Black or Black British - Other Black	13	2	15
Other Ethnic Group - Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	65	27	92
Not stated	6,571	1,057	7,628

As a Foundation Trust, the Trust would normally work closely with its membership and strive to involve and engage members in the Trust's strategic direction through sustained, two-way communication plans.

However, such activities continued to be hindered during 2021/22 due to the COVID-19 pandemic, with face to face activities such as Governor Surgery's not being undertaken.

As in 2020/21, the Trust ensured members, and the general public remained informed on relevant non pandemic matters through media activities and general briefings. The Governors were given access to electronic material which they were encouraged to circulate amongst their personal and business contacts or social networks.

In establishing a Trust Public Panel, the Governors were initially invited to form the core of the panel until such time that members and the general public could become more involved. The Governors have been instrumental in promoting the Public Panel across their networks.

The Governor Member Engagement Group continued to meet virtually during 2021/22 and commenced a process to cleanse the membership database, in readiness for undertaking more proactive membership engagement opportunities once the COVID restrictions were lifted.

The membership database cleanse commenced in early September 2021, running for 90 days, and included a letter having been sent to circa 10,000 public members seeking their e-mail address in order that the Trust could issue speedier, more real time information.
The process also provided for members to update their personal details, trust services they would like to remain informed about, and the option to be removed from the membership database.

During 2021/22 the Council of Governors approved its Member Engagement Strategy 2022 – 2025, which was also approved by the Board of Directors. The strategy has two specific objectives, supported by a number of milestones. The objectives are:

- Objective 1 : To build and maintain our membership numbers by actively recruiting and retaining our members
- Objective 2 : To effectively engage and communicate with members

On behalf of Council of Governors, the Governor Members Engagement Group will support and monitor implementation of the milestones.

The Group now meet regularly to draw up plans and strategies working in collaboration with Trust officers to widen member engagement in readiness for when the country moves out of the pandemic. However, the 2021/22 has provided the ability for the Governors and the Trust to refresh its approach to engagement, and the communication platforms to communicate with members and to also expand the membership base. The Group will also focus on ensuring a diverse and representative membership, which in time will be reflected on the

Council of Governors.

The Annual Members Meeting is also another opportunity we utilise to meet members and the public, share achievements made within the year and outline future plans. Due to COVID-19 the Annual Members Meeting was once again a virtual event. Although not as well attended on the day as the Trust would have wished, subsequently there have been over 500 views of the recording of the Annual Members Meeting.

Looking ahead into 2022/23 the Council of Governors through the work of the Member Engagement Group, will be preparing for the Governor Elections which will commence in March 2021. There are eleven seats subject to election – eight public and three staff – which are a combination of vacancies and terms of office concluding. It is anticipated that through the activities planned these seats will be filled and represent the diversity of the Rotherham membership.

Members have and continue to be able to contact their Governor by sending an e-mail to: rghtr.public.governors@nhs.net indicating the name of the Public Governor they wish to contact in the subject line of the e-mail.

In a similar manner staff members are able to contact their Governor by sending an e-mail to: rghtr. staffgovernors@nhs.net also including the name of the governor in the subject line of the e-mail.

Public Members are able to contact the Trust's Directors through a variety of mechanisms: via the public virtual Board of Directors meeting or the public virtual Council of Governors meetings; via their Governor; via the Trust's your.experience@nhs.net e-mail or the Trust's switchboard.

Governor Nominations Committee / Non-Executive Director Appointments 2021/22

The Governor Nomination Committee (The Committee) has responsibility for giving assurance that the independence, skill, diversity and experience of each of the Non-Executive Directors, which includes the Chairman, reflects the needs of the Trust through the composition of the Board of Directors to achieve the Trust's objectives and safeguard the quality of care provided.

The Committee is chaired by the Trust Chairman and comprised of no more than nine Governors (Public, Staff and Partner), including the Lead Governor.

The Committee met on three occasions during 2021/22.
The Chair and Non-executive Directors annual appraisal and objective setting process was undertaken early in quarter one of 2021/22.

In May 2021, the Committee considered the outcome of the appraisal reviews for each Non-Executive Director, including the Chairman.

The performance appraisal and objective setting for the Chairman was jointly undertaken by the Senior Independent Director and the Lead Governor. The process for the other Non-Executive Directors was led by the Trust Chairman in conjunction with the Lead Governor.

Both appraisal processes were informed by a collective view on individual Non-Executive Director performance provided by fellow Non-Executive Directors, the Executive Directors and the Council of Governors. The process for the Chairman followed the guidance from NHS England / Improvement and also sought the views from key external stakeholders.

The Committee utilised these appraisals as part of their discussions when considering any terms of office for the Non-Executive Directors, including the Chairman.

The meetings held in July and November 2021 considered the terms of office for Ms Lynn Hagger, Mr Michael Smith and Dr Rumit Shah. In terms of Ms Hagger the Committee reaffirmed the decision taken in October 2020 to offer Ms Hagger a further one year term of office until the end of September 2022. In line with previous decisions, the Committee aligned Ms Hagger's remuneration to the NHS England / Improvement guidance.

The Committee agreed that the term of office for Mr Smith which was due to conclude at the end of March 2022 would be extended by a further six months to the end of September 2022, with remuneration aligned to the guidance.

Having served his first two year term, and based upon a satisfactory appraisal, the Committee agreed a further three year term for Dr Shah until the end of December 2024.

All extensions to the terms of office and remuneration were subsequently approved by the Council of Governors.

At the end of March and in early May 2021 the Trust bid farewell to Mr Joe Barnes and Mr Mark Edgell, who had been long serving Non-Executive Director's. Also in September 2021, Mr Michael Killick tendered his resignation.

Following notification of the resignation of Mr Killick, the Committee had considered the position as to whether there would be a requirement to undertake a further recruitment campaign. However, having initially appointed Mr Kamran Malik as Associate Non-Executive Director in April 2021, the Committee had considered that in demonstrating the required skills and Board behaviours, he would be offered the post of Non-Executive Director for a three year period. Throughout the year the Committee also remained informed of the process, and discussions, to appoint a substantive Chief Executive.

Other matters considered by the Committee during 2021/22 have been the annual review of its Terms of Reference and the Board skills, knowledge and diversity.

Looking ahead to 2022/23, the Committee will focus on success planning and recruitment as a number of Non-Executive Directors, including the Trust Chairman, will have concluded their terms of office.

The Committee make recommendations as appropriate to the Council of Governors following each of its meeting, with the minutes also routinely provided to all Council of Governor members.

NHS Foundation Trust Code of Governance Disclosures
Guidance on good corporate governance practice can be found in the NHS Foundation Trust Code of Governance (updated July2014). The purpose of the Code of Governance is to assist NHS Foundation Trus Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. Whilst the Code is issued as a best practice advice, some disclosure requirements are imposed.

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

The Trust is compliant with all the required provisions as set out on the following pages.

NHS Foundation Trust Code of Governance Disclosures

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement
2: Disclose	Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directorsshould include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. The detail can be found at Annex 3 of the current Trust Constitution. The Schedule of Matters reserved to the Board was last reviewed in October 2021.
2: Disclose	Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration21 committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.26 as part of the directors' report. Details contained within the Directors' Report from page 18
2: Disclose	Council of Governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. Detail can be found at page 47
Additional requirement of FT ARM	Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors. Detail can be found at page 47
2: Disclose	Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary. Detail can be found from page 18
2: Disclose	Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust. The skills and expertise of each Director of the Board is detailed within the Directors Report from page 19
Additional requirement of FT ARM	Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated. Length of appointments are detailed from page 19
2: Disclose	Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. Detail can be found at page 51

Part of schedule A	Relating to	CoG ref	Summary of requirement
Additional requirement of FT ARM	Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director. Included within the Directors Report at page 51
2: Disclose	Chair / Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report. Nil to disclose during the reporting period
2: Disclose	Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. Governors have been consulted on the Operational Plan at the Council of Governors meeting held via virtual means
Additional requirement of FT ARM	Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012) Non-Executive Directors and Executive Directors routinely attend the Council of Governors to provide updates on the Trust's performance. Details of attendance can be found at page 48 As a result of the above routine practice, the Council of Governors have not exercised their power under Paragraph 10C of Schedule 7 of the NHS Act 2006 during the reporting period.
2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted. This can be found at page 51 for Executive and Non-Executive Directors and page 23 for the Board and its Committees
2: Disclose	Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust. The last external review of governance took place in 2018/2019. The Trust plans to arrange the next cycle for 2022- 23
2: Disclose	Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). The Director's explanation of responsibilities can be found at page 61 and in the Annual Governance Statement from page 62

Part of schedule A	Relating to	CoG ref	Summary of requirement
2: Disclose	Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls. The Annual Governance Statement at page 66 details the review of the effectiveness of the internal controls.
2: Disclose	Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; Details can be found at page 66
2: Disclose	Audit Committee / Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position. Not applicable for this reporting period.
2: Disclose	Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. Detail can be found in the Director's Report at page 23.
2: Disclose	Board / Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings. Not applicable for this reporting period as no Executive Directors were released to serve as a Non-Executive Director.
2: Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report. Details can be found at pages 48 and 51
2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. Details can be found at page 48.
2: Disclose	Board / Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. Details can be found at page 50 within the Director's Report

Part of schedule A	Relating to	CoG ref	Summary of requirement
Additional requirement of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members. Detail can be found at page 49
Additional requirement of FT ARM (based on FReM requirement)	Board/Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. Details of the registers and how the public can access them can be found at pages 23 and 48
6: Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. Comply: Details can be found in the Performance section at page 9
6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Comply: Detail can be found in the Performance section at page 9
6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance. Comply: Detail can be found in the Annual Governance Statement at page 62
6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement (Monitor) for advising the board and the council and for recording and submitting objections to decisions. Comply: Detail is set out in the Trust Constitution and has not been invoked during the reporting period.
6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life. Comply: The Trust has in place an approved Standards of Business Conduct Policy in addition to a written Code of Conduct that all Board members are expected to sign up to.
6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. Comply: See response to A.1.8 above
6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. Comply: The Trust has in place appropriate insurance.
6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust. Comply

Part of schedule A	Relating to	CoG ref	Summary of requirement
6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director. Comply
6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Comply
6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. Comply: Nil concerns raised during the reporting period
6: Comply or explain	Council of Governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. Comply
6: Comply or explain	Council of Governors	A.5.2	The council of governors should not be so large as to be unwieldy. Comply
6: Comply or explain	Council of Governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. Comply
6: Comply or explain	Council of Governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. Comply
6: Comply or explain	Council of Governors	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns. Comply: Process in place but not invoked during the reporting period
6: Comply or explain	Council of Governors	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective. Comply
6: Comply or explain	Council of Governors	A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board. Comply: Process in place but not invoked during the reporting period
6: Comply or explain	Council of Governors	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties. Comply
6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent. Comply
6: Comply or explain	Board / Council of Governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust. Comply
6: Comply or explain	Nomination Committee(s)	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. Comply
6: Comply or explain	Board / Council of Governors	B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence. Comply

Part of schedule A	Relating to	CoG ref	Summary of requirement
6: Comply or explain	Nomination Committee(s)	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate. Comply
6: Comply or explain	Nomination Committee(s)	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s). Comply
6: Comply or explain	Nomination Committee(s)/ CoG	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and nonexecutive directors. Comply
6: Comply or explain	Nomination Committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors. Comply
6: Comply or explain	Council of Governors	B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position. Comply
6: Comply or explain	Council of Governors	B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and nonexecutive directors. Comply
6: Comply or explain	Nomination Committee(s)	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s). Comply
6: Comply or explain	Board	B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity. Comply: Process in place. Not applicable during the reporting period
6: Comply or explain	Board / Council of Governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. Comply
6: Comply or explain	Board	B.5.2	The board, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. Comply
6: Comply or explain	Board	B.5.3	The board should ensure that directors, especially nonexecutive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Comply
6: Comply or explain	Board / Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties. Comply
6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson. Comply
6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members. Comply

Part of schedule A	Relating to	CoG ref	Summary of requirement
6: Comply or explain	Chair / Council of Governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities. Comply
6: Comply or explain	Council of Governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties. Comply
6: Comply or explain	Board / Remuneration Committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment. Comply
6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. Comply: Detail at page 17 of the Director's Report
6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance. Comply
6: Comply or explain	Board	C.1.4	a) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. Comply
6: Comply or explain	Board / Audit Committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors. Comply
6: Comply or explain	Council of Governors / Audit Committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. Comply
6: Comply or explain	Council of Governors / Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. Comply

Part of schedule A	Relating to	CoG ref	Summary of requirement
6: Comply or explain	Council of Governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision. Not applicable during the reporting period
6: Comply or explain	Audit Committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. Comply
6: Comply or explain	Remuneration Committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. Comply
6: Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other nonexecutive directors should reflect the time commitment and responsibilities of their roles. Comply
6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. Comply
6: Comply or explain	Remuneration Committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. Comply
6: Comply or explain	Council of Governors / Remuneration Committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a nonexecutive. Comply
6: Comply or explain	Board	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums. Comply
6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. Comply
6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to cooperate. Comply
6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. Comply

NHS England and NHS Improvement's NHS System Oversight Framework

NHS England and NHS Improvement's NHS System Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five national themes;

- quality of care, access and outcomes
- preventing ill health and reducing inequalities
- finance and use of resources
- people
- leadership and capability

Based on information from these themes, providers are segmented from 1 to 4 where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found in breach or suspected breach of its licence.

The Rotherham NHS Foundation Trust continues to be classified by NHS Improvement as being in segment 3 as at 31 March 2022. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England and NHS Improvement website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

Statement of the chief executive's responsibilities as the accounting officer of The Rotherham NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require [name] NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of [name] NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

Signed: R. Jelly

Interim Chief Executive
Dated: 20 June 2022

Annual Governance Statement

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 polices, 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.*

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 risks 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 identity and prioritise the risks to the achievement of the policies, aims and objectives of The Rotherham NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in The Rotherham NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk Risk Leadership

The Trust Board of Directors ("the Board") has overall responsibility for providing leadership on the overall governance agenda. The Board is supported by a number of Assurance Committees that scrutinise and review assurances on internal control. Our Assurance Committees comprise Quality Committee, Finance and Performance Committee, People Committee and Audit Committee. The roles and responsibilities of each of the aforementioned Committees is described in detail in the Director's Report section of the Annual Report.

As Interim Chief Executive and designated Accounting Officer, I have responsibility for the oversight of risk management across all clinical, financial and organisational activities.

Senior leadership is delegated through the Executive Directors and operationally through Divisions, Departments and Committee structures. Responsibility for the operational processes relating to risk management was transferred into the portfolio of the Director of Corporate Affairs in December 2021 to bring this in line with standard practice. All staff within the Trust have a role in ensuring risks are assessed and reviewed on a regular basis.

Risk Management within the Trust is supported by the Risk Management Policy. The Risk Management Policy provides clarity in the accountability arrangements for the management of risk within the Trust, establishing the responsibilities of the Executive Directors and Senior 94 Managers with regard to leadership on risk management in addition to affirming the role all staff have within the Trust in identifying and reporting risks.

Equipping staff to manage risk

Managers at all levels of the organisation have responsibility to manage risk relevant to their areas in addition to promoting a culture whereby proactive reporting enables the early identification of real or perceived risks to patient care, staff and the environment. Each Division and Department maintains a risk register overseen by the relevant Divisional Governance Group. Risks that are scored 15 or more are escalated to the Risk Management Committee, Executive Team Meeting, Audit Committee and ultimately the Trust Board. During the latter part of the year, the Trust reassessed and strengthened the way in which the Risk Management Committee functioned ensuring robust scrutiny and challenge around management of risk at Divisional and Departmental level. We will continue to build on the progress over the next financial year.

The Trust recognises the importance of supporting staff through appropriate training and development. Risk Management training is mandatory for all staff and our compliance was 86% at 31 March 2022. The level and frequency is identified through our training needs analysis which ensures that our staff remain fully equipped to carry out their roles and responsibilities with regards to risk management.

Towards the end of the financial year, our newly appointed Quality, Governance, Compliance and Risk Manager carried out a total of five bespoke training sessions to a total of 24 senior managers which provided further insight and skills in how to identify and assess risks. The Trust learns from good practice through a range of mechanisms including peer reviews, effective performance management, continuing professional development, clinical audit and the application of evidence-based practice.

The Risk and Control Framework

The Trust's Risk Management Policy provides the framework for managing risks across the organisation and sets out the specific responsibilities of each Board member, Board Assurance Committee, Divisional Management Teams, Governance Leads, Risk owners in addition to the roles and responsibilities of partner organisations and contractors in relation to the management of risks. Notwithstanding the ongoing review of the Risk Management Policy, the document remains in date and continues to support the risk management function to manage and control all identified risks including clinical, non-clinical and financial. This is achieved through the established organisational framework which promotes early identification of risks, the co-ordination of risk management activity, the provision of a safe environment for patients and staff in addition to the effective use of financial resources.

The Trust has an established Board structure that enables the organisation to discharge overall responsibilities for risk management as follows:

- Audit Committee: Reviews, on behalf of the Board the establishment and maintenance of an effective system of internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives and also ensures effective internal and external audit functions.
- Quality Committee: Provides assurance to the Trust Board and Audit Committee that there are adequate controls in place to monitor the care given to patients using the services provided by the Trust, and

ensure that their experience of our services and outcomes are as expected. This includes progress against action plans generated as a result of Inspections by the Care Quality Commission.
- Finance and Performance Committee: Responsible for scrutinising aspects of financial and operational performance as requested by the Board in addition to scrutinising business cases, proposed investment decisions and regular review of contracts with key partners.
- People Committee: Responsible for providing leadership and oversight for the Trust on workforce issues that support the delivery of the Board's approved workforce objectives and for monitoring the operational performance of the Trust in people management, recruitment and retention and employee health and wellbeing.

Risk Management is 'operationalised' via the Divisional Governance meetings. The Risk Analysis Group, Chaired by the Chief Nurse (until December 2021) met on a monthly basis to review and agree Divisional risks with a score of 15 or more. Each risk had been allocated to an Assurance Committee and reviewed on a quarterly basis until December 2021 when the Assurance Committees began to review the risks on a monthly basis to create further rigour around management of high level risks.

The Risk Management Committee, Chaired by the Director of Corporate Affairs from December 2021 reviews the risks discussed at the Risk Analysis Group. Following an internal review of the risk management processes during December 2021 and January 2022, consultation began on the merits of retaining the Risk Analysis Group due to duplication across the Group and the Risk Management Committee. In addition, the Trust's Internal Audit function carried out a review of the management of and reporting on the organisation's risk register resulting in an opinion of Limited Assurance, which was consistent with our own findings following the aforementioned internal review in particular in relation to the use of the Datix system for recording action plans against risks. A robust improvement plan to address the issues found during the reviews and remains ongoing.

The risk management process begins with a systematic identification of risk which are evaluated, graded and either managed at a local level or escalated to the Audit Committee and Trust Board via the Risk Management Committee and Executive Team Meeting. To ensure consistency throughout the assessment of risks, risks are identified using a standardised approach. Identified risks are analysed using the risk management grading matrix of consequence and likelihood (5x5 matrix), producing a risk score that enables consistent prioritisation within the risk register. Risks scored 15 and above are discussed at the Risk Management Committee and feature on the relevant Board Assurance Committee agendas.

I

n August 2021, the Board of Directors, during a Strategic Board session discussed and agreed the Trust's Risk Appetite Statement, articulating what level risk the Board is willing or unwilling to accept. The Risk Appetite Statement clearly defines the balance of risk relating to patient safety and quality, financial and reputational. Further work will be carried out during the next financial year to strengthen the interaction between the risk register and the Risk Appetite Statement.

The Board Assurance Framework (BAF) has been scrutinised at the relevant Board Assurance Committees and the Trust Board with the following key in year strategic risks to the delivery of the Trust's Strategic Objectives as follows:

- Standards of quality of care do not deliver the required patient safety, clinical effectiveness and patient experience that meet regulatory requirements
- Demand for care exceeds the resources available leading to failure to achieve recognised healthcare standards and to recover performance to the required levels within agreed timeframes
- Should the Trust fail to actively engage with, or listen to the experience of service users, there is a risk that the organisation will not learn or improve the quality of care (experience, quality and outcomes) for those who use our services.
- Lack of effective staff engagement will impact on staff experience resulting in poor staff survey results which impact on the organisation's ability to deliver the Trust's Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans/objectives
- There is a risk that robust financial governance arrangements are not embedded across the Trust which could impact on the achievement of Trust plans/objectives and subsequent removal of the financial planning undertakings and breach of the provider licence
- The financial plan is not delivered
- The lack of capital investment may affect the delivery of some services
- There is a risk that the Trust has insufficient governance in place with partners in the South Yorkshire and Bassetlaw ICS which will impact on the Trust's ability to contribute effectively to the partnerships in place, provider collaborative and digital and data to drive systems.
- Joint working with key partners is developing steadily and relationships are in formative periods. Unless these relationships continue to develop there is a risk to continuity and poor service configuration across Rotherham Place.

The Head of Internal Audits' Final Annual Opinion provided a 'Significant Assurance' opinio in relation to the use of the BAF noting it to be fit for purpose, has been kept live in year and routinely discussed at Board and Committees.

As the Trust developed and approved the next 5 Year Strategy, the BAF work remains ongoing over the next financial year to further develop and refine our BAF in line with our new Strategic Ambitions.

The Trust has in place a Risk Management Strategy (2020-2025) which has been based on the implementation and sustainability of the following three actions:

1. Enhance the knowledge and skills base of staff in Risk Management across the Trust, thereby also further encouraging an open and transparent reporting culture and increasing engagement;
2. Strengthen the system of assurance regarding risk reporting and
3. Improve the action planning of risks.

The Risk Management Committee will continue to monitor the continued implementation of the above reporting directly to the Executive Team Meeting and the Audit Committee.

As we develop and move further towards wider system working, it is essential that we continually develop our controls and governance arrangements to reflect this.

Compliance with Developing Workforce Standards
The Board receives assurance that the processes relating to safe, sustainable and effective staffing are in place within the Trust and compliant with the 'Developing Workforce Safeguards'. Staff establishments are reviewed annually during the budget setting cycle and the Quality Committee and Board receive a Safer Staffing Report every six months.

The Board of Directors and its associated Assurance Committees receive regular reports detailing the staffing arrangements in place to provide assurance in respect of quality, safety, sustainability and effectiveness. Our people remain intrinsic to what we do and our Board approved People Plan contains key objectives to support and enable Clinical Divisions and Corporate Services to develop robust workforce planning strategies.

Information Governance
Information governance provides the framework for handling information in a secure and confidential manner. Taking into consideration the collection, storage and sharing of information, it provides assurance that personal and sensitive data is being managed legally, securely, efficiently and effectively to deliver the best possible care and service.

As an NHS organisation we have in place a Caldicott Guardian who is a Board member and is responsible for protecting the confidentiality of people's healthcare and information and ensure we have systems in place to support the proper use of information. In addition, the Trust has a dedicated Senior Information Risk Owner (SIRO) who is a Board member with responsibility for assuring the Board with regard to the progress against the Trust's information governance work programme.

The key roles of the SIRO and the Caldicott Guardian in association with the Information Governance Committee is to ensure that we comply with the Data Security & Protection Toolkit in addition to overseeing any improvements in relation to managing risks to information; organisational compliance with legislative and regulatory requirements relating to our handling of information, including compliance with the Data Protection Act 2018 and the Freedom of Information Act 2000.

In addition to the above, in response to the Trust's responsibilities under the Data Protection Act and the General Data Protection Regulations we have a dedicated Data Protection Officer who provides advice on data protection legislation in addition to monitoring our compliance with the relevant legislation.

The Caldicott Guardian and the SIRO review and monitor any serious incidents relating to information governance, data loss, confidentiality and data security. During the reporting period 2021-22 the Trust reported a total of four incidents to the Information Commissioner, one of which remains under investigation with the Information Commissioner. The remaining three incidents were not deemed reportable by the Information Commissioner and therefore closed.

The Trust continues to carry out an annual assessment of its position against the Data Security and Protection Standards.

Data Quality
The Trust continues to have arrangements in place to ensure it processes data that is accurate, reliable, timely, complete and sufficient for it to be meaningful. Our Data Quality Team continue to work hard with our heads of service, lien managers and health professionals across the Trust ensuring our colleagues are supported to enable accurate and complete input of data. Risks to data quality are continuously assessed and monitored through our Information Governance Committee with any high risks being escalated to the Risk Management Committee and Executive Team Meeting where necessary.

Cybersecurity
During 2021/22 we upgraded key components of our IT infrastructure, such as migrating to a managed wifi and firewall services and addressing ageing applications in order to mitigate any cybersecurity threats, plus continued to work with NHS Digital in deploying national cybersecurity solution such as NHS Secure Boundary. In December 2021 our Trust board received Cybersecurity training from NHS Digital and along with others in the NHS, responded to the Log4jShell and in detail assessed all our applications against this vulnerability with urgent patches being applied where necessary. Finally we received investment funding from NHS England, to update our IT backup systems, which when fully implemented and tested, will mean quicker recovery times should backups ever be required.

Digital Improvements
The Trust continues to progress its digital transformation agenda, with 2021/22 being the third and final year of the Trust participation in the National Digital Aspirant programme.

Using this national investment, across our organisation and the Rotherham place, we've integrated our EPR into the Rotherham Health App, gone live with our state of the art Digital Command Centre powered by enhanced predictive dashboards, a cloud based escalation management system and integrated porting into our EPR. Across our wards, outpatient and community services we continued to digitize clinical process, standardise care and remove wasteful paper records, and have gone-live with PatientHub, sending appointment reminders digitally to patients.

Outside of the Digital Aspirant programme, in 2020/21 we implemented numerous innovative solutions such as digitizing 12-15 covid vaccinations, Lydia an online Human Resource chatbot and contact centre technology with our Radiology department.

Provider Licence
Throughout the last financial year, a significant amount of work was carried out in relation to implementing the financial governance plan put in place as a result of Enforcement Action by Monitor in April 2013.

The Trust received the very welcome notification on 13 August 2021 that it was no longer in breach of its Provider Licence.

In accordance with the NHS Provider Licence, Condition 4(8)(b), the Trust is required to assure itself of the validity of its Corporate Governance Statement. The Board reviews the Corporate Governance Statement on an annual basis to ensure that any declarations made are supported with evidence. The Board considers its risks and any

mitigating actions in addition to work overseen directly by the Board. The annual self-certification for 2021-22 was considered and approved at the Board meeting on 13 June 2022. The self-certification was made available on the Trust website on 21 June 2022.

The NHS Oversight Framework outlines the approach NHS England/ Improvement take when overseeing organisational performance. During the last financial year, the Trust remained in Segment 3.

Compliance with the Health and Social Care Act 2008 – Care Quality Commission Registration Requirement
The Trust is registered with the Care Quality Commission (CQC) and is currently fully compliant with the registration requirements and the current registration status is 'Registered with Conditions'

In October 2018, the CQC served the Trust with a Section 31 Condition on the Trust's Registration relating to mitigating the risk within the paediatric area of the Urgent and Emergency Care Centre with a focus on medical and nursing staffing levels. An application was submitted to the CQC in February 2022 to have the regulatory condition lifted with a decision from the CQC expected early April 2022.

A Warning Notification under Section 29A of the Health and Social Care Act 2008 was issued to the Trust in November 2020 following concerns raised in relation to the quality of healthcare in the Acute Medical Unit (AMU). This expired during the last financial year, the Trust receiving confirmation from the CQC that no further action was required.

The CQC carried out a routine Inspection during week commencing 10 May 2021. During May and June 2021, four core services, namely Urgent and Emergency Care, Medical Care (including care of the older person), maternity and services for Children and Young People were inspected. In addition a Well-Led Review was conducted on 22-23 June 2021. A Warning Notification under Section 29A of the Health and Social Care Act 2008 was issued to Urgent and Emergency Care (August 2021) in response to concerns identified across the department. The final report from the Inspection was published in September 2021 and the Trust' overall rating remained as 'Requires Improvement'. The Trust continues to make progress against the comprehensive Improvement Plan developed in conjunction with each core service.

A further unannounced Inspection took place on 2 and 8 March 2022 as a follow up on progress against the action plan relating to the Section 29A Warning Notification for Urgent and Emergency Care. The final report from this visit is expected in June 2022.

In addition, the Trust was notified of further action under the Police and Criminal Evidence Act relating to suspected breaches of Regulation 13(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to historical Serious Incidents around safeguarding children from 2019 to early 2020.

Health and Safety Executive
The Health and Safety Executive carried out a focused inspection at the Trust during 30 November and 02 December 2021 in relation to the management of violence and aggression, moving and handling and the Trust's response to COVID-19. A number of ontraventions to the Health and Safety at Work etc Act 1974 were identified. The Trust provided a comprehensive response to the Health and Safety Executive on 31 March 2022 following which confirmation was received that no further action would be taken by the Health and Safety Executive.

The Trust received notification from the Health and Safety Executive in March 2022, under the Police and Criminal Evidence Act in relation to an incident that occurred in July 2020. At the end of the reporting period, this matter remained ongoing.

Review of economy, efficiency and effectiveness of the use of resources
The Trust continues to have in place processes to ensure that resources are used economically, efficiently and effectively.
Through the annual planning cycle, detailed plans are submitted reflecting the operational and service requirements including the achievement of a financial control total. In addition,
monthly Performance Reviews were carried out with each Division with any issues of escalation discussed at the Finance and Performance Committee.

Our performance against our objectives has been monitored and actions identified through a number of ways as follows:

- Operational Plan approved by the Board of Directors
- Monthly reporting and attendance cycle for Divisions at the Assurance Committees on key performance indicators relating to quality, finance, activity and recovery following COVID-19
- Monthly finance reports to the Finance and Performance Committee and Board in addition to weekly reporting to the Executive Team Meeting on any key factors that may affect the Trust's financial position

The Trust has in place a robust process for the assessment of business cases to ensure value for money with scrutiny of each business case brief and subsequent business case at the Executive Team Meeting.

Stakeholder Involvement
Established and effective arrangements are in place to enable the Trust to work with key public stakeholders across the health economy and system including but not limited to:

- Rotherham Metropolitan Borough Council
- HealthWatch Rotherham
- Rotherham and Barnsley Chamber of Commerce
- Rotherham PLACE Board
- South Yorkshire and Bassetlaw Integrated Care System
- South Yorkshire and Bassetlaw Acute Federation
- South Yorkshire Police
- Rotherham College/University College Rotherham
- NHS England/Improvement
- Voluntary Action Rotherham
- Health Select Commission (RMBC)
- Trust Council of Governors, Trust members and members of the public.

The Trust has a number of patient experience groups whereby patient and service users have the ability to oversee and monitor activity relating to patient experience.

The Trust has published on its website an up-to-date register of interests, including gifts and

hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer of 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.

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

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of our internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within The Rotherham NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on 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, Finance and Performance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Notwithstanding the Trust's response to the COVID-19 pandemic, the Board continued to meet every month, alternating between a full Board meeting and Board development sessions. Throughout the last year, the Board has continued to receive reports on operational performance via the Integrated Performance Report. The aforementioned report incorporates performance monitoring in respect of key national priorities, regulatory and statutory indicators, quality, patient safety and workforce.

The Audit Committee has supported the Board and provided an independent and objective review of the corporate governance and financial control within the Trust via the Chair's log to the Board. The Finance and Performance Committee and the Quality Committee have provided the Board with assurance throughout the year on our clinical and financial governance and where any remedial action is required has provided clarity on those actions to the Board via the Chair's logs.

The Trust has undertaken a review of the effectiveness of the Committees reporting directly into the Board Assurance Committees and in particular the Quality Committee reporting stream. This has resulted in the Trust commencing in year a re-structure of the committees reporting into Quality Committee in order to enhance the rigour and scrutiny required. This work will progress and embed during the next financial year.

The Trust works very closely with our External Auditors (Mazars) and Internal Auditors (360 Assurance) who in turn work closely with our Audit Committee. As stated above, my review has been informed by the reviews undertaken by the Internal Audit function with the results being shared with the Audit Committee. During the last financial year, the Audit Committee received a total of 13 reports relating to mandated, risk based and advisory reviews, the outcomes detailed as follows:

- Four 'Significant Assurance' relating to Strategic Quality Governance, General leger and financial reporting arrangements, Estates procurement and Performance management
- Two split 'Significant /Limited Assurance' relating to Learning from Incidents and Complaints
- Two 'Limited Assurance' relating to Strategic Risk Management and Learning from Deaths.
- Five advisory reports relating to Head of Internal Audit Opinion Stages 1,2 and 3, Legal Services and CQC Action Plan

In addition to the above, my review has been informed by the Head of Internal Audit Opinion which has contributed to this Annual Governance Statement. The Head of Internal Audit is required to provide an overall annual opinion statement based upon and limited to the work undertaken and on the overall adequacy and effectiveness of the Trust's control and governance processes.

The Trust has received a statement from the Head of Internal Audit based upon work undertaken during 2021-22 and the overall opinion provides 'Significant Assurance' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Conclusion

The Board remains committed to continuous improvement of its governance arrangements to ensure that robust systems are in place to identify and manage risks. In summary, I am assured that through the work carried out during the last financial year and through the opinion of our Internal Auditors we have a sound system of internal control in place.

However, as Accounting Officer, I am reporting that we continue to have a significant internal control issue relating to the quality of care for patients. These issues are being dealt with in conjunction with our Regulators and formal improvement plans are in place to address any weaknesses, progress of which continues to be reported to Board via the Assurance Committees.

Signed

Dr Richard Jenkins
Interim Chief Executive
20 June 2022


NHS
SIDHIL

The Rotherham NHS Foundation Trust

Annual Accounts 2021/22

Foreword to the accounts

The Rotherham NHS Foundation Trust

These accounts, for the year ended 31 March 2022, have been prepared by The Rotherham NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

R. Jenkins

Name Dr. R Jenkins
Job title Interim Chief Executive
Date 20 June 2022

Independent auditor's report to the Council of Governors of The Rotherham NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of The Rotherham NHS Foundation Trust ('the Trust') for the year ended 31 March 2022 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity , the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities 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

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the 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 Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2021/22 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

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. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accounting Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in April 2021.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2022.

In July 2021 we identified a significant weakness in relation to Governance and Improving economy, efficiency and effectiveness. In our view this significant weakness remains for the year ended 31 March 2022:

Significant weakness in arrangements – issued in a previous year	Recommendation
Care Quality Commission inspections The Care Quality Commission (CQC) took enforcement action against the Trust during 2020/21. The issues raised by CQC included the safeguarding of children, the quality of care in the Acute Medical Unit, and concerns about patient harm. The Trust has developed an action plan to address each area for improvement. In our view, the matters identified by CQC during 2020/21 represent a significant weakness in arrangements in relation to: • 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.	In order to ensure systems, processes and training are in place to manage the risks relating to the health, safety, and welfare of service users we recommend that the Trust ensures that it embeds and sustains the action plans that it has put in place Trust-wide to address the patient care issues identified by the CQC. In particular, it needs to ensure that robust monitoring and reporting processes are maintained, and that challenge, scrutiny and escalation arrangements drive the required improvements for patients and sustain the progress made to-date in implementing the actions to address the issues raised by the CQC.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any further matters which we are required to report by exception.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

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

We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves 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 work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22; and
- the other information published together with the audited 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:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2021/22; or
- the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Council of Governors of The Rotherham NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust 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 Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

Mark Dalton, Key Audit Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP

20 June 2022

Audit Completion Certificate issued to the Council of Governors of The Rotherham NHS Foundation Trust for the year ended 31 March 2022

In our auditor's report dated 20 June 2022 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 20 June 2022 that would have a material impact on the financial statements on which we gave our unqualified opinion.

The Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

In our auditor's report dated 20 June 2022 we reported that we had identified a significant weakness in the Trust's arrangements for the year ended 31 March 2022. On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have no further matters to report in this respect.

Certificate

We certify that we have completed the audit of The Rotherham NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Mark Dalton, Key Audit Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP

25 August 2022

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	14	8,274	8,290
Property, plant and equipment	15	163,548	151,391
Receivables	23	373	52
Total non-current assets		**172,195**	**159,733**
Current assets			
Inventories	22	3,502	3,916
Receivables	23	8,754	8,760
Cash and cash equivalents	26	33,303	30,910
Total current assets		**45,559**	**43,586**
Current liabilities			
Trade and other payables	27	(38,649)	(39,400)
Borrowings	29	(2,119)	(2,257)
Provisions	32	(3,406)	(154)
Other liabilities	28	(1,711)	(815)
Total current liabilities		**(45,885)**	**(42,626)**
Total assets less current liabilities		**171,869**	**160,693**
Non-current liabilities			
Borrowings	29	(23,567)	(28,142)
Provisions	32	(1,332)	(1,002)
Total non-current liabilities		**(24,899)**	**(29,144)**
Total assets employed		**146,970**	**131,549**
Financed by			
Public dividend capital		166,750	161,872
Revaluation reserve		55,911	47,681
Income and expenditure reserve		(75,691)	(78,004)
Total taxpayers' equity		**146,970**	**131,549**

R. Jenkins

Name **Dr. R Jenkins**
Position **Interim Chief Executive**
Date 20 June 2022

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	314,262	274,972
Other operating income	4	26,169	49,127
Operating expenses	6, 8	(335,810)	(323,421)
Operating surplus/(deficit) from continuing operations		**4,621**	**678**
Finance income	10	18	3
Finance expenses	11	(608)	(597)
PDC dividends payable		(3,537)	(1,796)
Net finance costs		**(4,127)**	**(2,390)**
Other gains / (losses)	12	(33)	-
Surplus / (deficit) for the year		**461**	**(1,712)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	17	6,662	7,773
Other reserve movements		3,420	-
Total comprehensive income / (expense) for the period		**10,543**	**6,061**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		461	(1,712)
Remove net impairments not scoring to the Departmental expenditure limit		-	7,022
Remove I&E impact of capital grants and donations		398	(4,254)
Remove net impact of inventories received from DHSC group bodies for COVID response		583	(583)
Remove loss recognised on return of donated COVID assets to DHSC		35	
Adjusted financial performance surplus / (deficit)		**1,477**	**473**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**161,872**	**47,681**	**(78,004)**	**131,549**
Surplus/(deficit) for the year	-	-	461	**461**
Other transfers between reserves	-	(1,852)	1,852	**-**
Revaluations	-	6,662	-	**6,662**
Public dividend capital received	4,878	-	-	**4,878**
Other reserve movements	-	3,420	-	**3,420**
Taxpayers' and others' equity at 31 March 2022	**166,750**	**55,911**	**(75,691)**	**146,970**

Statement of Changes in Taxpayers Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**80,038**	**41,676**	**(78,060)**	**43,654**
Surplus/(deficit) for the year	-	-	(1,712)	**(1,712)**
Other transfers between reserves	-	(1,768)	1,768	**-**
Revaluations	-	7,773	-	**7,773**
Public dividend capital received	81,834	-	-	**81,834**
Taxpayers' and others' equity at 31 March 2021	**161,872**	**47,681**	**(78,004)**	**131,549**

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.

Formal valuations are conducted every 5 years, with desktop valuations in the interim as required. The last full revaluation of the trust's assets was at the 31 March 2021.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,621	678
Non-cash income and expense:			
Depreciation and amortisation	6.1	9,556	8,844
Net impairments	7	-	7,022
Income recognised in respect of capital donations	4	(51)	(4,370)
(Increase) / decrease in receivables and other assets		(563)	17,324
(Increase) / decrease in inventories		414	76
Increase / (decrease) in payables and other liabilities		1,942	6,529
Increase / (decrease) in provisions		3,596	(16)
Net cash flows from / (used in) operating activities		**19,515**	**36,087**
Cash flows from investing activities			
Interest received		18	3
Purchase of intangible assets		(1,293)	(1,027)
Purchase of PPE and investment property		(14,964)	(15,020)
Sales of PPE and investment property		7	-
Net cash flows from / (used in) investing activities		**(16,232)**	**(16,044)**
Cash flows from financing activities			
Public dividend capital received		4,878	81,834
Movement on loans from DHSC		(1,250)	(68,709)
Capital element of finance lease rental payments		(538)	(737)
Capital element of PFI, LIFT and other service concession payments		(80)	-
Interest on loans		(339)	(773)
Other interest		-	(1)
Interest paid on finance lease liabilities		(202)	(242)
Interest paid on PFI, LIFT and other service concession obligations		(87)	-
PDC dividend (paid) / refunded		(3,272)	(1,876)
Cash flows from (used in) other financing activities		-	4
Net cash flows from / (used in) financing activities		**(890)**	**9,500**
Increase / (decrease) in cash and cash equivalents		**2,393**	**29,543**
Cash and cash equivalents at 31 March	26.1	**33,303**	**30,910**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Rotherham NHS Foundation Trust ('the Trust') is a public benefit corporation authorised, in England, by Monitor (trading as NHS Improvement) in accordance with the National Health Service Act 2006. The Trust provides healthcare mainly to the region. The address of the Trust is Moorgate Road, Rotherham, S60 2UD.

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 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

The Rotherham NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The Trust is not aware of any material uncertainties in respect of events or conditions that would bring into question the going concern ability of the entity.

Note 1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of The Rotherham NHS Foundation Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

Critical judgements in applying accounting policies

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

• Management make judgements in determining when substantially all the significant risks and rewards of ownership of financial assets and lease assets are transferred to other entities.

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:

Income estimates

In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is not received until future periods, when the claims have been settled, an estimation must be made as to the collectability.

Expense accruals

In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

Impairment of property, plant and equipment

The Trust has undertaken an annual impairment exercise of its Property, Plant and Equipment. Following an interim professional valuation carried out at 31 March 2021, the Trust has considered items such as: indices movements; deterioration of assets and its further estates plans to support its impairment assessment. It is the judgement of management following this review that there is not an indication of impairment.

Recoverability of receivables
In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables and made appropriate adjustments to the existing allowance account for expected credit losses.

Provisions
In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

Note 1.4 Operating segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within The Rotherham NHS Foundation Trust.

Note 1.5 Revenue from contracts with customers

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

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

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

• the Trust is not required to disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less
• the Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard where the right to consideration corresponds directly with value of the performance completed to date
• the Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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.

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

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

NEST Pension Scheme

The Trust is a member of the National Employment Savings Trust (NEST) pension scheme which operates as a defined contribution plan. The Trust pays contributions into a fund but has no legal or constructive obligation to make further payments if the fund does not have sufficient assets to pay all of the employees' entitlements to post-employment benefits. The Trust's obligation is therefore limited to the amount it agrees to contribute to the fund and effectively place actuarial and investment risk on the employee. The amount recognised in the period is the contribution payable in exchange for service rendered by employees during the period.

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
• items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

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.

Measurement
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.

Where applicable, assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

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.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful 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.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless there is an expectation that the asset will be acquired at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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 asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable, that is:
    - management are committed to a plan to sell the asset
    - an active programme has begun to find a buyer and complete the sale - the asset is being actively marketed at a reasonable price
    - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged 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.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
Transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

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	3	90
Plant & machinery	5	15
Transport equipment	7	9
Information technology	2	20
Furniture & fittings	10	10

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

Note 1.9 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

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; it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are only recognised if, and only if, all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset
• the Trust can measure reliably the expenses attributable to the asset during development

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

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.

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

	Min life Years	**Max life Years**
Software licences	2	20

Note 1.11 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 1.12 Inventories

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

In 2020/21 and 2021/22, 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 1.13 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 1.14 Financial assets and financial liabilities

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or would be otherwise determined by reference to quoted market prices, where possible, or by valuation techniques where relevant. (See IFRS 9 B5.1.2A.).

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial assets at amortised cost
Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at fair value through other comprehensive income
Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

At present the Trust does not hold any financial assets or financial liabilities held for trading.

Financial assets at fair value through profit and loss
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Impairment of financial assets
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

A provision matrix approach is adopted, as one of the recommended methodologies, to calculate lifetime expected credit losses of trade receivables at the reporting date. The Trust does not currently hold any lease receivables or contract assets.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

Additionally, the DHSC provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

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 the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Financial Liabilities
Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished - that is, the obligation has been discharged or cancelled or has expired.

Financial Liabilities at fair value through profit and loss
Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

The Trust has reviewed all its main contracts and concluded that any derivatives the contracts may have are 'closely related' and therefore do not warrant separate disclosure or accounting.

Other Financial Liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

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 1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as a lessee

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

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

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

Contingent rents are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Private Finance Initiative (PFI) transactions
PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

1. payment for the fair value of services received - the cost of the services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

2. repayment of the finance lease liability, including finance costs - The Public Finance Initiative (PFI) assets are recognised as Plant, Property and Equipment when they come into use.

A PFI liability equal to the capital value of the contract is recognised at the same time as the PFI assets are recognised. This does not include service elements and interest charges within the PFI contract which are expensed in accordance with IFRIC 12 as adapted and interpreted by the FReM, and as detailed below.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

3. payment for the replacement of components of the asset during the contract 'lifecycle replacement' - Components of the asset replaced by the operator during the contract (lifecycle replacement) are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalise at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is predetermined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the trust to the operator for use in the PFI scheme: Assets contributed for use in the scheme continue to be recognised as items of Plant, Property and Equipment in the Trust's Statement of Financial Position.

Other assets contributed by the trust to the operator: Other assets contributed (e.g.. Cash payments, surplus property) by the Trust to the operator before the asset is brought into use, where these are intended to defray the operators capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

The trust as a lessor

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

Note 1.16 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 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

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 is recognised in the notes to the accounts 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 1.17 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 the notes to the accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the notes to the accounts, 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 1.18 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.

As part of the reforms to the NHS cash regime effective from 1 April 2020, any interim revenue loans, including specified working capital facilities, and interim capital debt at 31 March 2020 were extinguished during the 2020/2021 financial year. £67.459million of PDC was provided to the Trust to enable the principal repayment of the outstanding balance.

Note 1.19 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 1.20 Corporation tax

The Finance Act 2004 amended section 519A of the Income and Corporation Tax Act 1998 to provide power to HM Treasury to make certain non-core activities of NHS Foundation Trusts potentially subject to corporation tax.

However, the Trust has evaluated that it is has no Corporation Tax Liability, as all activities are either ancillary to healthcare or below the de minimis level of profit at which tax becomes payable.

Note 1.21 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 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 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Transfers of functions to / from other NHS bodies / local government bodies

As public sector bodies are deemed to operate under common control, business reconfigurations with the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place.

For functions that have been transferred to the trust from another NHS / local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity’s accounts are preserved on recognition in the trust’s accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.26 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 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2021/2022. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/2023, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases**:** The standard is effective 1st April 2022 as adapted and interpreted by the FReM.

IFRS 17 Insurance Contracts: Application required for accounting periods beginning on or after 1st January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

The Trust has considered the above new standards, interpretation and amendments to published standards that are not yet effective and concluded that, with the exception of IFRS 16 that is dealt with below, they are currently either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

This conforms with the Foundation Trust Annual Reporting Manual (FT ARM) which requires that any amendments to standards are applied in accordance with the applicable timetable, with early adoption not permitted.

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

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	16,989
Additional lease obligations recognised for existing operating leases	(16,989)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(2,492)
Additional finance costs on lease liabilities	(138)
Lease rentals no longer charged to operating expenditure	2,602
Other impact on income / (expenditure)	(107)
Estimated impact on surplus / deficit in 2022/23	**(135)**
Estimated increase in capital additions for new leases commencing in 2022/23	**-**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's Carbon Energy Scheme liability where future payments are indexed linked. The Carbon Energy Scheme liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Rotherham Foundation Trust occupies two buildings to provide Dental Services which it does not pay rent towards; these properties are sub-leased by South West Yorkshire Partnership Trust to Rotherham Foundation Trust. On transition to IFRS16, Rotherham will recognise these two buildings as 'donated assets' under right to use assets based on the rent paid by South West Yorkshire Partnership Trust pro-rated for the area occupied by the Trust.

Rotherham Foundation Trust provides a joint Pathology service with Barnsley Foundation Trust. Barnsley Foundation Trust has operating lease arrangements in place which covers equipment used in both hospitals, which it in turns recharges to Rotherham Foundation Trust. The Trust will bring these assets on to its balance sheet upon transition to IFRS16. The value of assets included within the above table relating to Pathology equipment is based on estimates, and the Trust is currently working with Barnsley Foundation Trust to establish the value of equipment.

Note 2 Operating Segments

All of the Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the large majority of the healthcare services provided occur at the one geographical main site. Trust revenue derives within the UK. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Foundation Trust Board of Directors, which includes senior professional non-executive directors. The Board of Directors review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Board of Directors contains summary figures for the whole Trust together with directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cash flow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		**Total**	
	2021/22	2020/21	**2021/22**	2020/21
	£000	£000	**£000**	£000
Income	**340,431**	**324,099**	**340,431**	324,099
Retained Earnings / (Accumulated Deficit)	**461**	**(1,712)**	**461**	(1,712)
Segment net assets	**146,970**	**131,549**	**146,970**	131,549

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with the Trust's accounting policies.

Note 3.1 Income from patient care activities (by nature)	2021/22	2020/21
	£000	£000
Acute services		
Block contract / system envelope income	290,463	253,921
High cost drugs income from commissioners (excluding pass-through costs)	1,252	114
Other NHS clinical income	91	3,696
Other clinical income from mandatory services	97	-
Block contract / system envelope income	8,644	8,554
Income from other sources (e.g. local authorities)	10	-
All services		
Elective recovery fund	4,546	-
Additional pension contribution central funding*	8,481	7,996
Other clinical income	678	691
Total income from activities	**314,262**	**274,972**

*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)	2021/22	2020/21
	£000	£000
Income from patient care activities received from:		
NHS England	30,497	31,648
Clinical commissioning groups	273,896	234,148
Other NHS providers	91	-
NHS other	-	61
Local authorities	9,061	8,439
Non-NHS: overseas patients (chargeable to patient)	52	110
Injury cost recovery scheme	602	544
Non NHS: other	63	22
Total income from activities	**314,262**	**274,972**
Of which:		
Related to continuing operations	314,262	274,972
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2021/22 £000	2020/21 £000
Income recognised this year	52	110
Cash payments received in-year	34	6
Amounts added to provision for impairment of receivables	3	100
Amounts written off in-year	-	-

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	439	-	**439**	295	-	**295**
Education and training	11,532	748	**12,280**	10,135	656	**10,791**
Non-patient care services to other bodies	6,231		**6,231**	6,254		**6,254**
Reimbursement and top up funding	654		**654**	20,992		**20,992**
Income in respect of employee benefits accounted on a gross basis	2,499		**2,499**	1,707		**1,707**
Receipt of capital grants and donations		51	**51**		4,370	**4,370**
Charitable and other contributions to expenditure		1,111	**1,111**		2,365	**2,365**
Rental revenue from operating leases		462	**462**		427	**427**
Other income	2,388	54	**2,442**	1,926	-	**1,926**
Total other operating income	**23,743**	**2,426**	**26,169**	**41,309**	**7,818**	**49,127**
Of which:						
Related to continuing operations			26,169			49,127
Related to discontinued operations			-			-

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

	2021/22 £000	2020/21 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	815	1,425
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

As at the year end the Trust has no performance obligations that are either partially or fully unsatisfied that it has not accounted for in revenue recognition in year. Therefore, there are no contracts that commenced prior to the period end, with performance obligations outstanding and income not yet recognised.

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2021/22 £000	2020/21 £000
Income from services designated as commissioner requested services	313,584	274,281
Income from services not designated as commissioner requested services	26,847	49,818
Total	**340,431**	**324,099**

Note 5.4 Profits and losses on disposal of property, plant and equipment

The Trust has not disposed of any land or buildings assets in year used in the provision of commissioner requested services.

Note 5.5 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

In 2021/22 The Rotherham NHS Foundation Trust had no fees or charges where the scheme individually resulted in income from that service exceeding £1,000k.

Note 6.1 Operating expenses

	2021/22 £000	2020/21 £000
Purchase of healthcare from non-NHS and non-DHSC bodies	3,644	2,581
Staff and executive directors costs	227,486	220,150
Remuneration of non-executive directors	173	176
Supplies and services - clinical (excluding drugs costs)	28,574	26,140
Supplies and services - general	4,877	6,260
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	19,055	16,847
Inventories written down	27	343
Consultancy costs	24	199
Establishment	2,614	2,955
Premises	16,097	14,429
Transport (including patient travel)	3,156	2,689
Depreciation on property, plant and equipment	8,247	7,414
Amortisation on intangible assets	1,309	1,430
Net impairments	-	7,022
Movement in credit loss allowance: contract receivables / contract assets	(115)	481
Movement in credit loss allowance: all other receivables and investments	3	20
Increase/(decrease) in other provisions	(187)	-
Change in provisions discount rate(s)	23	30
Fees payable to the external auditor:		
audit services- statutory audit (*)	108	121
Internal audit costs	104	87
Clinical negligence	9,352	7,962
Legal fees	506	105
Insurance	233	252
Research and development	419	307
Education and training	1,909	1,613
Rentals under operating leases	2,182	2,021
Redundancy	53	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	203	-
Losses, ex gratia & special payments	294	19
Other services, eg external payroll	4,307	1,092
Other	1,133	676
Total	**335,810**	**323,421**
Of which:		
Related to continuing operations	335,810	323,421
Related to discontinued operations	-	-

(*) Audit fees are inclusive of VAT

Note 6.2 Other auditor remuneration

No other External Auditor remuneration was paid during the 2021/22 financial for work over and above the statutory audit fee.

Note 6.3 Limitation on auditor's liability

Mazars LLP are appointed by the Trust as their External Auditors; their limitation of liability is unlimited.

Note 7 Impairment of assets

	2021/22 £000	2020/21 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	7,022
Total net impairments	**-**	**7,022**

In 2020/21, the Trust's assets were subject to a full revaluation which resulted in impairment costs for that year.

Note 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	166,596	165,265
Social security costs	16,915	15,532
Apprenticeship levy	829	767
Employer's contributions to NHS pensions	27,918	26,255
Pension cost - other	97	87
Temporary staff (including agency)	16,030	12,752
Total staff costs	**228,385**	**220,658**
Of which:		
Costs capitalised as part of assets	(452)	(221)
Costs relating to Research and Development	(394)	(287)
Redundancy costs	(53)	-
	227,486	**220,150**

Note 8.1 Retirements due to ill-health

During 2021/22 there were no early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is 0k (£165k in 2020/21).

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

Note 9 Operating leases

Note 9.1 The Rotherham NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where The Rotherham NHS Foundation Trust is the lessor.

The leases held by the Trust relate to various retail facilities provided at the General Hospital site, and land used for parking.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	462	427
Total	**462**	**427**

31 March 2022	**Land £000**	**Buildings £000**	**Other £000**	**Total £000**
Future minimum lease receipts due:				
- not later than one year;	-	470	-	470
- later than one year and not later than five years;	-	1,593	-	1,593
- later than five years.	-	5,571	-	5,571
Total	**-**	**7,634**	-	**7,634**

31 March 2021	**Land £000**	**Buildings £000**	**Other £000**	**Total £000**
Future minimum lease receipts due:				
- not later than one year;	-	457	-	457
- later than one year and not later than five years;	-	1,672	-	1,672
- later than five years.	-	5,999	-	5,999
Total	**-**	**8,128**	-	**8,128**

Note 9.2 The Rotherham NHS Foundation Trust as a lessee

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

The Trust has operating leases for items of medical and non-medical equipment, vehicles and property lets used to carry out service provision.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	2,182	2,021
Total	**2,182**	**2,021**

31 March 2022	**Land**	**Buildings**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Future minimum lease receipts due:				
- not later than one year;	-	1,897	201	2,098
- later than one year and not later than five years;	-	7,537	330	7,867
- later than five years.	-	5,264	-	5,264
Total	**-**	**14,698**	**531**	**15,229**

31 March 2021	**Land**	**Buildings**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Future minimum lease receipts due:				
- not later than one year;	-	1,533	488	2,021
- later than one year and not later than five years;	-	4,599	1,464	6,063
- later than five years.	-	-	-	-
Total	**-**	**6,132**	**1,952**	**8,084**

Note 10 Finance income

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

	2021/22 £000	2020/21 £000
Interest on bank accounts	18	3
Total finance income	**18**	**3**

Note 11.1 Finance expenditure

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

	2021/22 £000	2020/21 £000
Interest expense:		
Loans from the Department of Health and Social Care	333	364
Finance leases	202	242
Interest on late payment of commercial debt	-	1
Main finance costs on PFI and LIFT schemes obligations	87	-
Total interest expense	**622**	**607**
Unwinding of discount on provisions	(14)	(10)
Total finance costs	**608**	**597**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2021/22 £000	2020/21 £000
Amounts included within interest payable arising from claims made under this legislation	-	1

Note 12 Other gains / (losses)

	2021/22 £000	2020/21 £000
Gains on disposal of assets	3	-
Losses on disposal of assets	(36)	-
Total other gains / (losses)	**(33)**	**-**

Note 13 Discontinued operations

No services were discontinued in either the 2021/22 or 2020/21 financial years.

Note 14.1 Intangible assets - 2021/22

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**19,550**	**151**	**19,701**
Additions	1,293	-	**1,293**
Reclassifications	151	(151)	**-**
Valuation / gross cost at 31 March 2022	**20,994**	**-**	**20,994**
Amortisation at 1 April 2021 - brought forward	**11,411**	**-**	**11,411**
Provided during the year	1,309	-	**1,309**
Amortisation at 31 March 2022	**12,720**	**-**	**12,720**
Net book value at 31 March 2022	**8,274**	**-**	**8,274**
Net book value at 1 April 2021	**8,139**	**151**	**8,290**

Note 14.2 Intangible assets - 2020/21

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2020	**18,990**	**-**	**18,990**
Additions	754	151	**905**
Reclassifications	(194)	-	**(194)**
Valuation / gross cost at 31 March 2021	**19,550**	**151**	**19,701**
Amortisation at 1 April 2020	**10,063**	**-**	**10,063**
Provided during the year	1,430	-	**1,430**
Reclassifications	(82)	-	**(82)**
Amortisation at 31 March 2021	**11,411**	**-**	**11,411**
Net book value at 31 March 2021	**8,139**	**151**	**8,290**
Net book value at 1 April 2020	**8,927**	**-**	**8,927**

Note 15.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**6,450**	**108,223**	**16,708**	**29,899**	**218**	**8,797**	**393**	**170,688**
Additions	-	5,978	3,015	2,914	43	1,832	-	**13,782**
Revaluations	-	2,290	-	-	-	-	-	**2,290**
Reclassifications	-	14,723	(16,708)	325	-	1,660	-	**-**
Disposals / derecognition	-	-	-	(292)	(52)	-	-	**(344)**
Valuation/gross cost at 31 March 2022	**6,450**	**131,214**	**3,015**	**32,846**	**209**	**12,289**	**393**	**186,416**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**-**	**-**	**15,394**	**212**	**3,559**	**132**	**19,297**
Provided during the year	-	4,599	-	2,412	3	1,194	39	**8,247**
Revaluations	-	(4,372)	-	-	-	-	-	**(4,372)**
Disposals / derecognition	-	-	-	(252)	(52)	-	-	**(304)**
Accumulated depreciation at 31 March 2022	**-**	**227**	**-**	**17,554**	**163**	**4,753**	**171**	**22,868**
Net book value at 31 March 2022	**6,450**	**130,987**	**3,015**	**15,292**	**46**	**7,536**	**222**	**163,548**
Net book value at 1 April 2021	**6,450**	**108,223**	**16,708**	**14,505**	**6**	**5,238**	**261**	**151,391**

Note 15.2 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April	**6,450**	**110,943**	**4,556**	**20,065**	**217**	**5,493**	**403**	**148,127**
Additions	-	8,049	15,750	9,233	-	2,613	-	**35,645**
Revaluations	-	(13,266)	-	-	-	-	-	**(13,266)**
Reclassifications	-	2,497	(3,598)	613	1	691	(10)	**194**
Disposals / derecognition	-	-	-	(12)	-	-	-	**(12)**
Valuation/gross cost at 31 March 2021	**6,450**	**108,223**	**16,708**	**29,899**	**218**	**8,797**	**393**	**170,688**
Accumulated depreciation at 1 April 2020	**-**	**9,349**	**-**	**13,335**	**209**	**2,841**	**93**	**25,827**
Provided during the year	-	4,667	-	1,946	3	758	40	**7,414**
Impairments	-	7,022	-	-	-	-	-	**7,022**
Revaluations	-	(21,039)	-	-	-	-	-	**(21,039)**
Reclassifications	-	1	-	122	-	(40)	(1)	**82**
Disposals / derecognition	-	-	-	(9)	-	-	-	**(9)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**15,394**	**212**	**3,559**	**132**	**19,297**
Net book value at 31 March 2021	**6,450**	**108,223**	**16,708**	**14,505**	**6**	**5,238**	**261**	**151,391**
Net book value at 1 April 2020	**6,450**	**101,594**	**4,556**	**6,730**	**8**	**2,652**	**310**	**122,300**

Note 15.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	6,300	117,432	3,015	12,303	46	7,536	222	**146,854**
Finance leased	150	2,345	-	1,984	-	-	-	**4,479**
On-SoFP PFI contracts and other service concession arrangements	-	7,242	-	-	-	-	-	**7,242**
Owned - donated/granted	-	3,968	-	1,005	-	-	-	**4,973**
NBV total at 31 March 2022	**6,450**	**130,987**	**3,015**	**15,292**	**46**	**7,536**	**222**	**163,548**

Note 15.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	6,300	101,832	6,503	10,889	6	5,238	261	**131,029**
Finance leased	150	2,446	10,205	2,498	-	-	-	**15,299**
Owned - donated/granted	-	3,945	-	1,118	-	-	-	**5,063**
NBV total at 31 March 2021	**6,450**	**108,223**	**16,708**	**14,505**	**6**	**5,238**	**261**	**151,391**

Note 16 Donations of property, plant and equipment

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured ventilators and imaging equipment which it passed to NHS providers free of charge. The Trust received the following donated assets (from the Department of Health and Social Care):

	2021/22 £000	Capitalised £000	2020/21 £000	Capitalised £000
Donated imaging equipment	0	0	830	830
Donated ventilators	51	51	429	325
Total	**51**	**51**	**1,259**	**1,155**
Assets below the Trust's de-minimus level (charged to the I&E)		0		104
Total donated assets received in response to COVID-19 pandemic		**51**		**1,259**

Due to the value of some of the donated equipment being less than the Trust's de-minimus of £5k, these pieces of equipment were not capitalised and charged to the I&E.

Note 17 Revaluations of property, plant and equipment

A full 5 yearly cyclical valuation of the Trust’s estate was carried out during 2020/21. Following a full site inspection and review, the Trust’s independent qualified valuer, Clark Weightman, issued their report with a valuation date of 31 March 2021.

The report took account of changes in buildings cost indices, location factors and the effect of capital expenditure during the year. The report was completed in accordance with guidance issued by the Royal Institution of Chartered Surveyors (“RICS”) and gave an overall valuation of the Trust’s estate of £113.806million.

For 2021/22 a desktop exercise was conducted by Clark Weightman, who issued their report dated 31 March 2022. This represented an increase in the building cost index of 9.48% over the financial year.

Note 18 Investment Property

The Rotherham NHS Foundation Trust holds assets which are rented to other organisations and are not held for primary healthcare provision purposes. These are however deemed to support service provision and as such have not been categorised as Investment Property. They are the Lodge, the Creche and staff residencies.

Note 19 Investments in associates and joint ventures

In 2021/22, The Rotherham NHS Foundation Trust has no investments in associates and joint ventures, nor did it have in 2020/21.

Note 20 Other investments / financial assets (non-current)

In 2021/22 The Rotherham NHS Foundation Trust has no other investments or financial assets, nor did it have in 2020/21.

Note 21 Disclosure of interests in other entities

The Trust has considered the need to consolidate Charitable Funds (The Rotherham Hospital & Community Charity) within the main Trust accounts and concluded, although the Trust continues to meet the criteria within the accounting standard, the value of the Charitable Funds is not material and will not therefore be consolidated within the Trust's main accounts.

The table below summarises the Charitable Funds Statement of Financial Activities and Balance sheet.

	31 March 2022 £000	31 March 2021 £000
Total incoming resources	**79**	511
Resources expended	**(46)**	(425)
(Losses)/Gains on revaluation and disposals	**-**	18
Net movement in funds	**33**	**104**
Total Assets	**456**	632
Total Liabilities	**(3)**	(212)
Total Charitable Funds	**453**	**420**
Total funds made up of:		
- Restricted /endowment funds	**166**	122
- Unrestricted funds	**287**	298

The 2021/22 Charitable Funds accounts have not yet been subject to independent review. The 2020/21 Charitable Funds accounts were subject to independent examination and were finalised in December 2021.

Note 22 Inventories

	31 March 2022 £000	**31 March 2021 £000**
Drugs	1,036	927
Consumables	2,416	2,939
Energy	50	50
Total inventories	**3,502**	**3,916**

Inventories recognised in expenses for the year were £31,844k (2020/21: £23,805k). Write-down of inventories recognised as expenses for the year were £27k (2020/21: £343k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £859k of items purchased by DHSC (2020/21: £2,253k).

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

Note 23.1 Receivables

	31 March 2022 £000	31 March 2021 £000
Current		
Contract receivables	5,377	4,880
Allowance for impaired contract receivables / assets	(684)	(979)
Allowance for other impaired receivables	(33)	(37)
Deposits and advances	16	-
Prepayments (non-PFI)	3,139	2,476
PDC dividend receivable	-	248
VAT receivable	699	1,124
Other receivables	240	1,048
Total current receivables	**8,754**	**8,760**
Non-current		
Other receivables	373	52
Total non-current receivables	**373**	**52**
Of which receivable from NHS and DHSC group bodies:		
Current	2,835	2,845
Non-current	373	52

Note 23.2 Allowances for credit losses

	2021/22		2020/21	
	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	**979**	**37**	**498**	**19**
New allowances arising	192	9	321	21
Changes in existing allowances	-	-	393	-
Reversals of allowances	(159)	(6)	(233)	(1)
Utilisation of allowances (write offs)	(180)	(7)	-	(2)
Foreign exchange and other changes	(148)	-	-	-
Allowances as at 31 Mar 2022	**684**	**33**	**979**	**37**

Note 23.3 Exposure to credit risk

The level of allowance for credit losses (doubtful debts) is based upon analysis of the type of debtors and the age of the debt.

Note 24 Other assets

The Trust does not hold any other assets; all assets are shown under the appropriate balance sheet headings. This was the case at 31 March 2022, and 31 March 2021.

Note 25.1 Non-current assets held for sale and assets in disposal groups

At the 31 March 2022, the Trust did not have any assets that were held for sale, nor did it at 31 March 2021.

Note 25.2 Liabilities in disposal groups

At the 31 March 2022, the Trust did not have any liabilities in disposal groups, nor did it at 31 March 2021.

Note 26.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2021/22 £000	2020/21 £000
At 1 April	**30,910**	**1,367**
Net change in year	2,393	29,543
At 31 March	**33,303**	**30,910**
Broken down into:		
Cash at commercial banks and in hand	305	52
Cash with the Government Banking Service	32,998	30,858
Total cash and cash equivalents as in SoFP	**33,303**	**30,910**
Total cash and cash equivalents as in SoCF	**33,303**	**30,910**

Note 26.2 Third party assets held by the trust

At 31 March 2022 the Trust held no cash or cash equivalents which relate to monies held on behalf of patients or other parties, nor did it at 31 March 2021.

Note 27.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	12,596	9,769
Capital payables	4,392	6,206
Accruals	17,044	19,164
Social security costs	2,327	2,143
VAT payables	60	226
Other taxes payable	2,013	1,757
PDC dividend payable	17	-
Other payables	200	135
Total current trade and other payables	**38,649**	**39,400**
Of which payables from NHS and DHSC group bodies:		
Current	3,400	4,206
Non-current	-	-

The Trust had no non-current payables at 31 March 2022, nor did it at 31 March 2021.

Note 28 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	1,711	815
Total other current liabilities	**1,711**	**815**

The Trust had no non-current liabilities at 31 March 2022, nor did it at 31 March 2021.

Note 29.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	1,329	1,335
Obligations under finance leases	542	922
Obligations under PFI, LIFT or other service concession contracts	248	-
Total current borrowings	**2,119**	**2,257**
Non-current		
Loans from DHSC	12,750	14,000
Obligations under finance leases	3,779	14,142
Obligations under PFI, LIFT or other service concession contracts	7,038	-
Total non-current borrowings	**23,567**	**28,142**

Note 29.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**15,335**	**15,064**	**-**	**30,399**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,250)	(538)	(80)	**(1,868)**
Financing cash flows - payments of interest	(339)	(201)	(87)	**(627)**
Non-cash movements:				
Additions	-	-	581	**581**
Application of effective interest rate	333	201	87	**621**
Other changes	-	(10,205)	6,785	**(3,420)**
Carrying value at 31 March 2022	**14,079**	**4,321**	**7,286**	**25,686**

Note 29.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**84,452**	**4,018**	**-**	**88,470**
Cash movements:				
Financing cash flows - payments and receipts of principal	(68,709)	(737)	-	**(69,446)**
Financing cash flows - payments of interest	(773)	(244)	-	**(1,017)**
Non-cash movements:				
Additions	-	11,783	-	**11,783**
Application of effective interest rate	365	244	-	**609**
Carrying value at 31 March 2021	**15,335**	**15,064**	**-**	**30,399**

Note 30 Other financial liabilities

At the 31 March 2022, the Trust did not have any other financial liabilities to disclose; all liabilities held by the Trust are shown under the appropriate balance sheet headings. This was also the case at 31 March 2021.

Note 31 Finance leases

Note 31.1 The Rotherham NHS Foundation Trust as a lessor

The Trust does not have any finance leases where it is the lessor.

Note 31.2 The Rotherham NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2022 £000	31 March 2021 £000
Gross lease liabilities	**8,272**	**19,194**
of which liabilities are due:		
- not later than one year;	716	1,099
- later than one year and not later than five years;	1,809	3,795
- later than five years.	5,747	14,300
Finance charges allocated to future periods	(3,951)	(4,130)
Net lease liabilities	**4,321**	**15,064**

31 March 2022	**Land £000**	**Buildings £000**	**Other £000**	**Total £000**
Future minimum lease receipts due:				
- not later than one year;	-	17	525	542
- later than one year and not later than five years;	-	75	1,191	1,266
- later than five years.	-	2,513	-	2,513
Total	**-**	**2,605**	**1,716**	**4,321**

	-
Total of future minimum sublease payments to be received at the reporting date	
Contingent rent recognised as expense in the period	**-**

31 March 2021	Land	Buildings	Other	Total
	£000	£000	£000	£000
Future minimum lease receipts due:				
- not later than one year;	-	400	522	922
- later than one year and not later than five years;	-	1,603	1,595	3,198
- later than five years.	-	10,823	121	10,944
Total	**-**	**12,826**	**2,238**	**15,064**

Total of future minimum sublease payments to be received at the reporting date	-
Contingent rent recognised as expense in the period	-

The Trust holds finance leases for various pieces of medical and non-medical equipment.

The Trust also has two properties through finance leases which it uses to deliver services; these include Park Rehab and Breathing Space. Both properties are leased from NHS Property Services.

The Trust leases Breathing Space at a peppercorn rental; this was treated as a donated assets in 2020/21 when it was brought into the Balance Sheet. The lease for Breathing Space is due to expire 2031/32. The lease for Park Rehab will expire in 2067/68.

Note 32.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2021	**514**	**512**	**78**	**52**	**1,156**
Change in the discount rate	10	13	-	-	**23**
Arising during the year	35	42	83	3,550	**3,710**
Utilised during the year	(44)	(32)	(48)	-	**(124)**
Reversed unused	-	-	(13)	-	**(13)**
Unwinding of discount	(7)	(7)	-	-	**(14)**
At 31 March 2022	**508**	**528**	**100**	**3,602**	**4,738**
Expected timing of cash flows:					
- not later than one year;	45	32	100	3,229	**3,406**
- later than one year and not later than five years;	184	133	-	16	**333**
- later than five years.	279	363	-	357	**999**
Total	**508**	**528**	**100**	**3,602**	**4,738**

The Pensions (early departure) provision relates to the ongoing costs of making early payment of pensions. Legal claims relate to liabilities to third parties (administered by NHS Resolution). The main uncertainty in terms of the timing of the cash flows relates to the pensions provision as assumptions need to be made (in accordance with guidance) as to the estimated length of life of the pensioners and the consequent cost to the Trust. These are discounted per the guidance along with Injury Benefits provisions. At present there is no expectation that the Trust will receive any reimbursement in respect of these provisions.

Clinicians who are members of the NHS Pension Scheme and face an annual allowance tax charge for work undertaken in 2019/20 and thereafter can elect to have this charge paid by the NHS Pension Scheme. The employing Trust makes a contractually binding commitment to pay a corresponding compensated amount on retirement, therefore there is a future obligation upon retirement. This payment is nationally funded, therefore any provision recognised here is matched with a non-current receivable from NHS England.

The Trust has made provision during the year for potential legal claims; the Trust has made provision for expected costs based on third party advice. These are shown under 'Other Provisions.'

Note 32.2 Clinical negligence liabilities

At 31 March 2022, £137,903k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Rotherham NHS Foundation Trust (31 March 2021: £88,846k).

Note 33 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(40)	(29)
Employment tribunal and other employee related litigation	(150)	-
Gross value of contingent liabilities	**(190)**	**(29)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(190)**	**(29)**

Note 34 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	196	2,486
Total	**196**	**2,486**

Note 35 Other financial commitments

At 31 March 2022, there are no other financial commitments classed as other. This was also the case at 31 March 2021.

Note 36 On-SoFP PFI, LIFT or other service concession arrangements

Rotherham Foundation Trust enter into a 20-year Energy Saving Project agreement that supports third party investment in the energy provision infrastructure at the Rotherham General Hospital site. The contract for Energy Saving was procured through the Carbon & Energy Fund (CEF) framework. The service contract to enable energy savings across the Rotherham General Hospital site was signed on 12 December 2019.

The project involved significant investment in the hospitals energy infrastructure which will transfer the operational and financial risk to a third party with the intention of realising energy consumption reduction and a reduction in carbon emissions.

The Contract for the Energy Saving Project commenced 22 November 2021, following an installation period.

Note 36.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2022 £000	31 March 2021 £000
Gross PFI, LIFT or other service concession liabilities	**9,834**	**-**
Of which liabilities are due		
- not later than one year;	500	-
- later than one year and not later than five years;	2,000	-
- later than five years.	7,334	-
Finance charges allocated to future periods	(2,548)	-
Net PFI, LIFT or other service concession arrangement obligation	**7,286**	**-**
- not later than one year;	248	-
- later than one year and not later than five years;	1,123	-
- later than five years.	5,915	-

Note 36.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**21,514**	**-**
Of which payments are due:		
- not later than one year;	1,094	-
- later than one year and not later than five years;	4,376	-
- later than five years.	16,044	-

Note 36.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2021/22 £000	2020/21 £000
Unitary payment payable to service concession operator	**370**	**-**
Consisting of:		
- Interest charge	87	-
- Repayment of balance sheet obligation	80	-
- Service element and other charges to operating expenditure	203	-
Total amount paid to service concession operator	**370**	**-**

Note 37 Financial instruments

Note 37.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Currency risk

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

Interest rate risk

The Trust has low exposure to interest rate fluctuations as it has borrowings only from the Department of Health at fixed rates of interest.

Credit risk

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

Liquidity risk

The Trust's operating costs are incurred under annual service agreements with Clinical Commissioning Groups and Local Authorities, which are financed from resources voted annually by Parliament. The Trust finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Foreign currency risk

The Trust has negligible foreign currency income or expenditure.

Note 37.2 Carrying values of financial assets

Fair value is considered to equate to carrying value in the note below unless otherwise disclosed.

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	5,273	-	-	**5,273**
Cash and cash equivalents	33,303	-	-	**33,303**
Total at 31 March 2022	**38,576**	**-**	**-**	**38,576**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	4,964	-	-	**4,964**
Cash and cash equivalents	30,910	-	-	**30,910**
Total at 31 March 2021	**35,874**	**-**	**-**	**35,874**

Note 37.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	14,079	-	**14,079**
Obligations under finance leases	4,321	-	**4,321**
Obligations under PFI, LIFT and other service	7,286	-	**7,286**
Trade and other payables excluding non financial liabilities	34,232	-	**34,232**
Total at 31 March 2022	**59,918**	**-**	**59,918**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	15,335	-	**15,335**
Obligations under finance leases	15,064	-	**15,064**
Trade and other payables excluding non financial liabilities	35,274	-	**35,274**
Total at 31 March 2021	**65,673**	**-**	**65,673**

Note 37.4 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 2022 £000	31 March 2021 £000
In one year or less	37,000	37,955
In more than one year but not more than five years	9,712	9,821
In more than five years	21,442	24,090
Total	**68,154**	**71,866**

Note 38 Losses and special payments

	2021/22		2020/21	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	55	194	28	2
Stores losses and damage to property	12	28	12	15
Total losses	**67**	**222**	**40**	**17**
Special payments				
Compensation under court order or legally binding arbitration award	10	62	3	10
Ex-gratia payments	19	299	17	7
Total special payments	**29**	**361**	**20**	**17**
Total losses and special payments	**96**	**583**	**60**	**34**
Compensation payments received		-		-

Ex-gratia payments include £262k of one-off overtime corrective payments included as part of the Flowers Judgement.

Note 39 Gifts

During the 2021/22 financial year, the Trust did not receive any gifts, nor did it in 2020/21.

Note 40 Related parties

The Rotherham NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

The Trust is required, under International Accounting Standard 24 'Related Party Disclosures', to disclose any related party transactions. The objective of IAS 24 is to draw attention to the possibility that the reported financial position and results may have been affected by the existence of related parties and by material transactions with them. In the cases reported as related parties in year, all payments shown have been made by the Trust to the organisations concerned and not to the individual officers.

During the year the Trust entered into transactions with organisations with which key employees/directors of the Trust have some form of relationship (during 2020/21, the Trust had no related party relationship to disclose). Only those bodies outside the Department of Health & Social Care parent body, are detailed below and are not considered material.

	31 March 2022 Receipts from Related Party £000	31 March 2021 Receipts from Related Party £000	**31 March 2022 Payments to Related Party £000**	31 March 2021 Payments to Related Party £000
Royal College of Physicians	**0**	0	**44**	0
Marks and Spencer	**0**	0	**19**	0
Magna Enterprises Ltd	**0**	0	**2**	0
Total related party transactions	**0**	0	**65**	0

During the 2021/22 the following transactions were recorded as related parties, where a member of the Board was either related a person or persons employed by the organisation, is a Trustee or Director of the Board, or a member of the organisation:

£44k expenditure was incurred with the Royal College of Physicians on a clinical record and service review within the Gastro section.

£19k expenditure with Marks and Spencer was incurred to purchase vouchers for staff as an incentive to fill out the annual staff survey; Each member of staff was given a gift voucher totalling £4.00.

£2k was spend on a deposit with Magna to hold a Trust event; this event was subsequently cancelled due to COVID.

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures. The Government Accounting Manual interprets this such that Department of Health and Social Care group bodies must disclose the Department of Health and Social Care as the parent department and provide a note of the main entities within the public sector with which the body has had dealings. During the year, the Trust has had a significant number of material transactions with other entities within the public sector. These entities are listed below:

- Rotherham Metropolitan Borough Council
- Her Majesty's Revenue and Customs (HMRC)
- NHS Pension Scheme

Note 41 Transfers by absorption

There have been no transfers by absorption during the 2021/22 financial year, nor were there any in 2020/21.

Note 42 Prior period adjustments

There have been no transfers by absorption during the 2021/22 financial year, nor were there any in 2020/21.

Note 43 Events after the reporting date

There are no events after the reporting date at the point at which these accounts were approved on 20 June 2022.

Acknowledgements

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NHS