



The Rotherham  
NHS Foundation Trust



*The Rotherham NHS Foundation Trust*

# *Annual Report and Accounts*

## *2020/21*



**Ambitious  
Caring  
Together**



# **The Rotherham NHS Foundation Trust**

## Annual Report and Accounts 2020/21

Presented to Parliament pursuant to Schedule 7,  
paragraph 25 (4) (a) of the National Health Service Act 2006



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# Welcome from the Chairman

**2020/2021 will be a year that everyone remembers because of the COVID-19 pandemic. This document, The Rotherham NHS Foundation Trust's Annual Report and Accounts for 2020/21, 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.**

In February 2020 we welcomed Dr Richard Jenkins as our Interim Chief Executive, a joint position he holds with Barnsley Hospital NHS Foundation Trust. During the year we extended Richard's secondment with the Trust and we appointed Michael Wright as our substantive Deputy Chief Executive.

The year has been dominated by COVID-19, which has had a massive impact on our plans, our services, our colleagues, our patients and the community we serve. We often say our people are our greatest asset and this year they have proven it time and time again and I would like to congratulate and thank my colleagues across the Trust, in the hospital and the community, for their hard work and dedication in such unprecedented circumstances.

I would also like to thank the people of Rotherham and the public across the country for the overwhelming support shown towards the NHS. We have received many generous donations for staff and patients through our Rotherham Hospital and Community Charity, including our Rotherham NHS Superheroes campaign, which has raised over £24,500 since it launched in April 2020.

In response to the pandemic, we have changed and adapted to new ways of working so that we can continue providing 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.

In July 2020 we welcomed inspectors from the Care Quality Commission (CQC) who carried out an unannounced, focussed inspection on the children's safeguarding pathway through the Urgent and Emergency Care Centre (UECC) and our Family Health services. We were pleased that the inspectors found improvements had been made since the previous UECC inspection in August 2019, and identified where further work is still required. We were also asked to make further improvements in the inspected areas. As this was a focussed, short notice inspection, the services inspected were not rated and our overall Trust CQC remains as 'Requires Improvement'. We still have improvements to make and we have plans in place which are being implemented.

During the year we have improved our financial position and governance but achieving financial sustainability is a continuing challenge.

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 to provide more effective services to patients.



The Trust is a partner in the South Yorkshire and Bassetlaw Integrated Care System (ICS) which continues to develop and system working is the key focus of the Government's recent white paper.

Staff engagement has been one of our key priorities in 2020/21 and the national staff survey results announced in February this year show our Trust as the third most improved acute trust nationally. We have also focussed on the wellbeing of our colleagues, especially given the challenges of the COVID-19 pandemic, by putting a number of programmes of support in place.

Our apprentices, based in departments across our services, have had some fantastic achievements with a number of them receiving local and regional awards. Our midwifery team were named as runners up in the 'Maternity Service of the Year' category in the Royal College of Midwives annual awards in May 2020, while one of our midwives was runner up in the 'Midwives' Midwife of the Year' category. We were also proud that one of our colleagues was named in the New Year Honours list, receiving the British Empire Medal (BEM) for services to the NHS during the COVID-19 pandemic.

Even though we were unable to have our usual celebrations, we held our annual Proud Awards in November. The virtual ceremony was streamed live on our YouTube channel, with 13 teams and individuals being recognised for their contributions to the Trust and the NHS.

Our Trust has had an important role in the vaccination programme, efficiently and effectively vaccinating our colleagues, care staff and local authority staff across Rotherham. We are now able to plan for the challenge of recovering our services to address the significant waiting lists that have increased during the year.

Looking forward we have started the process of producing our next five year strategy and we will be consulting with our partners and stakeholders before presenting the new strategy in September 2021.

This year has been extremely challenging but our colleagues, working in the community and in the hospital have been remarkable in the way they have continued to care for our patients. As a Board of Directors, we are very proud of them.

Best wishes,

A handwritten signature in black ink that reads 'Martin Havenhand'. The signature is written in a cursive style.

Martin Havenhand  
**Chairman**



Fractures

Clinic

Reception

Nurses' Day

THANK YOU





## Performance Report

### Overview of Performance

The purpose of the overview is to provide a short summary with sufficient information to enable the reader to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year. It is a short summary which draws together information from across the Annual Report and Accounts to provide a holistic view of the organisation and its performance during the year.

#### Introduction to The Rotherham NHS Foundation Trust

In 2005 The Rotherham NHS Foundation Trust was established pursuant to section 6 of the Health and Social Care (Community Health and Standards) Act 2003. Prior to 2005 the Trust was Rotherham General Hospitals NHS Trust. The sector regulator for Foundation Trusts is NHS Improvement<sup>1</sup> and the Care Quality Commission (CQC) regulates the quality of the services the Trust provides.

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

We serve a population of 264,700 of whom 19.5% is aged over 65 and 21.6% is aged 0 – 17.<sup>2</sup>

Rotherham's Black, Asian and Minority Ethnic (BAME) population is lower than the national average of 20% and was recorded as being 8.1% in the 2011 census. The Pakistani & Kashmiri community is the largest in Rotherham at 3.1% of the population. 'Other – white' is recorded as the second largest community (at 1.3% of the population) of whom the largest constituent community identified as being Slovak and Czech Roma. 91.9% of the Rotherham population identified as being 'White British'.

A report received at the Health Select Commission in September 2020 detailed the progress made in Rotherham since the Marmot review of health inequalities in 2010<sup>3</sup>. Some of the headlines included:

- Rotherham is one of the 20% most deprived districts/unitary authorities in England and has moved up the rankings in terms of deprivation according to the 2019 Indices of Deprivation findings.
- Life expectancy remains below the national average and inequalities are widening between the most and least deprived communities within Rotherham, particularly for women.
- Life expectancy is 9.9 years lower for men and 9.5 years lower for women in the most deprived areas of Rotherham than in the least deprived areas.

<sup>1</sup> Since April 2019 NHS Improvement and NHS England have been working together as a single organisation referred to in this document as NHS England / Improvement.

<sup>2</sup> Source: Rotherham Joint Strategic Needs Assessment (Resident Population) March 2020

<sup>3</sup> Source: HWBB REFRESH - tackling health inequalities located at: last accessed 26 April 2021

- Men in Rotherham can expect to have a disability free life expectancy of 57.9 years and women 56.3 years, compared to a national average of 62.9 years and 61.9 years respectively.

The Trust has 379 beds and circa 4300 whole time equivalent members of staff who provide a comprehensive range of services to the population of Rotherham as well as some specialised services across South Yorkshire and nationally.

### **Purpose and Activities of The Rotherham NHS Foundation Trust**

The Trust is registered with the Care Quality Commission (CQC) to provide the following legally regulated services:

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

The majority of acute services are provided at the Trust's Moorgate Road site (Rotherham General Hospital), 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.

The Rotherham NHS Foundation Trust has a divisional management structure to coordinate and deliver healthcare services. This is done through six Clinical Divisions each of which is led by a clinical Divisional Director. These are:

- Integrated Medicine
- Family Health
- Surgery
- Clinical Support Services and
- Urgent and Emergency Care
- Community (this sixth division was established during 2021/22)

Additional services covering Health Informatics, Estates and Facilities, Strategy and Planning, Workforce and Finance are provided through a corporate divisional structure each of which is led by a Director or Executive Director.

The Trust also provides care in partnership with other providers, including the third sector. This includes, but is not limited to:

- The Barnsley and Rotherham Integrated Laboratory Services (BRILS) which provides an integrated pathology service across the two Trusts
- A joint contract with Mesmac, one of the oldest and largest sexual health services in the country, to provide sexual health services within Rotherham
- A joint ENT on call rota with Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust to cover emergency care across the region and

- An Integrated Discharge Team which is run in collaboration with Rotherham Metropolitan Borough Council.

Additionally, the Trust has a number of pathways which are co-delivered with local specialist Trusts including Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's Hospital NHS Foundation Trust. This includes services such as those for Hyper Acute Stroke and complex cancer treatments.

The Trust is also part of the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS). The SYB ICS is one of the most developed integrated care systems within the country and continues to support collaborative working across organisations within the system. One of the developments within the ICS is the establishment of five 'hosted networks' across the five acute providers: Rotherham, Barnsley, Sheffield, Sheffield Children's and Doncaster and Bassetlaw Hospitals. The Trust leads the Maternity Hosted Network and will continue to develop this work over the next few years as the role of the network continues to mature.

As an organisation, the Trust continues to play a leading role in Place-based working with partners across the Rotherham Integrated Care Partnership (ICP). This has led to national awards in a number of areas, recognising the progress made across health and social care.





## Chief Executive's Statement

The Trust and the NHS have undoubtedly faced the most challenging year in their history. The COVID-19 pandemic impacted on every NHS service and required changes to the way that they were delivered. Our staff, have continued to deliver healthcare throughout the year at a time when the Trust was one of the most severely COVID-19 affected hospitals in the country. Every day, colleagues went above and beyond to make a massive difference to patients, families, in community settings and the hospital, frontline and corporate areas. The speed at which the Trust was able to implement the required new ways of working, and our colleagues' ability to cope with a quickly changing environment was, and has remained, inspiring.

During the final few months of 2020/21, a number of our colleagues rapidly established our COVID-19 vaccination centre at our Old Greenoaks site. By the end of March 2021 10,667 colleagues had received a vaccination, administered not only to our own staff, but also to other health and care colleagues.

The achievement of national targets both across the wider NHS and at the Trust was severely impacted by the pandemic. At the height of the second wave of COVID-19, 35% of our inpatient bed base was occupied by inpatients suffering from COVID-19. In the twelve month period from April 2020 to March 2021, the Trust cared for 2,532 inpatients with COVID-19.

Whilst the year was clearly dominated by the pandemic, the Trust achieved success in several key areas. The following paragraphs touch on both areas where the Trust encountered challenges during the year, but also areas where there were tangible improvements that should be celebrated.

We increased the number of critical care beds from 13 to 22 by creating a separate unit adjacent to the main unit; we developed a standalone non-COVID resuscitation unit within our Urgent & Emergency Care Centre and ward staff supported patients by creating COVID-19 specific wards.

The diagnostic waiting time target, which aims to support patients receiving their diagnostic test within six weeks, has traditionally been a standard the Trust has reliably achieved. However, along with a number of other standards we did not deliver against this performance measure during 2020/21 with all specialities reducing planned activity to support emergency COVID-19 services.

The cancer service team had spent a great deal of time over the previous year decreasing the Patient Tracking List (PTL) from in excess of 1,000 patients to 700 patients by the end of 2020. Unfortunately the first phase of the pandemic meant we had to modify our cancer services to support emergency patients. This resulted in the numbers on the waiting list going back up to the previous year's numbers of over 1000.

We have since recommenced the majority of our cancer services, although the need to socially distance, allow time between patients, and the reduction in face-to-face appointments has meant we have lost a lot of our normal capacity. In order to counter this teams have staggered appointments, undertaken a significant number of phone and video consultations, and reviewed all patients on the PTL to ensure anyone who needs treatment can get it as soon as possible.

The main cancer standard of 62 days to treatment from referral also deteriorated as predicted with only 60% of patients seen against a national target of 85%. Further work is taking place to improve this position as we recover from the pandemic.

Given that we have been a field test site for the proposed new A&E standards during 2020/21, we are unable to compare our urgent care performance against some of the well-known national indicators, such as the 4-hour access target. Nevertheless, we continued to track our performance through existing indicators and the new pilot measures.

Length of time spent in A&E by our patients is an issue that the Trust has been focused on; having seen a number of 12-hour trolley breaches during the previous year (2019/20). This year we have seen a marked reduction in patients waiting for long periods with no patients reported as waiting over 12 hours from a decision to admit (compared to 27 in 2019/20). The Trust has taken significant steps to address this position, a number of which were influenced by the pandemic and the requirements to stream COVID-19 and non-COVID-19 patients. We have also dramatically reduced our ambulance handover times.

Clearly there is a lot of work to be undertaken, and as we move out of this phase of the pandemic and plan for the next phases we will continue to strive to ensure that services are improved and patients and their families receive the care they need. The Trust has an improvement plan in place and will continue to further improve the quality and performance of Urgent and Emergency services and the care of our inpatients.

The Trust continues to strive to deliver the highest quality of compassionate, patient-centred and harm-free care as possible, and to continue its improvement journey. Whilst this has been challenging during the COVID-19 pandemic, the Trust has seen a number of positive improvements. The fundamentals of care will be a key objective for 2021/22.

The Trust will continue its proactive engagement in the national 'Get It Right First Time' (GIRFT) programme, for which the Trust has one of the best reputations for improvement and engagement in the whole of Yorkshire and the Humber.

The Trust's mortality scores (HSMR and SHMI) continue to be significantly higher than the national average and mortality will therefore continue to be a key improvement priority for the Trust and the Trust's Medical Director throughout 2021/22. The impact of COVID-19 on death rates has made it difficult to measure the effect of the work the Trust has done in this area but there has been recent evidence of a fall in underlying mortality rates.

We will continue to ensure that we fully understand and address the drivers of this performance, focussing on the '3C's' of quality of Care; Case mix; and Coding, and will continue monthly reporting to the Trust's Clinical Governance Committee, Safe & Sound Mortality Group, Quality Committee, and the Board of Directors.

The Trust has made progress on key patient flow initiatives throughout 2020/21, such as the 'SAFER flow bundle', but key work streams will continue to focus on flow throughout 2021/22, supported by a new, central Command Centre which will be fully integrated into the Trust's IT systems. Such patient flow initiatives will also be supported by the introduction and embedding of new 'Safe & Sound Ward Round and Acute Assessment Standards' and 'Safe & Sound Discharge Standards'.

As stated previously, our workforce has responded fantastically to the management of the pandemic. During the year we launched our Trust's People Strategy, which has a core theme of the importance of the health and wellbeing of our people. During 2020/21, we took part in the National Staff Survey exercise and achieved the highest response rate that the Trust has ever achieved. In addition, when published the results demonstrated that the Trust is the third most improved in the country. Whilst accepting that we are on a journey of improvement, the survey results were really positive and give the Trust a strong platform from which to move forwards.

During 2020/21, the Trust also made improvements to financial governance which are now embedded. The Trust saw financial challenges particularly at the end of 2019/20. During 2020/21, the Trust over delivered against the financial plan by £8.126M, ending the year with a surplus of £0.473M against a planned deficit of £7.653M. Whilst this represents a significant achievement, the funding mechanisms in place during 2020/21 were amended to support the effective management of the pandemic. Funding was made available to ensure that the Trust could meet its obligations in responding to the pandemic.

The effective and efficient use of resources remains critical and central to our planning for 2021/22, and the risk to the financial sustainability of the Trust remains; and accordingly, we will need to manage this on a longer term basis, beyond 2021/22.

We continued to develop and build upon our Trust 5-year strategy, although the normal centrally-led annual planning processes for 2020/21 were paused when the pandemic started. As a result, for 2020/21, we had a condensed operational plan which became our key focus. The plan included a number of COVID-19 specific objectives which were a key focus throughout the year.

As we move forward into the recovery phase of the pandemic, we will take with us lessons learnt from this unprecedented period in the history of healthcare, and continue to apply our knowledge to making our services better and more sustainable for the population of Rotherham and beyond.



# 24 hour

Emergency care,  
Community services, GP and  
Primary Care services



Rotherham CCG  
fund approximately  
**87%**  
of the Trust's activity

**4,500**  
staff members

**21.8%**  
of children in Year 6 are  
classified as obese, worse  
than the average for  
England



**500**  
In-patient beds

**1,846**  
Alcohol-related hospital  
stays per year.  
Worse than the average for  
England.

Around  
**115**  
Volunteers

We serve a Rotherham  
population of around  
**265,000**

Average of  
**15**  
Home births  
per year

A summary of the principal risks faced and how these have affected the delivery of objectives, how they have changed, how they have been mitigated and any emerging risks that may affect future performance.

## Quality of Care

The Trust continues to strive to deliver the highest quality of compassionate, patient-centred and harm-free care as possible, and to continue its improvement journey towards a CQC rating of 'Good'. It will do this by living and breathing the Trust's Values of 'Ambitious', 'Caring' and 'Together'. The Trust will continue its proactive engagement in the national 'Get It Right First Time' (GIRFT) programme, for which the Trust has one of the best reputations for improvement and engagement in the whole of Yorkshire and the Humber.

The Trust will also continue its intense focus on improving its mortality rates and the learning from deaths by continuing the Mortality Improvement Group, chaired by the Interim Chief Executive and led by the Trust's Medical Director, until the Trust's HSMR is within the expected range. It will also continue to improve its learning from deaths by embedding divisional Safe & Sound Mortality Sub-Groups in the medical and surgical divisions, by ensuring robust local mortality and morbidity discussions and learning, and by introducing a new Associate Medical Director for Mortality and Learning from Deaths, along with a new Learning from Deaths Manager. Key learning will continue through the Trust's new '*Mortality Matters*' bulletin and Safety Bulletins.

## Workforce

The Rotherham NHS Foundation Trust recognises that having a stable, flexible and highly skilled workforce, with a broad range of skills across the differing professions, is key to delivering our ambition to be an outstanding Trust delivering excellent care at home, in our community and in hospital. It follows therefore, that having the right workforce with the right skills in the right place is one of the key risks to the organisation delivering its objectives.

During 2020/21, the Trust has made significant progress in addressing workforce vacancies across a range of different staff groups. In particular, the vacancy rate amongst our biggest staff group, nursing and midwifery, has reduced consistently over the year. In addition to recruiting from traditional sources, the Trust, working with colleagues across the Integrated Care System, has been successful in attracting international nurses. Work will continue in the coming year to continue to address workforce vacancies.

As we have seen improvements in our vacancy rates, we have also seen a significant reduction in our bank and agency expenditure that we will seek to maintain in the forthcoming year.

2020/21 has been one of the most challenging years faced by the NHS and The Rotherham NHS Foundation Trust as we responded to the COVID-19 pandemic. Throughout the year the staff of the Trust have responded magnificently to the challenges presented including expanding our critical care capacity to meet the increased number of COVID patients presenting at the Trust. We have also had to



significantly change working practices in the hospital and the community to ensure safe environments for both staff and patients. This has been done whilst maintaining urgent and emergency services. We have also delivered a successful and unprecedented COVID-19 vaccination programme, ensuring priority health and care staff across the wider Rotherham area received their vaccination.

Staff engagement was identified at the start of the year as a key priority for the Trust. Whilst the pandemic impacted across all of our services it was pleasing to see that our annual NHS staff survey results improved significantly: Rotherham was identified as the third most improved Trust in the country. In 2021/22 we will continue to build on this improvement and aim to improve staff engagement and satisfaction even further.

One of the lessons learnt during the pandemic response was the importance of supporting our staff particularly in relation to their health and wellbeing. We will also be working with other partners in our local Integrated Care System to ensure we have the right health and wellbeing offer for our staff.

During 2020/21 the Board of Directors approved our People Strategy which outlines four key themes for taking forward workforce initiatives, these are:

**Build** How we will build our workforce

**Engage** How we will engage with all our people

**Lead** How we will develop our leadership culture and nurture talent

**Learn** How we will ensure there are learning opportunities for all

The aim is to create a workforce that supports and sustains the delivery of high quality care and services combined with the ambition to be in the top 20% of NHS employers nationally for staff experience (by 2023) as measured by the national staff survey.

## Finance

The Trust's financial plan for the first six months 2020/21 was set at the time the national COVID-19 pandemic was in the first wave. Funding was made available to the Trust to ensure that services could be effectively delivered at a very challenging time. This covered the costs associated with managing the pandemic and normal operational activities. The second half of 2020/21 had a separate financial plan set which, when consolidated with the first half of the year, resulted in a planned deficit of £7.653M. The Trust lived within the financial envelope and actually achieved a year end surplus of £0.473M, which is £8.126M favourable to the original plan.

During the second half of 2020/21, the Trust did set a Cost Improvement Plan of £1,453k and delivered £1,821k.

## Operational Delivery

### Emergency Access

The Rotherham NHS Foundation Trust is taking part in the field test of the proposed new national standards, which the Trust is reporting separately to NHS England. As such, information about the field test is available from NHS England directly. In 2019/20 27 patients waited for longer than 12 hours following a decision to admit into the hospital, in the 2020/21 period no such waits occurred.

The organisation's journey of development this year has been to continue to embed effective discharge planning by ward teams with the development and roll out of the national 'right to reside' indicators and development of a team of ward based discharge coordinators.

Through 2021/22 we will maintain our focus on the importance of improving flow through the medical wards and Acute Medical Unit to support the Urgent and Emergency Care Centre. This includes 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 ongoing development of our operations hub integrated discharge and site management teams.

In response to the increased demands placed on the health service over the pandemic and the winter period, the Trust took part in the development of a system-wide Pandemic Plan and Winter Plan combined. This consisted of detailed 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 Trust's elective care activity was also reduced during the main pandemic and the busiest periods to support critical care and COVID-19 capacity for emergency admissions.

The Trust placed significant focus on the challenges posed by the pandemic and the winter with colleagues working closely with partner organisations. As described, the operational, medical and nursing teams coped admirably and we mitigated the acute pressures, and balanced the need for COVID-19 beds and increased critical care. At key times, we created additional 12-14 critical care facilities and beds, which over the pandemic were fully utilised.

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.

During the pandemic, the 18-week Referral to Treatment performance indicator was not achieved. From March 2020, we saw large numbers of cancellations of elective activity to create capacity for COVID-19 patients. We are now putting in place robust recovery actions over 2021/22 to treat all elective and diagnostic patients as soon as practicable.

## **Cancer Waiting Times**

Timely management of patients referred onto the cancer pathway is an important focus for the Trust. The organisation alongside all other NHS organisation modified cancer activity to deal with the pandemic during which we maintained urgent and life threatening services whilst refocusing and continuing to drive performance in two-week waits and breast screening.

During the last 12 months, the Trust was non-compliant with the 62-day standard of patients being treated following urgent referral from their GP.

The Trust continues to monitor performance against a 28-day cancer diagnosis standard, due for national implementation in 2021. Introducing the monitoring of this standard, which requires patients to be given a confirmed diagnosis within 28 days of referral, has helped identify opportunities for faster cancer pathways and 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, previously the Trust delivered 99% plus performance, however due to the pandemic this standard was not maintained during 2020/21. Performance should be recoverable throughout 2021/22.

## **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. A significant amount of focus has also been put into the Looked After Children service and working closely with Rotherham Metropolitan Borough Council on developing new approaches in order to deal with the changing demand that is being experienced across the borough.

## **Looking ahead to 2021/22**

The Trust's mortality scores (HSMR and SHMI) continue to be significantly higher than the national average and mortality will therefore continue to be a key improvement priority for the Trust and the Trust's Medical Director throughout 2021/22. We will continue to ensure that we fully understand and address the drivers of this performance, focussing on the '3C's' of quality of care; case mix; and coding, and will continue monthly reporting to the Trust's Clinical Governance Committee, Safe & Sound Mortality Group, Quality Committee, and the Board of Directors.

Another key area of focus will be embedding clinical standards, building on the Trust's 'Internal Professional Standards', by introducing both 'Safe & Sound Ward Round and Acute Assessment Standards' and 'Safe & Sound Discharge Standards'.

The Trust has made progress on key patient flow initiatives throughout 2020/21, such as the 'SAFER flow bundle', but key work streams will continue to focus on flow throughout 2021/22, supported by a new, central Trust Control Room, which will be fully integrated into the Trust's IT systems. Such patient flow initiatives will also be supported by the introduction and embedding of the new 'Safe & Sound Ward Round and Acute Assessment Standards' and 'Safe & Sound Discharge Standards' referred to above.

How we exit the COVID-19 pandemic will also be a key focus area for the Trust. It is essential that we support the health and wellbeing of our colleagues who have undoubtedly experienced the most challenging and traumatic working conditions in the history of the NHS. It is also critical that our recovery of elective activity is in line with the planned trajectories and that patient waits return to pre-pandemic levels

## Preparation of Accounts and Going Concern

NHS foundation trusts are required to prepare their accounts in accordance with the relevant accounting rules, which are set out in the International Financial Reporting Standards (IFRSs) and International Accounting Standards (IASs) as interpreted by Department of Health Group Annual Reporting Manual (GAM).

The requirement to prepare accounts on a going concern basis is set out in IAS 1 - Presentation of Financial Statements, which states:

‘An entity should prepare its financial statements on a going concern basis, unless:

- (a) The entity is being liquidated or has ceased trading; or
- (b) The directors have no realistic alternative but to liquidate the entity or to cease trading, in which circumstances the entity may, if appropriate, prepare its financial statements on a basis other than going concern.’

‘When preparing financial statements, directors should assess whether there are significant doubts about the entity’s ability to continue as a going concern’

In addition to the above, the Trust is also mindful of table 6.2 of the Government Financial Reporting Manual (FReM), which notes that:

*‘...the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.’<sup>4</sup>*

To comply with IAS 1 management must, in preparing the annual statement of accounts, undertake an assessment of the Trust’s ability to continue as a going concern. In making this assessment, management should take into account all information about the future that is available at the time the judgment is made.

As a minimum, this assessment should cover at least a 12-month period from the date of approval of the accounts, although this period will need to be extended where management is aware of events and related business risks further in the future that may cast doubt on the going concern assumption.

After making enquiries, the Directors have a reasonable expectation that the services provided by the 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.

<sup>4</sup> IAS 1 Presentation of Financial Statements (3), p. 38 *Government Financial Reporting Manual 2019/20*

However, the Trust recognises the challenges ahead including the existence of a material uncertainty in relation to the funding envelope associated with the second half 2021/22. It should be noted that the income available during the first half of 2021/22 has been agreed. Prior to the COVID19 pandemic, the Trust, had an underlying deficit which needs to be managed to improve financial sustainability.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and working capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £67.459M were paid off in the year. As the repayment of these loans was funded through the issue of PDC, this does not present a going concern risk for the Trust.

Also, see note 1 of the financial statements and the report from the Audit Committee detailing the significant issues considered by the Committee in relation to the financial statements as required by the Foundation Trust Code of Governance (provision C.3.9) in the Governance and Organisational Structure section of this Annual Report.



## 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 is a field test site for the proposed A&E standards for the last year of 2020/21, 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 involved a prolonged period of intensive work. The new standards require a different approach to managing patients in the UECC in particular, with patients requiring a different type of care to that of a department operating under a 4-hour target.

We have redesigned our IT systems to support the delivery of the different sets of standards which has involved a number of additional data submissions and engagement events for the organisation. We are in an excellent position to take advantage of our almost two years of piloting these standards, and have fed back to the national team as part of their consultation on NHS access standards for urgent and emergency care, the results of which will be released in the new financial year.

Our operational improvement journey has continued, with a continued 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 2020/21 there has been a continued 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.

In response to the increased demands placed on the health service by both the winter period and the pandemic, the Trust participated in the development of a system-wide Winter Plan in partnership with the Place (Rotherham) system.

This consisted of detailed 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 October 2020, and beds from the previous winter 2019 being maintained in the acute Trust. Additional beds were also provided by RMBC and the Clinical Commissioning Group (CCG) within the care and nursing home sector.

The Trust's elective care activity was reduced for most of the year and further reduced in mid-winter during the busiest periods for emergency admissions in December 2020 and January 2021. 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.

However, as described above, due to these challenges the number of patients waiting over 52 weeks for elective operations increased from 0 at the end of 2019/20 to almost 800 at its peak in 2020/21. The Trust continues to work closely with health and social care partners in Rotherham to reduce avoidable hospital admissions and avoid unnecessarily prolonged hospital stays.

### **18 Week Referral to Treatment Waiting Times**

During 2020/21, the organisation continued to monitor and manage elective pathways, with waiting list numbers improving significantly due to reductions in referrals. Capacity pressures and requirements to manage the pandemic will continue to be monitored and a full recovery action plan has been developed to mitigate risks, and ensure that the Trust returns to pre-COVID-19 levels of activity as soon as it is practical and safe to do so.



### **Cancer waiting times**

The timely management of patients referred onto a cancer pathway is, and has always been, an important focus for the Trust. During the pandemic the organisation, along with all NHS organisations, limited and reduced access to some diagnostics and treatment. We did review all patients on our waiting list to ensure all clinically urgent cancer patients were treated appropriately and recommended a number of diagnostic services as soon as we felt it safe to do so. Workforce challenges due to sickness and staff shielding led to some delays in key areas, and some reviews of our processes to ensure we treat patients safely slowed down our pre-COVID-19 processes. We have since reviewed these and commenced caring for cancer patients in a safe and sensible way: reducing numbers in waiting areas; increasing waiting area space and reducing the numbers of patients going through our services.

## **Mortality**

Mortality performance continued to be a key area of focus during 2019/20 and 2020/21. Unfortunately, however, the Trust continued to see a gradual deterioration in both its HSMR and SHMI throughout the first half of the year. As such, increased focus, attention and oversight was put in place, including the establishment of a new Mortality Improvement Group, chaired by the Interim Chief Executive, with the Medical Director as the Senior Responsible Officer.

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, the Medical Director has facilitated 'deep dive' reviews of deaths involving some key mortality alerts, in particular around pneumonia, chronic obstructive airways disease (COPD), and intestinal obstruction without hernia. This has all resulted in a sustained improvement in the 12-month rolling HSMR and SHMI throughout the last four months of 2020/21.

However, it is recognised that significant work and progress still needs to be made, in particular around improving the Trust's learning from deaths at all levels of the organisation.

Harm free care performance has remained good during the year, despite the COVID-19 pandemic, however reporting of this has been suspended. 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**

Patients experiencing delayed transfers of care and requirements to ensure reductions in people waiting for discharge have been met all year thanks to RMBC's and the CCG's response to the pandemic through increasing access to social services and designated community beds and facilities.

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.

## **How equality of service delivery to different groups has been promoted through the organisation**

The Rotherham NHS Foundation Trust produces an annual report in relation to the Public Sector Equality Duty (this can be found at [https://www.therotherhamft.nhs.uk/Equality\\_and\\_Diversity/Equality\\_and\\_diversity\\_monitoring\\_data/](https://www.therotherhamft.nhs.uk/Equality_and_Diversity/Equality_and_diversity_monitoring_data/) alongside all of the other equality data that the Trust is required to publish).

During 2020/21, there has been a significant focus on supporting more robust Equality Impact Assessment (EIA) of all new and revised Trust policies, with the Head of Equality and Diversity and the Engagement Inclusion Lead reviewing all



such documents and supporting policy authors to engage with relevant patient, public and third sector groups where appropriate. A new EIA Policy has been developed, and will be supported by a detailed toolkit to further strengthen this work.

In late 2020, the Trust redesigned its Friends and Family Test questionnaire to enhance its ability to collect and analyse patient satisfaction data by protected characteristics. Once data from this is available, it will be used to support service improvement and enhance outreach work.

During 2020/21, the Trust launched the NHS Rainbow Badge scheme, which is designed to show LGBT+<sup>5</sup> patients, visitors and staff that the wearer is a safe person to talk to about LGBT+ issues, and that the Trust is a safe space for LGBT+ people. This launch was supported by the launch of LGBT+ awareness training, which was created in collaboration with local LGBT+ charities and has so far been delivered to over 100 staff. The scheme has been publicised to the local community via articles on the Trust website and in local press, as well as at Rotherham (virtual) Pride 2020.

In July 2020, the Trust launched a scheme called *Call it Out, Work it Out*, which supports patients, visitors and staff to challenge and report instances of discriminatory behaviour on Trust premises. The scheme enables users to either report anonymously, or give their details if they would like feedback about action taken. As well as enabling the Trust to take action on specific incidents, the overall data from this scheme is analysed alongside other sources of information (such as Freedom to Speak Up reports) to identify areas of the Trust where underlying issues may exist and support targeted action, including listening events and further training.

During 2020/21 the Trust has significantly increased its work around public and patient engagement. A key example of this work has been with the deaf community. Work with this community has supported the Trust to identify issues with British Sign Language (BSL) interpretation services, which will be used to inform the re-tendering of interpretation services. This engagement has also been helpful in supporting the Trust to make adjustments to support communication with deaf patients during the COVID-19 pandemic, including via the use of Google Transcribe and the provision of portable clear screens to support communication without face masks whilst adhering to infection prevention and control protocols.

In late 2020, the Trust's Patient Information Group was re-formed, alongside a Patient Panel, which supports the work of the group to improve the quality and accessibility of patient information produced by the Trust. For more information about the Public Panel please see 'improvements in patient / carer information' in the Directors' Report section of this Annual Report.

The Trust has commissioned Accessable to review the accessibility of all clinical areas on the main hospital site and produce accessibility guides. This work has unfortunately been delayed due to the COVID-19 pandemic. During 2020/21, the Trust's relatively new Disability Staff Network has started to work in partnership with the Estates and Facilities team to identify areas of the Trust estate where there are



<sup>5</sup> Pertaining collectively to people who identify as lesbian, gay, bisexual, or transgender, and to people with gender expressions outside traditional norms, including nonbinary, intersex, and others including those questioning their gender identity or sexual orientation, along with their allies.

accessibility issues and resolve them. This has led to minor issues sometimes being resolved on the day of reporting.

During 2020/21, members of the Board of Directors attended a seminar on 'Understanding Privilege and Becoming Anti-Racist', led by the Head of Equality, Diversity and Inclusion. Following this, the Board committed to participating in a reciprocal mentoring programme, which will commence in partnership with the NHS Leadership Academy during 2021/22.

### **Modern Slavery Act**

The Trust's procurement process has been reviewed to ensure that human trafficking and modern slavery issues are considered at an early stage, requiring self-certification from potential suppliers that their supply chains comply with the law. We procure many goods and services through frameworks endorsed by the Cabinet Office and Department of Health & Social Care, under which suppliers such as Crown Commercial Services and NHS Supply Chain adhere to a code of conduct on forced labour.

We operate professional practices relating to procurement and supply, including a sustainable procurement policy which includes reference to the Modern Slavery Act. Additionally, we also undertake the following as part of approach to supplier and contract management:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes.
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials.
- Randomly request that the main contractor provide details of its supply chain, or compliance to the Modern slavery Act.
- Ensuring invitation to tender documents contain a clause on human rights issues.
- Ensuring our standard contract terms also contain clauses giving the Trust the right to terminate a contract for failure to comply with relevant labour laws.

All staff receive a comprehensive induction programme which includes information on, and guidance regarding, slavery and human trafficking and procurement staff attend regular training on changes to procurement legislation. The Trust also requires all staff to complete safeguarding courses, which cover obligations under the Act.

Performance Report signed by the Chief Executive in his role as Accounting Officer:



**Dr Richard Jenkins**  
**Interim Chief Executive**  
**11 June 2021**



## Accountability Report

### Directors' Report

This report is presented in the name of the directors of the Board of Directors who occupied the following positions during the year:

Name	Position	In year changes
Martin Havenhand	Chairman	
Richard Jenkins	Interim Chief Executive	
Michael Wright	Interim Deputy Chief Executive Deputy Chief Executive	To 31 October 2020 From 01 November 2020
Nicola Bancroft	Non-Executive Director	
Joe Barnes	Non-Executive Director and Senior Independent Director	To 31 March 2021
George Briggs	Chief Operating Officer	
Steven Ned	Joint Director of Workforce	
Heather Craven	Non-Executive Director	
Mark Edgell	Non-Executive Director	
Callum Gardner	Medical Director	
Lynn Hagger	Non-Executive Director and Vice Chair	
Rumit Shah	Non-Executive Director	
Stuart Diggles	Interim Director of Finance	From 14 November 2020
Mike Smith	Non-Executive Director	
Angela Wood	Chief Nurse	
<b>Directors who served during the year, but who had left before year-end</b>		
Simon Sheppard	Director of Finance	To 13 May 2020
Steve Hackett	Interim Director of Finance	From 14 May 2020 to 13 November 2020

Directors' biographies can be found within the Governance and Organisational Structure part of this Annual Report, together with details of Directors' attendance at Board and Board Committees.

#### *Directors' Register of Interests*

The Directors' Register of Interests is available to view on the Trust's website ([http://www.therotherhamft.nhs.uk/Corporate Governance Information/Our Board of Directors/](http://www.therotherhamft.nhs.uk/Corporate_Governance_Information/Our_Board_of_Directors/)) or by requesting a copy from the Company Secretary at the address below:

Ms Julie Dawes,  
Interim Company Secretary,  
General Management Department Level D,  
The Rotherham NHS Foundation Trust  
Moorgate Road,  
Rotherham  
S60 2UD

Under the NHS Act 2006, NHS Improvement has directed The Rotherham NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction.

The Directors are responsible for preparing the accounts on an accrual basis, which gives a true and fair view of the state of affairs of The Rotherham NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Directors are required to comply with the requirements of NHS Improvement's *NHS Foundation Trust Annual Reporting Manual 2020/21* and the Department of Health & Social Care's *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
- 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 Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Directors are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors consider that 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 Trust's performance, business model and strategy.

### **Cost Allocation and Charging Guidance**

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

### **Political Donations**

There are no political donations to disclose.

## 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 2020/21 the Trust paid 88.42% (by number) of all of its bills within the 30-day target.

	Number	Value £000's
<b>NON NHS</b>		
Total Bills Paid in Year	42647	103537
Total Bills Paid Within Target	38042	87482
<b>Percentage of Bills Paid in Target</b>	89.20%	84.49%
<b>NHS</b>		
Total Bills Paid in Year	2066	13623
Total Bills Paid Within Target	1495	8758
<b>Percentage of Bills Paid in Target</b>	72.36%	64.29%
<b>Total</b>		
Total Bills Paid in Year	44713	117160
Total Bills Paid Within Target	39537	96240
<b>Percentage of Bills Paid in Target</b>	88.42%	82.14%

In April 2020 the funding regime of the NHS was changed to help support NHS bodies deal with the financial pressures brought about by the COVID-19 pandemic, this saw the system of payments by result replaced by block funding arrangements during the 2020/21 financial year.

This availability, and greater certainty, around funding has helped the Trust achieve higher performance against the Better Payment Practice Code compared to previous years where the Trust has had to manage its cash flow to ensure sufficient liquidity.

In addition to the Better Payment Practice Code, the Trust has worked to the Procurement Policy Note 02/20, *Supplier Relief Due to COVID-19*, issued in March 2020 by the Cabinet Office, requiring contracting authorities (including the NHS) to ensure invoices submitted by suppliers were paid immediately on receipt, where undisputed.

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 2020/21 was £594.

## 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 2020/21.

### **Disclosures relating to NHS Improvement's Well-led Framework**

During 2020/21 the Trust received two inspections / reviews by the Care Quality Commission. In July 2020, concerns were raised about the safeguarding children pathway and in November 2020 in relation to quality of health care in the Acute Medical Unit and learning throughout the organisation. As a result, a Section 29A of the Health and Social Care Act 2008 warning notice was issued. Immediate actions were undertaken in response to both inspections and an ongoing action plan was developed for each issue. Assurance continues to be provided to the CQC in relation to addressing the concerns identified on a regular basis.

Further information relating to the CQC inspections can be found in the Annual Governance Statement section of this Annual Report.

There are no material inconsistencies between the Annual Governance Statement, Annual Report, the Trust's Corporate Governance Statement and reports from the Care Quality Commission.

### **Patient Care**

The Trust has had an exceptionally busy year due to the COVID-19 pandemic, which has put much of the Trust (both acute and community), as well as the wider NHS, under immense strain. Nevertheless, the Trust has still managed to progress a number of service developments that have positively impacted on patient care, such as the move of ophthalmology to the Rotherham Community Health Centre (RCHC); the introduction of new Purple Butterfly rooms on our Labour Suite and Gynaecology Ward, B11; and the creation of extra critical care surge capacity on two of our wards.

All Trusts monitor their mortality data in the form of a monthly Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Index (SHMI). HSMR provides a rolling 12-month picture of mortality data for a time period ending six months previously at the time of publishing, or 12 months previously in the case of SHMI. Unfortunately, the Trust saw a continued deterioration in both its HSMR and SHMI throughout the first half of the year. Whilst this is considered to be multi-factorial, particular focus continues to be given to making improvements around all of the '3C's' (quality of care; case mix; and coding).

Increased focus, attention and oversight of mortality and learning from deaths was implemented throughout the last financial year, including the establishment of a new Mortality Improvement Group, chaired by the Interim Chief Executive, with the Medical Director as the Senior Responsible Officer. This Group, supported by a new Mortality Analytics Group and the outputs of the Trust's Safe & Sound Mortality Group, has continued to identify key actions required around themes and trends and to drive

improvements around these '3C's'. Furthermore, the Medical Director has facilitated 'deep dive' reviews of deaths involving some key mortality alerts, in particular around pneumonia, chronic obstructive airways disease (COPD), and intestinal obstruction without hernia. This has all resulted in a sustained improvement in the 12-month rolling HSMR and SHMI throughout the last four months of 2020/21. However, it is recognised that significant work and progress still needs to be made, in particular around improving the Trust's learning from deaths at all levels of the organisation.

The Trust appointed its second Medical Examiner during 2020/21 and is in the process of fully recruiting to its Medical Examiner Officer team. The Medical Examiner has responsibility for reviewing all deaths and discussing the quality of care given to the patient prior to their death with the deceased patient's next-of-kin. Despite the impact of the COVID-19 pandemic, the Trust's Medical Examiners have still managed to review 100% of all deaths over several months of the last financial year. In addition, the Medical Examiner has a key role to play in helping the Medical Director improve the Trust's learning from deaths, although responsibility for this will transition from the Medical Examiner service to a new Trust Associate Medical Director for Mortality and Learning from Deaths (supported by a new Learning from Deaths Manager), during the first quarter of 2021/22.

The Trust has a monthly Safe & Sound Mortality Group, which reviews performance and learning from deaths, and which in turn reports into the Clinical Governance Committee (chaired by the Medical Director), as well as to the Trust's Mortality Improvement Group which is chaired by the Interim Chief Executive. This group is supported by a Mortality Analytics Group, which focusses on the analysis of the Trust's mortality data, with a view to further enhancing the learning from deaths.

Throughout 2021/22, there will be a continued focus on improving the Trust's learning from deaths, including by embedding Safe & Sound Mortality Sub-Groups within both the Medical and Surgical Divisions, as well as by enhancing local specialty Mortality & Morbidity (M&M) reviews and learning. The Trust will also continue to ensure that all deaths are reviewed via a Stage 1 review process within one month of death, and any deaths that are identified as requiring a more in-depth, Stage 2 (Structured Judgement Review or SJR) review, are completed via a multi-disciplinary review team within two months of death. The outputs, themes and learning from such reviews will feed in to the Trust's Safe & Sound Mortality Group, and also to the Trust's Organisational and Learning Action Forum (OLAF), which looks to further improve the triangulation of learning within the Trust.

In addition, all deaths involving patients with learning disabilities and all deaths going for a Coroner's investigation and / or inquest, continue to have a Stage-2 SJR review and are reviewed at the Trust's Serious Incident Panel, chaired by the Medical Director or Chief Nurse, to ensure that all appropriate learning is identified in a timely manner, such that the Trust can continuously improve the quality of care within the organisation.

As part of the Trust's Safe & Sound Quality Framework, for which the Chief Nurse and Medical Director are jointly responsible, the Trust has enhanced its senior leadership structure. This has included the appointment of a new Deputy Chief Nurse post for patient safety and quality and the appointment of a new Associate

Medical Director for human factors. The Medical Director has also reviewed his medical leadership structure and has appointed two new Deputy Medical Directors, one for Quality and the other for Professional Standards, along with a new Business Manager. These enhanced structures will increase oversight, leadership and clinical engagement across a number of quality domains, including patient safety, human factors and clinical engagement.

Throughout 2020/21, the Trust continued to focus on supporting the health and wellbeing of staff, and is in the process of introducing virtual Schwartz Rounds<sup>6</sup> to the organisation; such support will continue to be a key priority for the Trust as it starts to recover from the impact of the COVID-19 pandemic.

Following a successful pilot in 2019, the Trust rolled out electronic prescribing across all inpatient and outpatient areas throughout 2020, including to intensive care. The Trust is now starting to introduce community electronic prescribing, following a very successful pilot within the community continence service.

The Medical Director and Chief Nurse have introduced key new mandatory training e-learning for clinical staff, including sepsis training and medication management, and will continue to explore the introduction of Human Factors e-learning throughout 2020/21. Despite the COVID-19 pandemic, the Trust has continued to perform well for mandatory staff training (MaST), with all staff, including medical and dental staff, achieving the required national standards.

Following approval of the business case for a new, enhanced 24/7 Acute Response Team (ART), the Trust is in the process of introducing this to the hospital. The Trust has also approved business cases to significantly enhance the palliative care resource within the organisation. This will enable the Trust to provide an enhanced level of support to palliative patients, as well the roll out of more enhanced palliative care / end of life training for clinical staff, which has been identified as a key area for enhanced focus through the learning from deaths and complaints processes.

The Trust continues to hold a weekly 'Harm Free' meeting, chaired by the Medical Director and Chief Nurse, at which any quality issues and significant incidents are discussed and actions taken as appropriate. This meeting identifies any incidents which need further discussion at the Trust's weekly Serious Incident Panel. The Serious Incident Panel is chaired by the Medical Director and / or Chief Nurse, in conjunction with the Deputy Chief Nurse, Head of Patient Safety, Medical Examiner and Trust's Head of Legal Services.

The Trust now has a large cohort of colleagues trained in the investigation of serious incidents and is also looking to implement Human Factors training in 2021/22. The Patient Safety Team have now commenced the investigating well programme, in preparation for all changes that will be implemented through the national patient safety agenda in 2022.

<sup>6</sup> A group reflective practice forum which provides an opportunity for staff from all disciplines to reflect on the emotional aspects of their work

As at 31 March 2021, there were five serious incident reports overdue for completion. This has been a tremendous improvement from the previous year. The Deputy Chief Nurse for patient safety has implemented a number of changes in process, to ensure that all serious incident reports are completed in a timely manner and provided to patients and / or their families. This has meant that we are now able to provide outcomes for patients and / or their families, and to ensure that any necessary learning is acted upon without unnecessary delay. Patients and families are now engaged early in the reporting process and have the ability to discuss outcomes with the teams involved or the Patient Safety Team.

There is now a weekly patient safety bulletin that identifies the summary of any serious incident reports, what we have learnt as an organisation, and what we can do to try and avoid any further incidents happening in the future. This is shared Trust wide via the communications team and access to all historical bulletins is provided via the Trust's intranet site 'The Hub'.

There is also a weekly '5 in 5' bulletin produced by the Patient Safety Team, which is delivered to all staff via the communications team and which contains '5 key learning points in 5 minutes' briefings. The Patient Safety Team focus on any action points or learning from incidents, Datix<sup>7</sup> reports, complaints / concerns or new practice to ensure this is captured within the bulletin.

## **Service Improvements**

### **Health Informatics**

Using internal and national Digital Aspirant Programme capital the Trust has been able to significantly accelerate our digital capabilities and invest in providing solid digital foundations. The Trust procured IT solutions to transform how we produce clinic letters and send appointment letters to patients, new observation and point of care machines that directly connect into our Electronic Patient Record systems and electronic patient check-in systems.

In addition, a programme has been commenced to upgrade our telecommunications and IT storage systems and we have supported the Trust to respond to the COVID-19 pandemic by procuring and deploying hundreds of laptops, webcams and headsets to staff working from home or providing teleconsultations to patients.

### **Estate Improvements**

The 2020/21 capital programme was the largest estates capital funding allocation for several years. The pandemic hampered early progress with the mandated lockdown and resultant supply chain issues significantly limiting availability of resources and materials. Despite these challenges, the Estates and Facilities team has innovated to deliver the following schemes utilising significant levels of additional capital funding made available via Public Dividend Capital funding which enabled:

- UECC: new entrance, providing safe and socially distanced shelter for patients
- UECC: resuscitation suite partitioned to COVID-19-safe cubicles
- New discharge lounge, enabling significantly improved patient flow and UECC capacity improvement

<sup>7</sup> Datix is the software system used by the Trust to report incidents and to undertake risk assessments

- Improvements to the Intensive Care unit and adjacent Ward B6, creating additional capacity and improving electrical systems resilience
- Installation of a new lift at the Breathing Space community hub
- High risk backlog infrastructure funding for replacement of aging infrastructure.

The significant Carbon Energy Fund backed scheme to replace and upgrade the Combined Heat and Power Unit, boilers, heating and cooling infrastructure also commenced in January 2020. The £11.3m contract value is a significant investment in backlog maintenance reduction and reduction in the Trust's carbon footprint, enabling the Trust to make excellent progress towards Sir Simon Stevens 2040 NHS Net Zero carbon strategy.

### **Medical Equipment**

Due to receipt of £4.6M of additional national funding, the Trust's purchasing power was significantly boosted in year. Consequently, the Trust has been able to spend circa £6.0M on new and replacement medical equipment during the financial year.

This has been used directly in relation to equipment procured to support the response to the COVID-19 pandemic (£1.0M) and other essential equipment across clinical areas based upon a risk-assessment approach considering the age, reliability, maintenance costs, etc. of the Trust's equipment portfolio.

- Equipment procured in response to the pandemic included additional ventilators, ultrasound machines and blood gas analysers
- Risk-based assessment equipment included a range of items across numerous specialties but most significantly £2.6M for new and replacement endoscopy equipment which has helped the team to clear its backlog of patients that had built up as a result of the pandemic

In addition, the Trust also received a further £1.2M of equipment procured centrally by national procurement teams in direct response to the pandemic. This included additional ventilators as well as patient monitors, endoscopes and clinical imaging equipment. Ownership of these assets has been legally transferred to the Trust at 31 March 2021.

### **Monitoring improvements in the quality of healthcare**

Improvements in the quality of care, progress made against local and national targets, and the implementation of actions emanating from the Trust's CQC inspections, are all monitored at Trust-level by the Clinical Governance Committee (operational level committee), the Trust's CQC Delivery Group chaired by the Interim Chief Executive, and the Quality Committee (one of the Board Assurance Committees).

Furthermore, each of the Clinical Divisions also monitors the quality of care they provide, their achievement of local and national targets / key performance indicators (KPIs), and progress made against their actions in relation to the CQC inspections, at each of their own Divisional Governance meetings.

Board Assurance Committees seek evidence of performance and compliance, in order that they are able to provide assurance to the Board of Directors that quality objectives are being met. Such assurance has been enhanced throughout 2020/21

by the introduction of a new 'Chairs Log' from each Board Assurance Committee to the Board of Directors.

The Clinical Governance Committee, chaired by the Medical Director and supported by the Chief Nurse, is the highest level operational committee responsible for monitoring all aspects of the quality of healthcare the Trust provides. The Committee's work plan has been regularly reviewed and refined throughout 2020/21 to ensure that it continues to focus on all key areas relating to quality of care, and it has also continued to receive monthly updates from a number of sub-groups, including those relating to patient experience, patient safety, and clinical effectiveness.

### **Progress towards targets as agreed with local commissioners, together with details of other key quality improvements**

In 2020/21, the primary focus for the Trust has been managing the impact of the COVID-19 pandemic. In line with national guidance, the Commissioning for Quality and Innovation (CQUIN) schemes were stood down and therefore no information is available for inclusion in this year's Annual Report.

Despite the national and local quality requirements being relaxed from a contractual perspective, the Trust has continued to meet regularly with commissioners to discuss and review a range of key quality indicators. The Trust has sustained or made improvements in the following areas during 2020/21:

- *MRSA and C.difficile rates*
- *Reductions in Falls with Harm*
- *VTE Assessments*
- *Complaint response time*

The Trust has continued to embed its 'Safe and Sound' framework during 2020/21 following its launch last year. This approach embraces the ethos and growth of a learning culture, built up across the organisation through the use of continuous improvement techniques. Its principles bring together patient safety, clinical effectiveness and patient experience to put quality at the heart of everything we do. Each one of us has a part to play in improving the quality of patient care we provide and our Safe and Sound approach encourages collaborative working to facilitate and deliver positive improvements in quality.

### **Any new or significantly revised services**

The focus of work during 2020/21 has been dominated, and predominantly driven by, managing the impact of the COVID-19 global pandemic. It forced NHS providers of acute services to review and reconfigure many of their services to support ongoing provision to patients wherever possible. Throughout 2020/21 the Trust has:

- Redefined the acute bed base configuration to support the demands of the pandemic
- Introduced more effective streaming of patients attending UECC to allow their needs to be appropriately met in a safe and timely manner
- Increased its ability to flex critical care capacity
- Reviewed and enhanced the community based bed capacity to support the transfer of medically fit patients to a more suitable environment

- Introduced remote first and follow-up outpatient consultations through use of digital technology
- Updated respiratory pathways and reviewed requirement for managing long COVID
- Undertaken a review of the community diabetes service delivery model

The Trust has continued to progress the 'Digital by Default' agenda which is a significant contributing factor in allowing more innovative changes to clinical pathways to be considered.

### **Service improvements following staff or patient surveys / comments and CQC reports**

A number of service improvements have been undertaken as part of the Trust's Quality Priorities and following on from the Care Quality Commission (CQC) inspection and recommendations. During 2020, the CQC suspended all four of their national acute trust patient experience surveys however work has continued throughout this period to complete actions identified from previous patient surveys.

Following on from inspections by the Care Quality Commission, a number of actions have been undertaken to improve the quality of care across the organisation. This is monitored through a monthly group led by the Interim Chief Executive and has led to improvements across a range of services including Children's Safeguarding, Trust- wide governance processes and clinical care within the Acute Medical Unit.

### **Improvements in patient / carer information**

A 'sounding-board' for the Trust is being built: the 'Public Panel'. This will eventually consist of a large and diverse group of the public that will be able to input on the Trust's strategy, quality priorities and service developments as well as conveying general community feeling.

Within this Public Panel, there will be members of the public more interested in reviewing patient information, and documents coming through the re-established Patient Information Group (PinG), which reviews all patient leaflets prior to publication, will be circulated to these members of the Public Panel for comment. PinG aims to ensure that the Accessible Information Standard (AIS) is met for patients within the Trust. This is the means to be aware, to record the need and support all patients who require assistance with their communication when using health services.

Engagement has been undertaken with the deaf community and resulted in funding being approved to supply the Trust with clear screens to allow staff to remove their masks so that deaf or hard of hearing patients or carers can lip read. Approval has also been gained for the use of transcribing software for deaf or hearing impaired patients. Tablets, already used on wards to help patients communicate with loved ones, have also had this software installed prior to distribution. Video consultations can also be used to link with British Sign Language (BSL) interpreters where appropriate.

### **Information on complaints handling**

In the vast majority of cases patients, relatives and carers are satisfied with the care, treatment and services they receive. However, on occasions where they are

dissatisfied, it is important that they feel comfortable in raising their concerns so that the Trust can resolve any misunderstandings or failings and ensure that learning and improvements take place. As such the Trust recognises the importance of managing all concerns and complaints raised in a timely and effective manner and has a strong focus on improving patient experience. It is important to us that people find it easy to raise their concerns with us and that they feel their feedback is welcomed and dealt with at the earliest opportunity.

In the past we have encouraged face to face meetings between patients and staff. However, due the pandemic has meant these have been limited and either a written response or virtual meetings via Microsoft Teams have taken place. Local Resolution Meetings will resume once it is safe to do so.

NHS England and NHS Improvement released guidance on the local determination to support a system wide 'pause' of the NHS complaints process. This was proposed to allow all NHS health care providers, in all sectors to concentrate their efforts on their front-line duties and responsiveness to COVID-19.

However, the Trust's decision was to operate so far as possible, in line with the usual system for managing complaints, as we appreciate that any missed targets for responding reflects poorly on the Trust and we have continued to focus on the quality of our work whilst ensuring that they receive that response within the agreed timeframe

This work has resulted in the Trust's overall response rate reaching 100% over the last three quarters of the financial year. The Trust's achievement against the internally set target of responding to all new complaints within agreed timescales was 91.86% for the year.

## **Stakeholder relations**

### **Descriptions of significant partnerships and alliances**

The Trust is an active member of the Rotherham Together Strategic Partnership. We are also a member on the Rotherham Place Board working alongside Rotherham Metropolitan Borough Council, Rotherham Clinical Commissioning Group, Rotherham Doncaster and South Humber NHS Foundation Trust and Voluntary Action Rotherham.

Our aim is to provide the best possible services and outcomes for the Rotherham population and we are committed to a whole system partnership approach to optimise service provision, make best use of the Rotherham Health pound and future proof services making them sustainable in the long-term.

The Trust also operates within the South Yorkshire and Bassetlaw Integrated Care System (ICS) which is a partnership of 23 NHS and non-NHS organisations responsible for looking after the health and care of the 1.5 million people living across the region. The aim is similar to that described above of the Rotherham Place but working across a larger population to provide the benefits of partnership working to our patients.

The Trust has developed excellent working relationships with Connect Healthcare, the Rotherham GP Federation. We have continued to effectively deliver

Physiotherapy services within Practices, a service which has demonstrated benefits across the whole health community. Throughout 2020/21 we have continued to engage with the six Primary Care Networks within Rotherham, a collaborative of GPs working together to agree and deliver services on behalf of their geographical population.

The Trust continues to work in well-established partnerships with Doncaster & Bassetlaw Teaching Hospital NHS Foundation Trust for the delivery of ENT and Oral Maxillofacial services. Management of these services across the sites is embedded and has been in place for a significant number of years.

This year the Trust continued to provide a combined pathology service via the joint pathology partnership with Barnsley Hospital NHS Foundation Trust – Barnsley and Rotherham Integrated Laboratory Services (BRILS). BRILS serves a population of over 500,000 across both Barnsley and Rotherham

The Trust also has strong collaborative working relationships with Sheffield Teaching Hospitals NHS Foundation Trust for neurology, vascular and cardiology services and throughout 2020/21 we have been seeking to agree joint working arrangement with Barnsley NHS Foundation Trust in relation to gastroenterology.

Through a range of transformational developments, the Trust has continued to work very closely with Rotherham Metropolitan Borough Council and other health and voluntary sector organisations to support delivery of its overall vision.

### **Development of services involving other local services / agencies and involvement in local initiatives**

The Trust continues to work collaboratively with other services and agencies both in Rotherham and across the wider geographic area aligned to the Integrated Care System.

Within Rotherham we work with partner agencies including health, social care, mental health, primary care and private / charitable organisations. This provides excellent opportunities for delivering a full and rounded care package with agreed referral pathways understood by all organisations. This has proved successful in a number of areas including:

- Children's Services – 'Every Child Counts'
- Access to specialist stop smoking and alcohol services
- Developing the Integrated Point of Contact to incorporate other agencies
- Continued development of the clinical record across multiple platforms (within the remit of data protection legislation and regulation)
- Progression of the locality based model/hubs to deliver multi-disciplinary team working based around the patient

We continue to develop our locality based model enabling direct links to general practice teams. Regular multi-disciplinary case reviews of adult patients allow health, social and emotional needs to be identified and an individualised package of care to be established to support the patient.

As previously mentioned, during 2020/21 we have continued to work closely with Connect Healthcare, a Federation of General Practitioners in Rotherham coming together to identify how they can work more collaboratively to meet the needs of the local population. The model of Physio First has proved successful and is embedded within primary care practices. We continue to review other options for collaborative working, along with the Primary Care Networks to establish other potential areas that will benefit patients.

This multi-disciplinary, multi-agency approach brings significant benefits for patients in terms of continuity of care and allows valuable exchange of knowledge within and across organisations. This approach ultimately shapes and streamlines services to be patient focused, with the aim of improving clinical outcomes and providing a better patient experience.

The overall aim of the Trust is to provide the right service, by the right person, in the right place at the right time through embracing the Home First model and supporting Health Prevention and Lifestyle promotion schemes.

The demands and impacts of managing the COVID-19 pandemic throughout 2020/21 has necessitated an even greater emphasis on working as a whole system and supported greater collaboration and breaking down of barriers and boundaries to best meet the needs of our patients. This has benefitted both the patients in our care and colleagues working across The Rotherham NHS Foundation Trust, the Rotherham Clinical Commissioning Group and Rotherham Metropolitan Borough Council to ensure seamless services have been available to support responsive COVID-19 testing facilities and a successful vaccination programme.

### **Consultation with local groups and organisations**

During 2020/21 the Trust appointed a lead for Patient and Public Engagement and Inclusion and a baseline of patient and public involvement activity within the Trust was established. However, due to the pandemic some of the engagement groups and channels that were active in March 2020 have been put on hold. The Engagement and Inclusion Lead is now working with group leaders to plan for re-starting engagement activities.

The Engagement and Inclusion Lead has established links with a number of local organisations to drive future improvements. This includes Rotherham Clinical Commissioning Group, Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) and the Maternity Voices Partnership. The Engagement and Inclusion Lead is also working with the Health Inequalities Group within the local area to tackle health inequalities in Rotherham and has established good links with the local hearing impaired community.

A patient information repository has been established on the Trust's intranet site, The Hub, which displays key internal and external contacts and resources for reaching communities. Resources for colleagues will also be collated in this location over time.

A 'sounding-board' for the Trust is being built: the 'Public Panel'. This will eventually consist of a large and diverse group of the public that will be able to input on the Trust's strategy, quality priorities and service developments as well as conveying general

community feeling. The Trust's Governors are some of the first individuals to be recruited to the Public Panel, and will help to shape the format and structure of the group, ensuring maximum impact within the organisation. Within this Public Panel, there will be members of the public more interested in reviewing patient information, and documents coming through the Patient Information Group will be circulated to these people for comment.

In addition to this, the Engagement and Inclusion Lead will seek ways to give access to all, including vulnerable, marginalised or unheard groups and wider stakeholders, so that they are fully included in the establishment of Trust processes, clinical guidelines, service change and delivery leading to local confidence and strengthened loyalty to the services here in Rotherham, working with local community organisations.

The Trust seeks to always do justice to the efforts service users make to work with us, by committing to hear, act and feedback on suggestions for service development or transformation, responding positively and proactively to their feedback and reporting on what we have done as an organisation to ensure that we value this co-production.

Working with Healthwatch, we identified that some asylum seekers were finding it difficult to attend the Woodside pre-operative swabbing site. This has now been resolved and solutions to this are found on an individual basis dependent upon their situation.

The Rotherham NHS Foundation Trust recognises and values the benefits of engaging with the public, colleagues and partners to inform decision making. It is therefore always our intention to consult widely on matters affecting the public, in particular, in relation to service or provision redesign. Where large scale consultation is required, the Trust undertakes this in conjunction with partners.

In February 2021 the Trust presented its proposed Quality Priorities for 2021/22 to colleagues. This allowed all staff members to contribute to achieving these priorities and identify how they could be delivered to ensure that there is a continuous drive to improve the quality of care provided for our patients.

### **Public and patient involvement activities**

As a Foundation Trust, we held our Annual Members' Meeting in September 2020 for members of the public to hear about key developments. This was held virtually due to COVID-19 restrictions. At the meeting, the Board of Directors presented the Trust's Annual Report and Accounts for 2019/20, alongside the operational plan, future plans and priorities.

The monthly Board of Directors meeting, usually open and accessible to the public, has been held virtually throughout 2020/21 due to COVID-19 restrictions. Board papers have been made available on the Trust's website with the option for members of the public to submit questions in advance of each meeting. The April 2020 to November 2020 meetings were recorded and uploaded to the Trust's YouTube channel shortly after each meeting. From December 2020, the meetings have been live streamed on the Trust's YouTube channel.

Some of the usual activities carried out throughout the year have been interrupted due to the COVID-19 pandemic. Awareness stalls usually held within the Health Information area and Community Corner in the hospital's main entrance have been suspended throughout 2020/21 and plans are in place to restart such events once conditions allow. During the pandemic, however, we have increased our social media and website posts, particularly around health awareness and promotion, as well as COVID-19 related content. We have seen a significant increase in our social media following and engagement during 2020/21 as a result of this.

The Trust's quarterly publication, Your Health, has also been interrupted due to the pandemic. Plans are in place to restart the publication early in 2021/22. As a result of the pandemic, there will be an increased emphasis on the digital aspects of the publication to reduce the number of printed copies in waiting rooms which could contribute to spreading viruses.

Patient and public involvement is now a well-established tool in the relationship between healthcare provision and the patient's experience as the end user of services. The inclusion of patients, families and carers in the planning, development and review of a wide range of the Trust's care provision must always be integral to everything that we do. Engagement and involvement is, however, not simply a case of asking for patient feedback, it requires the creation of diverse and creative opportunities to engage, building public confidence in joining in and speaking up and ensuring the validity of this endeavour for all who directly or indirectly experience services and freely participate. The Trust seeks to always do justice to the efforts service users make to work with us, by committing to hear and act on their proposals for service development or transformation, responding positively and proactively to their feedback and reporting on what we have done as an organisation to ensure that we value this co-production.

This year we have welcomed our first designated Trust lead for Patient and Public Engagement and Inclusion, a new role to reach out to the local population and wider communities who use our services, to ensure that we are really working together on how we provide those services. The expected benefits of this role are to also seek ways to give access for all, including vulnerable, marginalised or unheard groups and wider stakeholders, so that they are fully included in the establishment of Trust processes, clinical guidelines, service change and delivery leading to local confidence and strengthened loyalty to the services here in Rotherham.

The Rotherham NHS Foundation Trust recognises and values the benefits of engaging with the public, colleagues and partners to inform decision making. It is therefore always our intention to consult widely on matters affecting the public, in particular, in relation to service or provision redesign. Where large scale consultation is required, the Trust undertakes this in conjunction with partners. These activities have been limited by the circumstances of the past year but increased activity is planned for the coming year.

To support this, an 'Equality Impact Assessment Scrutiny Panel' has been created which makes recommendations to the Trust's policy 'Document Ratification Group' (DRG) as appropriate. This also ensures that patient and public involvement is an integral part of Trust policy revisions

Examples of supportive activity undertaken by the Engagement and Inclusion Lead include:

- Successfully bidding to the Cancer Alliance alongside the Lead Cancer Nurse, to obtain support from The Cancer Improvement Collaborative to help set up a Cancer Involvement Group and to shape a future Trust action plan for cancer services and
- Working with the Rotherham Clinical Commissioning Group (RCCG) in relation to the provision of Neurological Rehabilitation Services and a new service specification

Engagement has been undertaken with the deaf community and resulted in funding being approved to supply the Trust with clear screens to allow staff to remove their masks so that deaf or hard of hearing patients or carers can lip read. Approval has also been gained for the use of transcribing software for deaf or hearing impaired patients. Tablets, already used on wards to help patients communicate with loved ones, have also had this software installed prior to distribution. Video consultations can also be used to link with British Sign Language (BSL) interpreters where appropriate.

### **The Rotherham Hospital and Community Charity**

The Rotherham Hospital and Community Charity has engaged with colleagues, the public, businesses and schools throughout the region and beyond this year. The COVID-19 pandemic has provided an opportunity to engage with our hard working colleagues about the funds raised locally and nationally in their honour. The charity set up its first staff fundraising campaign: the Rotherham NHS Superheroes appeal.

We discussed with staff what they would like to spend these funds on and this resulted in the new Wellbeing Garden, the Woodland Walk and the introduction of some mental health initiatives such as the Trauma Resilience Management Programme and the Florence Nightingale Foundation's 'Nightingale Frontline Service'.

The Charity has engaged with more than 250 businesses, schools and community groups during the year in response to the pandemic. We have received everything from Personal Protective Equipment (PPE), refreshments, hot meals, toiletries and treats for colleagues at a time when the moral boost and extra resources mattered the most.

We have also engaged with the community in various ways, with many providing 'thank you' messages and coloured rainbows, which became synonymous with the NHS during the pandemic.

Fundraising provided a great opportunity to engage with the public with some fantastic activities taking place in honour of our NHS charity, from sponsored head shaves to children's football matches.

## Remuneration Report

### Annual Statement of Remuneration from the Chair of the Remuneration Committee

I am pleased to present the Remuneration Report for the financial year 2020/21 on behalf of the Board of Directors' Remuneration Committee with regard to Executive Directors, and the Council of Governors' Nomination Committee with regard to Non-Executive directors.

In accordance with the requirements of the HM Treasury Financial Reporting Manual (FReM) and NHS Improvement, we have divided this report into the following parts: The Directors' Remuneration Policy sets out the Trust's senior managers' remuneration policy; and The Annual Report on Remuneration which includes more detailed information and governance details.

#### *Major decisions taken on senior managers' remuneration 2020/21*

In detailing below, the definition for 'senior managers' as contained in the FReM has been applied and refers to Executive and Non-Executive Directors only, i.e. those who influence the decisions of the Trust as a whole, rather than the decisions of individual directorates or sections within the Trust.

During 2020/21 the Remuneration Committee and the Council of Governors continued to use annual benchmarked data, including that provided by NHS Providers, as the pay and reward framework upon which to base Executive and Non-Executive salary amounts.

In determining the salaries of Executive Directors for 2020/21, the Remuneration Committee took account of the Executive Remuneration Framework. In particular, the Committee were mindful to ensure that levels of remuneration were sufficient to attract, retain and motivate directors of quality, with the skills and experience required to lead the Trust successfully, but the Trust should avoid paying more than is necessary for this purpose.

The Committee also reviewed the guidance from NHSE/I - 'Established pay ranges in acute NHS Trusts and foundation trusts'. This guidance gives suggested pay ranges for different executive roles in different size (by turnover) Trusts.

Finally, the Committee reviewed the survey conducted by NHS Providers of Executive remuneration across providers Trusts in England and also took into account pay and employment conditions elsewhere in the NHS Foundation Trust, especially when determining annual salary increases.

The Committee recommended that the cost of living awarded to staff on agenda for change (top of Band 8c and above) be awarded to Executive Directors with effect from 01 April 2020. This equated to a consolidated payment of £1,212 for each Executive Director. Following the issuing of further national guidance, the Very Senior Manager (VSM) pay framework, the Remuneration Committee reviewed the cost of living increase and agreed to amend the award for 2020/21 to a consolidated uplift of 1.03%.

### **Colleagues subject to Agenda for Change 2020/21**

With regard to colleagues on agenda for change, the NHS Staff Council formally ratified a three year pay deal and the changes to the NHS Terms and Conditions of Service handbook in June 2018. The new structure increased starting salaries, reduced the number of pay points, and for most staff, shortened the amount of time taken to reach the top of their payment band.

For the purposes of this report, details of the final year of the three year pay deal are detailed as it applies to the year 2020/21. From April 2020 the final transitional pay point in bands 5, 6 and 7 was removed and the reform of the pay bands 8a to 9 was completed with pay bands 8a to 9 moving to a two-point structure with an entry point and a top point.

For staff in bands 8a to 9 who had not yet reached the top of their pay band (but for whom no other pay point other than that at the top of their band existed as at April 2020) a consolidated payment was made from April 2020 in monthly instalments until the date when the staff member reached their pay progression date to ensure they did not experience any detriment.

The top pay points in bands 2 – 8b were increased by 1.67%; and for 8c by 1.47%. The top pay points in bands 8d – 9 were also increased up to a cap at the level of increase for the top of band 8c.

*H A Craven*

**Signed:**  
**Heather Craven**  
**Chair, Remuneration Committee**



## Senior Managers Remuneration Policy

This section describes the policy relating to the components of the remuneration packages for Executive and Non-Executive Directors (senior managers). The remuneration policy for Executive Directors was updated during 2019/20 and remains in place for the period 2020/21. The aims of the pay and reward framework currently in place, are to:

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

In setting and reviewing pay, it is vital to recruit and retain talent and to operate the pay system fairly; however, it is also necessary to have a robust process for reviewing remuneration and to be able to demonstrate sensible use of public money. With the exception of the Interim Chief Executive and the Executive Directors, all other non-medical substantive employees of the Trust, are remunerated in accordance with the national NHS pay structure, Agenda for Change. The majority of the Trust's substantive medical colleagues are remunerated in accordance with national terms and conditions of service for doctors and dentists.

The Treasury threshold for senior pay controls in the NHS is set at £150,000. Above this figure, approval for payment is required from the Chief Secretary of the Treasury. The Cabinet Office approvals process does not apply to Foundation Trusts. However, the figure is considered to be a suitable benchmark for Trusts to disclose why they consider the remuneration is reasonable in situations where it is paid. In such cases the Trust would seek an opinion from HM Treasury on the relevant salary.

The figure of £150,000 was exceeded in the case of two Executive Directors during the financial year. These Executive Directors occupy statutory positions and their remuneration has been benchmarked with others respectively in the same posts.

The Trust's remuneration policy is transparent and no performance related elements make up the total amount of remuneration. In the case of the Interim Chief Executive the salary reflects the overall salary comprising the joint responsibilities as Chief Executive of Barnsley Hospital NHS Foundation Trust and Interim Chief Executive of The Rotherham NHS Foundation Trust. The pro-rata element for The Rotherham NHS Foundation Trust is beneath the £150,000 threshold.

### Senior Managers' Future Policy table

Element	Policy
Base pay	Base pay is determined by using annual benchmarked data in order to attract and reward the right calibre of leaders to deliver the Trust's short, medium and long-term objectives.
Pension	Executive directors are able to join the standard NHS pension scheme that is available to all staff members.
Bonuses	Bonuses were not given to staff, Executive or Non-Executive Directors during the period. Subject to the agreement of the

<b>Element</b>	<b>Policy</b>
	Remuneration Committee Mr Diggles will receive a termination bonus at the end of his contract.
On call payment	In relation to Executive pay, no Board members receive on call payment
Benefits	The Trust operates a number of salary sacrifice schemes including childcare vouchers and a car lease scheme. These are open to all members of staff. The individual forgoes an element of their basic pay in return for a defined benefit.
Travel expenses	Appropriate travel expenses are paid for business miles.
Declaration of gifts	As with all employees, Executive and Non-Executive Directors must declare any gifts or hospitality according to Trust policy with a value in excess of £25.

### ***Service Contracts Obligations***

The contracts of employment of substantive Executive Directors are standardised and contain a notice period of six months. All such contracts are open-ended but are subject to earlier termination for cause or if notice is given under the contract.

### ***Policy on payments for loss of office***

There is no entitlement to any additional remuneration in the event of early termination for any of the Executive Directors. During 2020/21 no Executive Director received additional remuneration for loss of office.

### ***Statement of consideration of employment conditions elsewhere in the Trust***

Except for 'senior managers' (as per the definition above) Trust colleagues are subject to national Agenda for Change, or national Medical and Dental Terms and Conditions. When setting the remuneration policy for senior managers, the pay and conditions of these employee groups was taken into consideration in accordance with the Executive Pay and Reward framework.

The Trust did not consult with employees when preparing the senior managers' remuneration policy, however annual benchmarked data, including that provided by NHS Providers, was used to determine the appropriate remuneration for the Executive and Non-Executive Directors during the year.

Executive salaries are in line with national Executive remuneration benchmarking and account is taken of the guidance published by NHS England / Improvement, and comprise a transparent process. By using benchmarking guidelines, the Trust ensures that salaries are sufficient to attract and retain high calibre candidates, and are appropriate for the benchmarked role.

No performance-related bonuses or long-term performance related bonuses have been paid. No additional fees or other items that are considered to be remuneration in nature are paid

### ***Policy on Diversity and Inclusion***

The national structure for payment of NHS colleagues, 'agenda for change', provides a transparent and fair system which supports NHS service modernisation and meets the reasonable aspirations of colleagues. It provides a modern workforce, with the right skills, experience and diversity, which is organised appropriately on a national level, and which aims to support the recruitment and retention of the NHS professionals.

Likewise, the Trust's policy for payment of senior managers provides the same transparency with salaries being benchmarked against peers (circa 168 organisations) with similar turnover, size, organisation type, and geographical location. There is an emphasis on providing salaries that are sufficient to attract, retain and motivate directors of quality with the skills and experience to lead the Trust successfully, but without paying more than is necessary for this purpose.

When considering senior manager remuneration, the principle of equal pay for work of equal value is adhered to.

### **Annual Report on Remuneration**

#### **Information not subject to audit**

#### **Service Contracts**

Executive Directors who were in post prior to 01 April 2020:

Richard Jenkins became Interim Chief Executive from 10 February 2020.

George Briggs, employed by the Trust since 01 April 2018.

Dr Callum Gardner employed by the Trust from 01 November 2019.

Steve Ned, employed by the Trust as Joint Director of Workforce with Barnsley NHS Foundation Trust from 01 April 2019.

Angela Wood, employed by the Trust since 01 February 2019.

With the exceptions listed below, all the Executive Directors served for the entirety of the financial year 1 April 2020 to 31 March 2021.

Michael Wright, took up the role of Interim Deputy Chief Executive from 10 February 2020 – 31 October 2020. The post became substantive from 01 November 2020.

Simon Sheppard was Director of Finance to 13 May 2020

Steve Hackett was appointed Interim Director of Finance from 14 May 2020 to 13 November 2020. Stuart Diggles commenced as Interim Director of Finance from 14 November 2020.

All Executive Directors who served during the year did so on substantive contracts of employment with no end dates which include a notice period of six months with the exception of Directors of Finance, Steve Hackett and Stuart Diggles.

None of the Trust's Executive Directors were released by the organisation to serve as a Non-Executive Director elsewhere. Dr Jenkins remains Chief Executive at Barnsley Hospital NHS Foundation Trust.

Non-Executive Directors are generally appointed on terms of three years and for up to two terms, but they can be appointed for up to one year further, at a time, on an exceptional basis, as follows:

Mark Edgell:

01.06.12 - 31.05.15

01.06.15 – 31.05.18

01.06.18 – 31.05.20

01.06.20 – 31.05.21

Joe Barnes:

26.09.13 – 25.09.16

26.09.16 – 25.09.19

26.09.19 – 30.09.20

01.10.20 – 31.03.21

Lynn Hagger (Vice Chair):

01.10.13 – 30.09.16

01.10.16 – 30.09.19

01.10.19 – 30.09.22

Martin Havenhand (Chairman):

01.02.14 – 31.01.17

01.02.17 – 31.01.20

01.02.20 – 31.01.23

Heather Craven:

17.02.17 – 16.02.20

17.02.20 – 28.02.23

Michael Smith

01.04.19 – 31.03.20

01.04.20 – 31.03.22

Nicola Bancroft

01.10.19 - 30.09.22

Dr Rमित Shah

01.01.20 - 31.12.21

Each of the Non-Executive Directors and Chairman are able to resign by giving notice.



### Remuneration Committee

This committee was chaired by Non-Executive Director, Joe Barnes and in accordance with the terms of reference the membership of the Committee is four Non-Executive Directors. During the period of 01 April 2020 to 31 March 2021 the committee met six times; each meeting was quorate.

Remuneration Committee	13/05/20	14/08/20	06/10/20	01/12/20	23/12/20	19/02/21	Attendance
Joe Barnes (Chair)	✓	✓	✓	✓	✓	✓	6/6
Nicola Bancroft	✓	✓	✓	✓	✓	✓	6/6
Heather Craven (Vice Chair)	✓	✓	✓	✓	x	x	4/6
Mike Smith	✓	✓	✓	✓	✓	x	5/6

The Interim Chief Executive has a standing invitation to attend, unless this is deemed inappropriate (for example, when discussing the Chief Executive's salary), the Director of Workforce acted as the Lead Executive and the Director of Corporate Affairs / Company Secretary also attends. The Committee can also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

Throughout 2020/21, the Committee ensured that arrangements were in place to monitor compliance with statutory responsibilities. This included the following key areas of review:

#### Setting levels of Executive Remuneration

- The Committee approved the remuneration packages for two Interim Directors of Finance
- The Committee approved the pay awards for Executive Directors
- The Committee approved the remuneration package for the substantive appointment to the Director of Finance position
- The Committee agreed cost of living increases for Executive Directors for 2020/21
- The Committee agreed to ratify the salary of Mr Wright as being £143,854.

#### Agreeing contractual payments

- The Committee agreed the payments for the former Director of Finance in accordance with his contract of employment (namely payment in lieu of notice and in lieu of annual leave) taking into consideration that such payments were in the best interests of the Trust and represented value for money

#### Considering performance criteria

- The Committee noted the performance of Executive Directors

## Reviewing the Remuneration Report prior to submission of the Annual Report 2019/20 and 2020/21

- The Committee reviewed the draft Remuneration Report 2019/20 prior to its inclusion in the Annual Report for 2019/20
- The Committee reviewed the requirements of the Annual Reporting Manual in relation to the Remuneration Report for 2020/21

## Monitoring compliance with IR35 / off payroll requirements

- The Committee received a number of reports on off payroll payments and the Trust's compliance with IR35 arrangements

## Reviewing the Committee Terms of Reference

- The Committee conducted the annual review of its Terms of Reference and, with some small changes, recommended these to the March 2021 Board meeting for approval

## Reviewing the Remuneration Committee Work Plan

- The Committee reviewed its work plan and ensured that this complied with the requirements of its Terms of Reference.

## Disclosures required by the Health & Social Care Act 2012

### Information not subject to audit

Details relating to the expenses of the Executive, Non-Executive Directors and Governors are set out in the table below:

	Number in Office		Number receiving expenses	
	2020/21	2019/20	2020/21	2019/20
Governors	26	25	0	3
Directors (including the Chair and Non-Executives)	17	20	4	9

Expenses shown in £00s	2020/21 £00	2019/20 £00
Aggregate sum of expenses paid to Governors	0	0*
Aggregate sum of expenses paid to Directors	31	71
<b>Total</b>	<b>31</b>	<b>72**</b>

\* figure subject to rounding, actual figure is £35

\*\*figures subject to rounding up

## Information subject to audit Single Total Figure Table (1)

### Salaries and Allowances

The following information is required by Paragraph 4 - 16 inclusive 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. Pension Benefits are affected by pension inflation in year and salary increases in year. See Pension Entitlements of Executive Directors table for further details.

Single Total Figure Table	Period 01/04/20 to 31/03/21					Period 01/04/19 to 31/03/20					
	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)
Dr R Jenkins, Interim Chief Executive	110 - 115	0	0	0	52.5 - 55	165 -170	15 - 20	0	0	92.5 - 95.0	105 - 110
Mr M Wright, Interim Deputy Chief Executive (to 31/10/20) Deputy Chief Executive (from 01/11/20)	145 - 150	0	0	0	35 - 37.5	180 - 185	20 - 25	0	0	97.5 - 100.0	115 - 120
Mr S Ned, Joint Director of Workforce	65 - 70	0	0	0	35 - 37.5	100 - 105	75 - 80	0	0	185 - 187.5	265 - 270
Mr S Sheppard, Director of Finance (in office to 13/05/20)	110 - 115	0	0	0	0	110 - 115	145 - 150	0	0	102.5 - 105	250 - 255
Mr S Hackett, Interim Director of Finance (in office from 14/05/20 to 13/11/20)	40 - 45	0	0	0	0	40 - 45					
Mr S Diggles, Interim Director of Finance (in office from 14/11/20)	55 - 60	0	0	0	0	55 - 60					
Dr C Gardner, Medical Director	180 - 185	0	0	0	42.5 - 45.0	225 - 230	180 - 185	0	0	60.0 - 62.5	240 - 245
Mrs A Wood, Chief Nurse	120 - 125	0	0	0	30.0 - 32.5	155 - 160	120 - 125	0	0	60.0 - 62.5	180 - 185
Mr G Briggs, Chief Operating Officer	125 - 130	0	0	0	20.0 - 22.5	145 - 150	125 - 130	0	0	30.0 - 32.5	155 - 160

Mr R Jenkins is seconded to The Rotherham FT from Bamsley FT on an interim basis as the Interim Chief Executive. Mr R Jenkins works for the Trust on a 0.45 Full Time Equivalent (that is 2.25 days per week). 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 The Rotherham FT, and Bamsley FT. Mr S Ned works for The Rotherham FT on a 0.5 Full Time Equivalent (that is, 2.5 days per week). Based on his full remuneration across both Trust, his salary and fees would fall within the band of £135k to £140k.

During his time at the Trust Mr S Hackett worked for the Trust on a 0.5 FTE (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 £130k to £135k.

Mr Michael Wright became the substantive Deputy Chief Executive on 01 November 2020.

Mr Simon Sheppard served as Director of Finance until 13 May 2020. The table above for the period 01/04/20 to 31/03/21 includes remuneration for the period up to his departure from the Trust on 30 September 2020.

Mr Steve Hackett served as Interim Director of Finance from 14 May 2020 to 13 November 2020. Mr Hackett's appointment was to cover the temporary absence of Mr Sheppard.

Mr Stuart Diggles served as Interim Director of Finance from 14 November 2020.

### Single Total Figure Table (2)

The remuneration for Non-Executive Directors including the Chairman has been determined by the Council of Governors and is set at a level designed to recognise the significant responsibilities of Non-Executive Directors in foundation trusts, and to attract individuals with the necessary experience, expertise and ability to make an important contribution to the Trust's affairs.

The following information is required by Paragraph 4 - 16 inclusive 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. Pension Benefits are affected by pension inflation in year and salary increases in year. See Pension Entitlements of Executive Directors table for further details.

Single Total Figure Table	Period 01/04/20 to 31/03/21							Period 01/04/19 to 31/03/20				
	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
Miss N Bancroft, Non Executive Director	15 - 20	0	0	0	0	15 - 20	5 - 10	0	0	0	0	5 - 10
Mr M Edgell, Non-Executive Director	10 - 15	0	0	0	0	10 - 15	15 - 20	0	0	0	0	15 - 20
Mr J Barnes, Non-Executive Director & Senior Independent Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Ms 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	0 - 5	0	0	0	0	0 - 5
Mr M Smith, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20

### Pension Entitlements of Executive Directors

Details of the pension entitlements of Executive Director are shown in the table below. As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Director. 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 (bands of £2,500) £000	Real increase during the reporting year in pension age (bands of £2,500) £000	Real increase during the reporting year in pension (bands of £2,500) £000	Total accrued pension at 31 March 2021* (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Cash Equivalent Transfer Value at 31 March 2021 £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	80.0 - 85.0	160.0 - 165.0	1,454	1,553	60	NA	
Mr M Wright, Interim Deputy Chief Executive (to 31/10/20)									
Deputy Chief Executive (from 01/11/20)	2.5 - 5.0	0.0 - 2.5	25.0 - 30.0	0.0 - 5.0	366	417	24	NA	
Mr S Ned, Joint Director of Workforce	0.0 - 2.5	0.0 - 2.5	60.0 - 65.0	145.0 - 150.0	1,179	1,255	45	NA	
Mr S Sheppard, Director of Finance (in office to 13/05/20)	0.0 - 2.5	0.0 - 2.5	45.0 - 50.0	90.0 - 95.0	799	777	0	NA	
Dr C Gardner, Medical Director	2.5 - 5.0	0.0 - 2.5	15.0 - 20.0	0.0 - 5.0	171	217	16	NA	
Mrs A Wood, Chief Nurse	0.0 - 2.5	0.0 - 2.5	20.0 - 25.0	35.0 - 40.0	367	415	24	NA	
Mr G Briggs, Chief Operating Officer	0.0 - 2.5	5.0 - 7.5	45.0 - 50.0	145.0 - 150.0	1,113	1,202	52	NA	

Mr Stuart Diggles and Mr Steve Hackett do not pay into the NHS pension scheme.

\* The majority of employees are covered by the provisions of the NHS Pensions Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practitioners and other bodies under the direction of the Secretary for State, in England and

Wales. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Further details can be found in the Annual Accounts at note 1.2.

The above table detailing the pension entitlements of Executive Directors does not include the potential impact of any decisions which may arise in the future from the McCloud judgement relating to alleged discrimination against younger members of public sector pension schemes.

#### [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.

### Fair Pay Multiple

The Trust is required to disclose the relationship between the remuneration of the highest paid director in the organisation and the median remuneration of the organisation's workforce at the reporting period end date (in this case 31 March 2021) on an annualised basis.

The banded mid-point remuneration of the highest paid director in The Rotherham NHS Foundation Trust in the financial year 2020/21 was £182,500 (2019/20, £182,500). This was 6.66 times (2019/20, 6.68 times) the median remuneration of the workforce (including directly engaged and seconded staff) which was £27,416 (2019/20, £27,260k).

	2020/21	2019/20 (Restated)
Mid-Point of £5k Band of Highest Paid Director's Total (Remuneration £000)	182.5	182.5
Median Total Remuneration (000s) (includes Direct Engagement and Agency)	27.4	27.3
Ratio of Median Remuneration to Midpoint of the Highest Paid Director's Band	6.66	6.68

In 2020/21, three (2019/20, ten) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £8,115 to mid-point band £247,500k (2019/20 £7,626 to mid-point band £232,500).

Of the 3 individuals who received remuneration in excess of the highest-paid director, 2 were secondary payroll staff who are in the main doctors with specialist skills which are in high demand due to limited availability.

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

The median is the middle number in a sorted list of numbers. The ratio is the number of times the median can be divided into the highest paid director's total remuneration

The Trust determined that the highest paid director in the 2019/20 Annual Report was the Interim Chief Executive (based the salary paid to him by the Trust being annualised and made full-time) and used this salary to calculate the Fair Pay Multiple for 2019/20. However, during the audit of the Trust's financial statements for 2020/21 the Trust's External Auditors advised that the Interim Chief Executive's salary should not have been used for this calculation during 2019/20. This is because the Interim Chief Executive works for both the Trust and Barnsley Hospital NHS Foundation Trust and the Fair Pay Multiple calculation should be undertaken based on the salary paid by the Trust alone to the highest paid director. Hence the Trust is restating the calculation for 2019/20.

### ***Definition of Senior Managers***

For the purposes of this Remuneration Report 'senior managers' are defined as those who influence the decisions of the Trust. This means those who influence the decisions of the Trust as a whole rather than the decisions of individual divisions or sections within the Trust. At The Rotherham NHS Foundation Trust, and for the purposes of this report, the term 'senior manager' applies to the Chair, Non-Executive Directors and Executive Directors only, whether substantive or interim.

This Remuneration Report covers all individuals who hold, or have held, office as Chairman, Non-Executive Director or Executive Director for The Rotherham NHS Foundation Trust during 2020/21, whether or not they were substantively appointed.

### ***Senior Managers with Additional Duties***

There were no payments made during 2020/21 to Senior Managers with additional duties.

### ***Payments for Loss of Office***

There were no payments made during 2020/21 to Senior Managers for loss of office

### ***Payments to Past Senior Managers***

There were no payments made during 2020/21 to past Senior Managers.

Remuneration Report signed by the Chief Executive in his role as Accounting Officer:



**Dr Richard Jenkins**  
**Interim Chief Executive**  
**11 June 2021**

## Staff Report

### Analysis of Staff Costs

Staff Costs	2020/21			2019/20		
	Permanent	Other*	Total	Permanent	Other*	Total
	£000	£000	£000	£000	£000	£000
Salaries and wages**	158,636	6,629	165,265	145,031	5,601	150,632
Social security costs	15,532	-	15,532	14,651	-	14,651
Apprenticeship levy	767	-	767	718	-	718
Employer's contributions to NHS pensions***	26,255	-	26,255	25,091	-	25,091
Pension cost - other	87	-	87	83	-	83
Termination benefits	-	-	-	-	-	-
Temporary Staff - External Bank	-	8,131	8,131	-	3,124	3,124
Temporary staff - agency/contract**	-	4,621	4,621	-	6,706	6,706
<b>Total gross staff costs</b>	<b>201,277</b>	<b>19,381</b>	<b>220,658</b>	<b>185,574</b>	<b>15,431</b>	<b>201,005</b>
<i>Of which: Costs capitalised as part of assets</i>	<b>148</b>	<b>73</b>	<b>221</b>	<b>319</b>	<b>205</b>	<b>524</b>

\*'Other' staff includes secondments in, and trainee medical 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 2020/21 and 2019/20.

## Analysis of Staff: Average Number of Employees (Whole Time Equivalent Basis)

	2020/21			2019/20		
	Permanent No.	Other* No.	Total No.	Permanent No.	Other* No.	Total No.
Medical and dental	438	108	546	424	86	509
Administration and estates	1,075	10	1,085	1,056	11	1,067
Healthcare assistants and other support staff	907	1	908	858	0	858
Nursing, midwifery and health visiting staff	1,182	38	1,220	1,170	48	1,219
Scientific, therapeutic and technical staff	446	11	457	429	8	437
Healthcare Science Staff	104	2	106	101	4	105
	<b>4,152</b>	<b>170</b>	<b>4,322</b>	<b>4,038</b>	<b>157</b>	<b>4,195</b>
<i>Of which: Number of employees engaged on Capital projects</i>	<b>3</b>	<b>1</b>	<b>4</b>	<b>7</b>	<b>5</b>	<b>12</b>

\*'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 of Staff

As at end March 2021 the breakdown of Trust employed staff by Gender was as follows:

	Headcount		
	Female	Male	Total
Executive Directors	1	6	7
Non-Executive Directors	3	5	8
Employees	4059	931	4990
<b>Grand Total</b>	<b>4063</b>	<b>942</b>	<b>5005</b>

## Analysis of Staff: Ethnicity of Staff

As at end March 2021 the breakdown of Trust employed staff by ethnicity was as follows:

<b>Ethnicity Group</b>	<b>Headcount</b>	<b>% of Headcount</b>
BAME	521	10.41%
Not Stated	113	2.26%
White	4370	87.33%
<b>Grand Total</b>	<b>5004</b>	<b>100.00%</b>

<b>Ethnic Origin</b>	<b>Headcount</b>	<b>% of Headcount</b>
A White - British	4241	84.75%
B White - Irish	21	0.42%
C White - Any other White background	71	1.42%
CA White English	10	0.20%
CB White Scottish	3	0.06%
CC White Welsh	1	0.02%
CP White Polish	2	0.04%
CQ White ex-USSR	1	0.02%
CU White Croatian	3	0.06%
CX White Mixed	2	0.04%
CY White Other European	15	0.30%
D Mixed - White & Black Caribbean	14	0.28%
E Mixed - White & Black African	9	0.18%
F Mixed - White & Asian	22	0.44%
G Mixed - Any other mixed background	13	0.26%
GC Mixed - Black & White	1	0.02%
H Asian or Asian British - Indian	154	3.08%
J Asian or Asian British - Pakistani	106	2.12%
K Asian or Asian British - Bangladeshi	8	0.16%
L Asian or Asian British - Any other Asian background	43	0.86%
LF Asian Tamil	1	0.02%
LH Asian British	3	0.06%
M Black or Black British - Caribbean	10	0.20%
N Black or Black British - African	72	1.44%
P Black or Black British - Any other Black background	7	0.14%
PC Black Nigerian	1	0.02%
R Chinese	14	0.28%
S Any Other Ethnic Group	36	0.72%
SC Filipino	1	0.02%
SE Other Specified	6	0.12%
Z Not Stated	113	2.26%
<b>Grand Total</b>	<b>5004</b>	<b>100.00%</b>

## **Sickness Absence Data**

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 applies 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.

Work has continued during 2020/21 to encourage employees to disclose disabilities, as disclosure rates in this area are historically low. These rates have been slowly increasing over the last two years. The Trust's Disability Staff Network has continued to grow during 2020/21, and has contributed to work around accessibility and to the development of a leadership programme for disabled staff, funded by the national Workforce Disability Equality Standard (WDES) Innovation Fund. This programme is currently ongoing, and the project work being completed by participants on this programme will underpin further improvements in support to disabled colleagues, particularly around reasonable adjustments, and will also be used to inform national policy.

Alongside Workforce Race Equality Standard (WRES) and 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 modern 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 2020/21, 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.

The Recruitment, Selection and Promotion policy contains full information on the processes for recruitment and the various training policies contain information on access to training for staff.

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. The Trust is a Disability Confident Employer.

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.

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.

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-to-one 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.

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, 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 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, 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 during the year; therefore the key priority for the organisation during 2020/21 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 created “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 at the end of November 2020 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 27 November 2020 which involved a large number of celebrities thanking our staff for the contribution they had made during the year.

### **International nursing recruitment**

In 2019 the UK government pledged to increase the registered nurse workforce by 50,000 by 2025 and the Trust has been working with the local Integrated Care System to support the achievement of this ambition. In November 2019 we identified a range of strategies to reduce the number of registered nursing vacancies including increased ‘Retire and Return’, ‘Return to Practice’ and international recruitment campaigns. We have exceeded our planned recruitment within all of these areas and between April 2020 and March 2021 the number of registered nursing vacancies reduced by 35.

The international recruitment campaign has been particularly successful and during the year we have welcomed 40 new recruits from the southern Indian area of Kerala. These experienced nurses have joined a variety of clinical teams in different areas of the hospital and have been supported throughout with a comprehensive training and pastoral care package, delivered by our own Nursing Workforce Team. The classroom skills, combined with support and education in the clinical setting from

ward teams has enabled our recruits to settle into Rotherham life and successfully meet the requirements to become UK registered nurses. To date none of the international recruits has left the organisation.

We plan to build on this success during 2021/22 with an expanded international programme which will help us eliminate vacancies within our nursing establishment.

### **Health & Safety and Occupational Health**

During 2019/20 a seventh 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.

Due to COVID-19 RoSPA have extended the deadline for its Occupational Health and Safety Awards 2020/21 such that the Trust will not find out whether it has been awarded its eighth consecutive gold award until after the publication of this Annual Report. Details of the outcome of the 2020/21 awards will therefore be included in the Trust's 2021/22 Annual Report.

The Trust's occupational health service (PAM) 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 year in NHS history. To support managers and colleagues the Trust launched 'Our People Pack' in July 2020 with an updated version being produced in February 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**

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 2020 to 2021 sets out The Trust's obligations, to safeguard NHS funds and resources through compliance with 23 standards for countering fraud, bribery and corruption:

**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 in May 2020 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.

### **Information on diversity and inclusion policies, initiatives and longer term ambitions and Gender Pay Gap**

The Trust has a Diversity and Inclusion policy. All workforce policies undergo Equality Impact Assessment (EIA). The Trust has equality objectives, which are published as part of the Trust's annual equality and diversity report, which can be accessed here, alongside all of the equality data that we report:

[https://www.therotherhamft.nhs.uk/Equality and Diversity/Equality and diversity monitoring data/](https://www.therotherhamft.nhs.uk/Equality%20and%20Diversity/Equality%20and%20diversity%20monitoring%20data/)

Significant progress has been made during 2020/21 against the Trust's current equality objectives, which were agreed during 2020. This progress will be reflected in the next annual equality and diversity report.

We continually strive to improve the diversity of our workforce and work to remove barriers that are within our control as we find them. Further details can be found in our published equality information, and especially our WRES and WDES reports and action plans.

In addition to this, the Trust has also published action plans relating to WRES and WDES, which can be accessed via the same web link, alongside the Trust's Gender Pay Gap report.

The annual equality, diversity and inclusion report highlights the increasing ethnic diversity of our workforce, and increases in the number of staff declaring that they are disabled or lesbian, gay or bisexual (the Electronic Staff Record system used by the Trust does not yet facilitate recording of gender identity).

The table below shows that as at 31 December 2020 the Trust's workforce was slightly more ethnically diverse than the local population was at the last census, with 11.62% of staff stating ethnicities other than 'White British', however this data should be treated with caution, as ethnic diversity within the local population has increased steadily over a number of census periods, and so is likely to have increased further since the 2011 census. 9.38% of the Trust's staff are BME (Black or Minority Ethnic), i.e. non-White (this is the definition the Trust is required to use for most national reporting, including WRES).

In line with local and national trends, the Trust's workforce is gradually becoming more ethnically diverse, although levels of diversity vary significantly between staff groups. The Trust's Board of Directors is more ethnically diverse than either the overall workforce or the local population.

<b>Ethnic Origin</b>	<b>Rotherham Population</b>	<b>Workforce</b>	<b>Board of Directors</b>
<b>Asian/Asian British: Bangladeshi</b>	0.04%	0.13%	
<b>Asian/Asian British: Chinese</b>	0.23%	0.17%	
<b>Asian/Asian British: Indian</b>	0.37%	2.65%	
<b>Asian/Asian British: Other Asian</b>	0.73%	0.86%	7.14%
<b>Asian/Asian British: Pakistani</b>	2.96%	1.97%	
<b>Black/African/Caribbean/Black British: African</b>	0.65%	1.33%	
<b>Black/African/Caribbean/Black British: Caribbean</b>	0.11%	0.17%	
<b>Black/African/Caribbean/Black British: Other Black</b>	0.06%	0.19%	

<b>Ethnic Origin</b>	<b>Rotherham Population</b>	<b>Workforce</b>	<b>Board of Directors</b>
<b>Mixed/multiple ethnic groups: Other Mixed</b>	0.23%	0.30%	
<b>Mixed/multiple ethnic groups: White and Asian</b>	0.34%	0.41%	
<b>Mixed/multiple ethnic groups: White and Black African</b>	0.12%	0.17%	7.14%
<b>Mixed/multiple ethnic groups: White and Black Caribbean</b>	0.31%	0.28%	
<b>Not Disclosed</b>		1.30%	
<b>Other ethnic group: Any other ethnic group</b>	0.28%	0.75%	
<b>White: English/Welsh/Scottish/Northern Irish/British</b>	91.90%	87.08%	71.43%
<b>White: Gypsy/Irish Traveller</b>	0.05%		
<b>White: Irish</b>	0.30%	0.43%	14.29%
<b>White: Other White</b>	1.33%	1.82%	
<b>Grand Total</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>

Whilst a significant proportion of the Trust's staff have chosen not to declare whether or not they are disabled, the percentage of staff declaring that they are disabled has gradually increased over a number of years from 3.08% on 31 December 2015 to 3.99% on the same date in 2020. Similarly, the proportion of staff indicating on ESR (Electronic Staff Record) that they are Gay, Lesbian or Bisexual has increased from 1.04% to 1.71% over the same time period.

The Trust's WRES report has seen gradual improvements against most metrics over the last few years, with a significant improvement in Board diversity.

The Trust's Gender Pay Gap has increased (in March 2019, the gap in mean hourly rate was 27.83%, and the gap in median hourly rate was 17.55%) and as at 31<sup>st</sup> March 2020, the Trust's overall Gender Pay Gap was as per the table below.

<b>Gender</b>	<b>Mean Hourly Rate</b>	<b>*Median Hourly Rate</b>
Female	£15.62	£13.96
Male	£22.03	£17.33
Difference	£6.41	£3.36
Pay Gap %	29.09%	19.41%

\* This data excludes Long Service Awards

Further information on the Trust's gender pay gap information can be found on the Trust's website here:

[https://www.therotherhamft.nhs.uk/Equality and Diversity/Equality and diversity monitoring data/](https://www.therotherhamft.nhs.uk/Equality%20and%20Diversity/Equality%20and%20diversity%20monitoring%20data/) and on the Cabinet Office website here: (<https://gender-pay-gap.service.gov.uk/>)

The Trust has three staff inclusion networks (BAME<sup>8</sup>, disability and LGBT+<sup>9</sup>), which are relatively new. During 2020/21 these networks have continued to grow and develop, and have been involved in projects including the Rainbow Badge launch and a successful bid to the national WDES Innovation Fund.

The WDES Innovation Fund bid has funded development and delivery of a leadership programme for disabled staff, working in partnership with Disability Rights UK. Alongside providing career development support for those staff participating in the programme, delegates have undertaken project work around reasonable adjustments and signage, which will support further work on inclusion for staff and work alongside the Trust's disability passport.

The Rainbow Badge scheme mentioned in the Performance Report section of this Annual Report, alongside its accompanying training, is supporting the inclusion of LGBT+ staff by increasing knowledge amongst all staff about LGBT+ issues.

The *Call it Out, Work it Out* scheme (also mentioned in the Performance Report section) has supported staff to challenge and report instances of discriminatory behaviour; has ensured that these issues are brought to the attention of Trust managers and that progress in addressing them is monitored. Analysis of data from this source alongside reports received by the Trust's Freedom to Speak Up Guardians (FTSUG) has supported partnership working between the Head of Equality Diversity and Inclusion and the Lead FTSU Guardian to support listening events in areas of particular concern, thereby supporting work with managers and colleagues to improve workplace culture and inclusion.

During 2020/21, the Trust's Executive Team has agreed a goal in line with the national Model Employer standard (prior to this, the Trust did not have any specific internal targets around diversity metrics). The Trust's goal is that by 2028, 1 in 13 colleagues at Agenda for Change Band 6+ and Band 8a+ will be from a BAME background, in line with the Trust's overall workforce. Progress against this target will be monitored as part of the annual WRES narrative report. During 2020/21 some rapid improvements have been carried out to the Trust's recruitment process and work has commenced to undertake more detailed analysis of recruitment data to support further improvement work.

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 2021, compliance with this training requirement is above the Trust's 85% target.

<sup>8</sup> Black, Asian and minority ethnic

<sup>9</sup> Pertaining collectively to people who identify as lesbian, gay, bisexual, or transgender, and to people with gender expressions outside traditional norms, including nonbinary, intersex, and others including those questioning their gender identity or sexual orientation, along with their allies.

## 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>

## 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 2020/21. 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 have had this agreement in place for many years which 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
24	<i>Between 1501 and 5000</i>

**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%	0
1-50%	24
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.

First Column	Figures
Provide the total cost of facility time	£78,000
Provide the total pay bill	£201,391,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.039%

**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	0.6%
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(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 2020/21 were £199,000 compared to £208,000 during 2019/2020. The consultancy work undertaken during 2020/21 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 2020/21 zero off-payroll engagements were entered into.

**Table 1. Highly paid off-payroll worker engagements as at 31 March 2021, earning £245 per day or greater**

Number of existing engagements as of 31 March 2021	0
<i>Of which:</i>	
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 2021 earning £245 per day or greater**

Number of off-payroll workers engaged during the year ended 31 March 2021	0
<i>Of which:</i>	
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
<i>Of which:</i>	
Number of engagements that saw a change to IR35 status following 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 2020 and 31 March 2021**

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	
	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20
Total number of exit packages by type	0	0	0	0	0	0
Total resource cost £000s	0	0	0	0	0	0

### *Analysis of non-compulsory departure payments*

In 2020/21 there were no non-compulsory departures, and therefore zero payments made (2019/20 £0). 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.

## Staff Survey

### Staff Engagement

The Rotherham NHS Foundation Trust has continued in its ambition to deliver high quality care through great staff engagement. In July 2020 the Trust formally launched “Our People Strategy” and our ambition by 2023 to be in the top 20% of NHS employers nationally as measured by the national staff survey. The Trust was the third most improved NHS organisation nationally in respect of the staff survey results and demonstrated our commitment to full stakeholder engagement, listening and acting on colleague feedback as well as working in partnership with different groups, e.g. trade unions, volunteers, etc.

The key components of our Engagement Framework are expressed in Our People Strategy and are underpinned by the principles of “We can all Lead the Rotherham Way”; and support staff engagement, involvement and recognition.

- Working in partnership with Trade Unions
- Health & Wellbeing
- Equality, Diversity & Inclusion
- Staff Survey
- Flexible working
- Volunteers
- Together We Can (process improvement at team level)
- Recognition and Reward

As a Trust we have taken some really positive steps but we recognise that there is more work to do. We recognised that improving colleague engagement in 202/21 would be a particular challenge given the impact of the pandemic and the operational pressures this placed on colleagues. Therefore, we have sought to embed the approaches outlined in Our People Strategy and focused on the health and wellbeing aspect of our engagement framework.

The Trust developed ‘Our People Pack’, a one stop shop document containing lots of hints and tips for staff and managers in relation to looking after themselves, each other as part of team and also at an organisational level. The People Pack also outlined all of the various health and wellbeing offers and support available at local, regional and national level, making it easier for colleagues to access wellbeing support if required. Our People Pack was implemented in July 2020 with a second, updated version being released in February 2021.

The launch of the national NHS People Plan in August 2020 provided organisations with a clear people direction and has enabled the Trust to align these core activities with Our People Strategy:

Build	How we will build our workforce
Engage	How we will engage with all our people
Lead	How we will develop our leadership culture and nurture talent
Learn	How we will ensure there are learning opportunities for all

The Trust continues to promote our core values in all that we do to recognise the importance of our culture and the colleagues that make The Rotherham NHS Foundation Trust a great place to work. Despite the very challenged year the Trust

still managed to celebrate, recognise and reward our colleagues for the work they do in delivering high quality care. We celebrated key achievements and unsung heroes in November 2020 during our Proud Week, recognition of long service awards and recognition of learning events culminating in our prestigious award ceremony, albeit this was done virtually. These awards were attended and supported by both colleagues and other stakeholders with whom we are in partnership; as well as getting some famous celebrity thank you and shout outs.

### **National Staff Survey 2020**

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2020/21 survey among Trust staff was 52% (2019/20:

Theme	2020/21		2019/20		2018/19	
	Trust	Benchmark	Trust	Benchmark	Trust	Benchmark
Equality, diversity & inclusion	9.3	9.1	9.2	9.2	9.2	9.2
Health & wellbeing	6.1	6.1	5.8	6.0	5.8	5.9
Immediate managers	7.0	6.8	6.8	6.9	6.7	6.8
Morale	6.3	6.2	6.0	6.2	5.8	6.2
Quality of care	7.4	7.5	7.2	7.5	7.2	7.4
Safe environment (bullying & harassment)	8.4	8.1	8.2	8.2	8.2	8.1
Safe environment (violence)	9.5	9.5	9.5	9.5	9.5	9.5
Safety culture	6.7	6.8	6.6	6.8	6.5	6.7
Staff engagement	6.9	7.0	6.7	7.1	6.6	7.0
Team working	6.6	6.5	6.5	6.7	n/a	n/a

48%). Scores for each indicator together with that of the survey benchmarking group (Acute and Acute & Community Trusts) are presented below.

The results from the national staff survey 2020 reflect the good progress which the Trust has made during a very challenging period for the whole of the NHS. The Trust returned statistically significant improvements in eight of the ten key indicator themes compared to their performance in the previous year; with similar improvements made against benchmark organisations. Overall the Trust was the third most improved Trust nationally.

## Survey Response Rate

The Trust changed its approach for the distribution of staff survey during 2020 and achieved its highest response rate in the last 5 years (52.2%) as is demonstrated by the table below:

	2016	2017	2018	2019	2020
Best	76.3%	72.6%	71.6%	76.0%	79.8%
TRFT*	40.2%	41.5%	38.5%	48.0%	52.2%
Median	42.3%	43.9%	43.6%	46.9%	45.4%
Worst	28.8%	27.3%	24.6%	27.2%	28.1%

\*TRFT stands for The Rotherham NHS Foundation Trust

## Areas of improvement

Our staff have rated the Trust as good as, or better than, most Trusts for:

- Morale
- Team working
- Equality, Diversity and Inclusion
- Immediate managers
- Safe environment from bullying and harassment
- Safe environment from violence
- Health and wellbeing

## Future Priorities and Targets

### Statement of key priority areas

The key areas where we aspire to do better and which will be a focus for all our colleagues during 2021/22 are:

- Care of patients is our top priority
- Reporting experiences of physical violence
- Staffing levels
- Avoid coming to work when unwell

### Performance against priority areas

The Trust improved against the key priority areas identified last year, with key improvements being made in relation to:

- Staff would recommend the Trust as a place to work
- If a friend or relative needed treatment, staff would be happy with the standard of care we provide
- Staff have adequate materials, supplies and equipment to do their job
- There has been a decrease in the number of staff planning to leave or likely to look for a job at another organisation

### Monitoring arrangements and 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 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 the monthly divisional performance meetings 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.



## Governance and Organisational Structure

### Board of Directors

The Trust's Board of Directors operates as a unitary board which is collectively responsible for all areas of the Trust's performance (clinical and service quality, operational performance, financial performance and management and governance). Best practice standards are used by the Board as part of its governance framework.

The Board is legally accountable for the services provided by the Trust, and its key responsibilities include:

- Setting the strategic direction (having taken into account the views of members of Council of Governors)
- Ensuring the maintenance of adequate systems and processes to deliver the Trust's annual Operational Plan
- Ensuring the provisions of safe, clean, high quality and professional care services for patients
- Ensuring the implementation of robust governance arrangements underpinned by an effective framework of assurance which support sound systems of internal control including the appointment and dismissal of Board Committees
- Undertaking rigorous performance management enabling the Trust to achieve local and national targets
- Seeking continuous improvement and innovation
- Measuring and assessing the effectiveness and efficiency of the Trust
- Approving proposed expenditure above specified financial limits
- Ensuring that the Trust remains compliant with its Licence, at all times, as issued by NHS Improvement
- Exercising the powers of the Trust established under statute, as described within the Trust's Constitution

The Board also leads the establishment of the values and standards of conduct expected of both the Trust and all of its colleagues ensuring these are in accordance with NHS values and the 'Nolan Principles'<sup>10</sup> of public life: selflessness, objectivity, integrity, accountability, openness, honesty and leadership. The 'Nolan Principles' describe the ethical standards expected of individuals who hold public office. The Trust has continued to ensure that during 2020/21 its systems remained compliant with NHS England's Conflicts of Interest guidance. During the year this involved the launch of an electronic module of the Electronic Staff Record system to enable annual declarations of interest or nil returns to be completed and recorded electronically.

The *Matters Reserved to the Board* and the *Scheme of Delegation* are two key corporate governance documents which detail the powers and decisions that the Board of Directors has resolved may only be exercised by itself during a formal session.

The day to day management of the organisation is delegated from 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

<sup>10</sup> <https://www.gov.uk/government/publications/the-7-principles-of-public-life>

achievement is monitored on a monthly and quarterly basis through updates from the Executive Director to the Board of Directors.

### *Composition of the Board of Directors*

The Board of Directors is comprised of both full time Executive Directors and part-time Non-Executive Directors. The Non-Executive Directors are appointed by the Council of Governors from the Membership of the Trust. Non-Executive Directors bring broad business, clinical or other experience and include individuals specifically appointed due to their financial and/or commercial experience, existing knowledge of the NHS, educational backgrounds, voluntary and charitable sector experience.

All the Non-Executive Directors are independent in character and they are free from material business or other relationships which may interfere with their judgement.

The Board of Directors considers that its range of skills, knowledge and experience is appropriate, balanced and complete for the challenges currently facing its Directors. Following both the external well-led review and the CQC inspections undertaken in 2018, the Board continued to increase the diversity of its members during 2020/21 through the appointment of two new Non-Executive Directors, its first Associate Non-Executive Director and a substantive Director of Finance who will join the Trust in the first half of 2021/22.

All Executive and Non-Executive Directors receive annual performance evaluations and appraisals. The performance appraisal and objective setting for the Chairman is undertaken jointly by the Senior Independent Director and the Lead Governor. Performance appraisal for the Non-Executive Directors is undertaken by the Chairman in conjunction with the Lead Governor. A collective view on each individual Non-Executive Director's performance provided by colleague Non-Executive Directors and the Executive Directors informs the appraisal processes.

The Chairman undertakes the Chief Executive's performance appraisal and the Interim Chief Executive undertakes the performance appraisals of the Executive Directors. A programme of Board Development days, Board seminar sessions and the on-going, quarterly review of the Board Assurance Framework have provided further evaluations of the performance of the Board. The Board has continued to work through a programme of Board Development with the support of an external facilitator to ensure best governance practice is embraced and embedded and that new members of the Board of Directors are able to participate fully in aspects of the Board's business.

The Trust did not receive a Use of Resources assessment during the year: the assessment planned for May 2020 having been postponed due to the pandemic. The Board Assurance Framework (BAF) provides a comprehensive review of the manner in which the Trust is identifying, managing and mitigating the risks to the achievement of its strategic objectives. Further refinement of the BAF took place during the first quarter of 2020/21 with a working group composed of members of the corporate governance team, Non-Executive Directors and the Trust's Internal Auditors leading the work. The resulting design of the BAF and the introduction of 'deep dive' reviews of all BAF items during the year were both well received by all

members of the Board and considered to have added further value to this key assurance process.

### *Meet the Board of Directors*

The descriptions which follow of the experience and expertise that each of the Directors bring to the Trust demonstrate the balance and relevance of the skills, knowledge and expertise of the Board of Directors as a whole. Details are provided for those Directors who were in post as at 31 March 2020.

## **Non-Executive Directors**

### **Martin Havenhand Chairman**

Martin is a very experienced Chairman and Non-Executive Director. He has a wealth of Executive and Non-Executive experience from both the public and private sectors and is knowledgeable and experienced in developing appropriate strategies and plans to achieve positive results.

He is passionate about improving health services and addressing health inequalities and is committed to improving the health and wellbeing of NHS staff post the COVID-19 pandemic.

He also brings to the Trust extensive experience and knowledge of the South Yorkshire and Bassetlaw community which is invaluable as the Trust is a partner in the South Yorkshire and Bassetlaw Integrated Care System and the Rotherham Place arrangements for developing and enhancing local health care services for the future.

The Rotherham NHS Foundation Trust is a key partner in the Rotherham Together Partnership and Martin is the Chairman of the Partnership's Place Board (Ambition Rotherham) which is made up of private and public sector leaders to promote the Rotherham Story on behalf of the Partnership.

Martin joined the Trust as Chairman in February 2014 and the Council of Governors initially re-appointed Martin as Chairman at their meeting in July 2016 for a further three-year term effective from February 2017.

Once a Non-Executive Director has served for six years at the Trust, the NHS Foundation Trust Code of Governance states that Non-Executive Directors should be subject to annual re-appointment following a rigorous review. Such a review was undertaken for Martin by the Council of Governors' Nomination Committee in February 2019. As a result, in April 2019 the Council of Governors again re-appointed Martin as Chairman for a further three-year term effective from February 2020, subject to satisfactory annual review. As at end March 2020 Martin had served just over six years as the Trust's Chairman.

Martin, as Chairman of the Trust, chairs the Board of Directors and the Board Nominations Committee. He is also the Chair of the Council of Governors' meetings and the Chair of the Governors' Nominations Committee.

The other significant commitments of the Chairman were disclosed before formal approval of the appointment by the Council of Governors and are documented in the Register of Interest. Details about how to access the Register of Interests are described above.

**Nicola Bancroft**  
**Non-Executive Director**

Nicola Bancroft was appointed as a Non-Executive member of the Board of Directors on 01 October 2019 for a three-year term of office.

She has over 30 years commercial experience in the retail sector, having worked for Walgreens Boots Alliance in a number of senior finance and strategy leadership roles and for DFS where she was Group Chief Financial Officer. She worked extensively on the implementation of various customer focused strategies and transformation programmes in both businesses.

Throughout her career Nicola has always been passionate about coaching and developing leaders and their teams to be at their best. She has a first class honours degree in accounting and finance and is a fellow of the Chartered Institute of Management Accountants. Nicola is also a member of the Finance and Risk Committee for Business in the Community, a charity dedicated to championing responsible business.

During 2020/21 Nicola was a member of both the Remuneration and Charitable Funds Committees. From April to July 2020 Nicola served as Vice-Chair of Audit Committee and as a member of the Finance & Performance Committee. In August 2021 Nicola became the Chair of the Finance & Performance Committee and continued as a member of the Audit Committee.

From 01 April 2021 continued as Chair of the Finance & Performance Committee, as a member of both the Audit and Charitable Funds Committees and became Vice Chair of the Remuneration Committee.

**Joe Barnes**  
**Non-Executive Director and Senior Independent Director**

Joe spent almost nine years as a Non-Executive Director at Doncaster and Bassetlaw NHS Foundation Trust where, at various times, he was Chair of the Audit and Clinical Governance Committees, Senior Independent Director and Deputy Chair. He spent most of his career with British Coal and the Coal Pension Funds and he is a qualified accountant.

Joe joined the Trust as a Non-Executive Director in September 2013 and became the Trust's Senior Independent Director in April 2018.

In July 2016 the Council of Governors re-appointed Joe for a further three-year term of office from September 2016.

Having served six years as a Non-Executive Director of the Trust, a rigorous review (as required by the Foundation Trust Code of Governance) was undertaken by the Council of Governors' Nomination Committee in June 2016 which led to Joe being

reappointed for a further one-year term of office from September 2019 to September 2020 by the Council of Governors at their July 2019 meeting.

In July 2020 the Council of Governors approved a six-month extension to Joe's term of office until the end of March 2021. Joe left the Trust on 31 March 2021 having served a total of seven and a half years.

During 2020/21 Joe served as Chairman of both the Audit Committee and the Remuneration Committee and a member of the People Committee.

### **Heather Craven Non-Executive Director**

Heather is a Chartered Accountant who trained with KPMG. She has spent most 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 she has helped a number of organisations, via interim and consultancy roles, to identify operational, commercial, and financial issues and weaknesses and has delivered solutions to resolve those problems. A key element of that work has been focus on developing and implementing strategies to deliver growth, profitability and sustainability.

Heather has been a Non-Executive Director at the Trust since February 2017. During this time Heather has served on three of the four Board assurance committees and currently serves on the Quality Committee.

She remains committed to using her skills and experience to assist the Trust in meeting the challenges it faces in delivering a quality healthcare service and improving its operational performance and its financial stability.

Heather was initially appointed as a Non-Executive Director in February 2017 for a three-year term of office. At its July 2019 meeting, the Council of Governors re-appointed Heather for a further three-year term of office from February 2020 to February 2023.

During 2020/21 Heather served as Vice-Chair of the Remuneration Committee. From April to July 2020 Heather served as Chair of the Finance & Performance Committee and as a member of the Charitable Funds Committee. From August 2020 Heather became a member of the Quality Committee and Vice-Chair of the Charitable Funds Committee.

From 01 April 2021 Heather continued as Vice Chair of the Charitable Funds Committee and as a member of the Quality Committee. She also became Chair of the Remuneration Committee.

**Mark Edgell**  
**Non-Executive Director**

Mark joined The Rotherham NHS Foundation Trust as a Non-Executive Director on 01 June 2012. Mark has lived in central Rotherham since the mid-1980s and has a deep commitment to the town, the Borough and South Yorkshire. He spent 13 years as a Councillor and was Leader of Rotherham Metropolitan Borough Council for several years in the early 2000s.

Through his role at the Trust and his passion for ensuring local people enjoy high quality public services that effectively meet their needs, Mark seeks to help The Rotherham NHS Foundation Trust meet its challenges, both now and in the future.

Once a Non-Executive Director has served for six years at the Trust, the NHS Foundation Trust Code of Governance states that Non-Executive Directors should be subject to annual re-appointment following a rigorous review.

Having served six years as a Non-Executive Director of the Trust such a review was undertaken for Mark by the Council of Governors' Nomination Committee in September 2017. As a result, the Council of Governors re-appointed Mark at their meeting in October 2017 for a further two-year term of office from 01 June 2018, subject to annual review, to maintain continuity on the Quality Assurance Committee which is chaired by Mark.

Following a satisfactory annual review, the Council of Governors offered Mark a further extension, subject to annual review, from June 2020 to May 2021. As at end March 2020 Mark had served as a Non-Executive Director at the Trust for 8 years and 10 months.

From April to July 2020 Mark was Chair of the Quality Committee and a member of both the Audit Committee and Nomination Committee. From August 2020 Mark became Vice-Chair of both the Quality and Audit Committees and continued as a member of the Nomination Committee.

From 01 April to 31 May 2021 Mark continued as Vice Chair of the Quality Committee and a member of the Nomination Committee. He also became a member of the People Committee.

**Lynn Hagger**  
**Non-Executive Director and Vice Chair**

Lynn joined the Trust as a Non-Executive Director 01 October 2013 for an initial three-year term of office.

After careers in social work and legal practice, Lynn became a legal academic with lectureships at the Universities of Manchester, Liverpool and then Sheffield. She has taught administrative / public law, contract, environmental and European law, then specialising in healthcare law and ethics at undergraduate and postgraduate level.

Lynn has published extensively in this area including two books: *The Child as Vulnerable Patient: Protection and Empowerment* and *A Good Death: Law and Ethics in Practice*. In parallel with these activities, Lynn has been involved in the

NHS for over 35 years, mostly as a Non-Executive Director of acute hospital boards, and including as Chair of Sheffield Children's NHS Foundation Trust and Non-Executive Director at Leeds Teaching NHS Trust.

The Council of Governors re-appointed Lynn for a further three-year term of office with effect from October 2016 at their meeting in July 2016. Having served six years as a Non-Executive Director of the Trust, a rigorous review (as required by the Foundation Trust Code of Governance) was undertaken by the Council of Governors' Nomination Committee in June 2019 which resulted in the Council of Governors re-appointing Lynn for a further two-year term, subject to annual review, from October 2019 to September 2021.

On 14 October 2020 the Council of Governors approved a one-year extension to Lynn's term of office from 01 October 2021 to 30 September 2022. As at end March 2021 Lynn had served seven and a half years as a Non-Executive Director.

During 2020/21 Lynn served as Deputy Chair of the Board of Directors, Chair of the People Committee, Vice-Chair of the Nomination Committee. From April to July 2020 Lynn was a member of the Quality Committee and Vice-Chair of the Charitable Funds Committee. From August 2020 onwards Lynn served as a member of the Charitable Funds Committee and stood down from the Quality Committee.

From 01 April 2021 continued as Deputy Chair of the Board of Directors, Chair of the People Committee, Vice Chair of the Nomination Committee and a member of the Charitable Funds Committee.

### **Dr Rumit Shah** **Non-Executive Director**

Dr Rumit Shah became a Non-Executive Director on 01 January 2020 for a two-year term of office.

Rumit is currently a full-time practicing General Practitioner in Hatfield, Doncaster. He arrived in the UK to pursue his further education from Kenya in 1977 at the age of 16. A graduate of the University of Sheffield, Rumit initially followed a career path in Trauma and Orthopaedics. His commitment to the NHS spans over 37 years and during this time he has been engaged in various capacities including with the Local Medical Committee (LMC), Primary Care Groups, Primary Care Trusts and he has now been elected to be a Clinical Director of East Doncaster Primary Care Network. He is also the Chair of Doncaster LMC.

Rumit has been a GP Appraiser, on the National Clinical Assessment Service (NCAS) assessing General Practices, a GP member on the Area Prescribing Committee, and the Scheduled Drug Monitoring subcommittee of Doncaster CCG.

Dr Shah is a very keen advocate for excellent quality of care delivered in a timely fashion and in a safe environment with a clear emphasis on good communication.

During 2020/21 Rumit served as Vice-Chair of the Finance & Performance Committee and a member of the Nomination Committee. From April to July 2020

Rumit has served initially as Vice-Chair of the Quality Committee, assuming Chairmanship of this committee from August 2020. From 01 April 2021 Rumit continued as Chair of the Quality Committee, Vice Chair of the Finance and Performance Committee and member of the Nomination Committee.

**Michael Smith**  
**Non-Executive Director**

Michael Smith was appointed on 01 April 2019 and is an experienced Non-Executive Director, currently on the Board at Humber Teaching NHS Foundation Trust, having previously served in a similar capacity at Rotherham Doncaster and South Humber NHS Foundation Trust.

He has an Honours Degree in Law and a Master's in Business Administration. In 2016, Michael received his third degree - a Master's in Mental Health Law for which he was given a commendation.

Michael is a local man who lives in Wickersley. He has extensive experience in the public and private sectors and has been the President of Rotherham Chamber of Commerce. He is a volunteer director / trustee of the Magna Science Adventure Centre and is an enterprise adviser to a local Special School.

Michael was initially appointed for a one-year term of office which was due to conclude in March 2020. Following a review of the Board's composition in November 2019 by the Council of Governors' Nomination Committee, the Council of Governors re-appointed Michael for further two-year period from 1 April 2020 to 31 March 2022 at its January 2020 meeting.

During 2020/21 Mike served as Chair of the Charitable Funds Committee, Vice-Chair of the People Committee and as a member of both the Audit and Remuneration Committees.

From 01 April 2021 Mike became Vice Chair of the Audit Committee and continued to serve as Vice Chair of the People Committee, Chair of the Charitable Funds Committee and member of the Remuneration Committee.

**Executive Directors**  
**Dr Richard Jenkins**  
**Interim Chief Executive Officer**

Richard joined the Trust on 10 February 2020 as Interim Chief Executive on a joint basis with Barnsley Hospital NHS Foundation Trust, where he is also Chief Executive. He is one of the few qualified and clinically active Chief Executives in the UK. 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 1991 with an intercalated degree in virology as well as his medical degree. He was a trainee doctor in South Yorkshire until becoming a consultant in 2002, specialising in diabetes and endocrinology. During his training, he held various

roles including as Lecturer at the University of Sheffield and he spent three years doing research for a Doctor of Medicine degree.

### **Michael Wright**

**Interim Deputy Chief Executive until 31 October 2020**

**Deputy Chief Executive from 01 November 2020**

Michael joined the Trust on 10 February 2020 as Interim Deputy Chief Executive.

Michael has worked across both the NHS and Department for Work and Pensions. Previous NHS roles include being the Turnaround Director at Liverpool University Hospitals NHS Foundation Trust and the Director of Finance at Barnsley Hospital NHS Foundation Trust.

### **George Briggs**

**Chief Operating Officer**

George and his family live in Lincolnshire. George has worked in the NHS for 40 years working in a variety of organisations including Trusts and CCGs. He has extensive experience as general manager and associate director in a number of specialties including cardiothoracic, intensive care, surgery and medicine. George has also held a number of director positions in acute Trusts. George is now the longest serving Executive Director at the Trust having been in post for over three years.

George has held multiple senior roles across the UK which gave him the opportunity to support and learn from a varied number of NHS organisations.

### **Stuart Diggles**

**Interim Director of Finance from 14 November 2020**

Stuart Diggles joined the Trust in November 2020 as Interim Director of Finance.

Stuart began his career as a Mechanical Engineer working in the Aerospace sector before training as a Chartered Accountant, qualifying in 1994. Up to 2012 Stuart worked across a number of commercial enterprises in the private sector holding senior financial positions including Board director positions from 2001. Since 2012 Stuart has worked across a number of organisations, predominantly in the NHS holding a number of Board positions including Interim Director of Finance and Turnaround Director roles and also working as a consultant and advisor with a focus on financial improvement and turnaround.

### **Dr Callum Gardner**

**Medical Director**

Dr Gardner initially joined the Trust as Interim Medical Director in September 2018, bringing a wealth of experience to the organisation. His previous role was as Divisional Director for the Emergency and Medicine division at North West Anglia NHS Foundation Trust, where he helped lead the division from 'requires improvement' to 'good' in the 2018 CQC inspection. He has also previously held a number of key roles, including Deputy Medical Director and Associate Medical Director: Patient Experience, and was a doctor in the Royal Navy for almost 18 years. He is also a Consultant acute and general physician with a sub-specialty interest in respiratory medicine.

Dr Gardner was appointed as Medical Director substantively in November 2019 and continues to hold joint responsibility for quality and clinical governance with the Chief Nurse, under the Safe & Sound Quality Directorate. He is also the Trust's Responsible Officer and Caldicott Guardian.

### **Steven Ned**

#### **Joint Director of Workforce**

Steven Ned joined the Trust on 01 April 2019 as Joint Director of Workforce with Barnsley Hospital NHS Foundation Trust. He was previously at Sheffield Children's NHS Foundation Trust where he was Director of Human Resources and Deputy Chief Executive.

Steven has more than 30 years NHS experience and over 10 years working in senior roles within South Yorkshire.

### **Angela Wood**

#### **Chief Nurse**

Angela Wood joined the Trust in October 2018 as Interim Chief Nurse before being appointed to the substantive Chief Nurse position on 01 February 2019.

Angela, who has been nursing for 33 years, joined the Trust on secondment from her substantive role as Deputy Director of Nursing for Lancashire and South Cumbria at NHS England. She has held a number of senior nursing roles throughout her career, both strategic and operational, including significant experiences in acute, specialist and regulatory settings. Angela has a track record of achievement in quality, patient safety and patient experience agendas, and also has extensive experience in workforce planning and design.

She represents the Chief Nurses across South Yorkshire and Bassetlaw, acting as the Integrated Care System Nursing Workforce Lead. Angela is passionate about patients receiving safe, good quality care and staff being supported to deliver it.



### **Non-Executive Director Attendance at Board of Directors' Meetings 2020/21**

<b>Board of Directors</b>	<b>Martin Havenhand (Chair)</b>	<b>Nicola Bancroft</b>	<b>Joe Barnes</b>	<b>Heather Craven</b>	<b>Mark Edgell</b>	<b>Lynn Hagger</b>	<b>Michael Smith</b>	<b>Rumit Shah</b>
<b>Total eligible</b>	15	15	15	15	15	15	15	15
<b>Total attended</b>	15	15	15	13	15	13	14	14

### **Executive Director Attendance at Board of Directors' Meetings 2020/21**

<b>Board of Directors</b>	<b>Richard Jenkins</b>	<b>George Briggs</b>	<b>Stuart Diggles</b>	<b>Callum Gardner</b>	<b>Steve Hackett</b>	<b>Steve Ned</b>	<b>Simon Sheppard</b>	<b>Angela Wood</b>	<b>Michael Wright</b>
<b>Total eligible</b>	15	15	4	15	8	15	1	15	15
<b>Total attended</b>	15	13	4	14	8	13	1	13	14

### **Directors' Register of Interests**

The Directors' Register of Interests is available to view on the Trust's website ([http://www.therotherhamft.nhs.uk/Corporate\\_Governance\\_Information/Our\\_Board\\_of\\_Directors/](http://www.therotherhamft.nhs.uk/Corporate_Governance_Information/Our_Board_of_Directors/)) or by requesting a copy from the Company Secretary at the address below:

Ms Julie Dawes,  
Interim Company Secretary,  
General Management Department Level D,  
The Rotherham NHS Foundation Trust  
Moorgate Road,  
Rotherham S60 2UD

The contact details above may also be used by Members who wish to communicate with Directors.

### ***Register of Staff Interests including these members of the Board of Directors***

In accordance with NHS England's Conflicts of Interest guidance the Trust also maintains a register of the interests declared by colleagues who are not members of the Board of Directors. This register is updated on a six monthly basis and is located on the Trust's website: ([http://www.therotherhamft.nhs.uk/key\\_documents/](http://www.therotherhamft.nhs.uk/key_documents/))

### **Committees of the Board**

The Board of Directors has the following statutory Committees of the Board:

- Audit Committee
- Nominations Committee
- Remuneration Committee

The Terms of Reference of each of these committees can be found on the Trust's website: ([http://www.therotherhamft.nhs.uk/key\\_documents/](http://www.therotherhamft.nhs.uk/key_documents/))

### ***Audit Committee***

The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the Audit Committee Handbook published by the Healthcare Financial Management Association (HFMA)<sup>11</sup>

In accordance with the terms of reference the membership of the committee is comprised of four Non-Executive Directors with at least one member having recent and relevant financial experience.

The Committee was chaired throughout the year by Joe Barnes, a Non-Executive Director with relevant financial experience. From April 2020 to March 2021 four of the Non-Executive Directors were members of the Audit Committee, all of whom were considered to be independent.

The Trust's Chairman is neither the Chair nor a member of the Audit Committee. The Director of Finance and Company Secretary attend every meeting, and in addition, other Executive or Operational Directors attend meetings as required. Since January 2014 two members of the Council of Governors have been invited, as observers, to attend the Audit Committee. This practice continued (albeit via virtual meetings) during 2020/21.

The Audit Committee meeting is held at least five times per financial year, but may be held more or less frequently should circumstances require. During the period of 01 April 2020 to 31 March 2021, the committee met five times and discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

<sup>11</sup> Fourth edition, 2018

## Attendance at Audit Committee 2020/21

Audit Committee	Joe Barnes (Chair)	Nicola Bancroft	Mark Edgell	Mike Smith
<b>2020</b>				
24 April (cancelled due to COVID-19)				
20 May	Y	Y	Y	Y
01 June	Y	Y	Y	Y
28 July	Y	Y	Y	Y
27 October	Y	Y	Y	Y
<b>2021</b>				
29 January	Y	Y	Y	Y
<b>Attendance</b>	5/5	5/5	5/5	5/5

The following areas were the significant issues considered by the Audit Committee during 2020/21:

- Annual Governance Statement 2019/20
- Annual Report and Accounts 2019/20
- Head of Internal Audit Opinion 2019/20
- External Audit ISA 260 review 2019/20
- Internal Audit annual work plan for 2020/21
- Counter Fraud self-review tool for 2019/20, draft annual work plan 2020/21 and risk assessment for 2020/21
- Board Assurance Framework 2020/21
- Trust's Risk Register (scores of 15 and above)
- Annual Review of Standards of Business Conduct
- Annual Report of the Audit Committee 2019/20
- Freedom to Speak up Guardian Annual Update 2019/20
- Changes to Accounting Policies 2020/21

Exceptional items considered were:

- External Audit re-procurement during 2020
- Cyber security report
- Freedom to Speak Up Strategy
- Requirements of International Financial Reporting Standard (IFRS) 8 relating to operating segments
- Going Concern

Review of:

- Internal Auditor effectiveness
- External Auditor effectiveness

The significant risks identified by the External Auditors (Mazars LLP) at the January 2021 Audit Committee meeting were:

- Risk of management override of controls
- Risk of fraud in revenue recognition
- Valuation of property plant and equipment
- Carbon Energy Fund

During 2020/21 the Audit Committee continued to critically assess and review judgements applied in relation to the significant risks identified by Mazars (the Trust's External Auditor). In addition, the Committee has assessed the Trust's compliance with the relevant accounting standards.

### **Internal Auditors**

During 2020/21 the Committee worked with 360 Assurance as its Internal Auditors reviewing and strengthening the organisation's internal control processes. The recommendations from internal audits are used to continually improve the effectiveness of these processes.

### **External Auditors**

During 2020/21 Pricewaterhouse Coopers LLP (PwC) continued as the Trust's external auditor until 31 September 2020. The Council of Governors approved the direct award of the Trust's external audit contract to Mazars LLP at their meeting on 15 July 2020.

The contract with Mazars LLP is for an initial three year term from 01 October 2020 to 30 September 2023 with the option to extend by 12 months if agreed in writing by both parties. The total value of the contract for three years is £311,925.

### ***Nominations Committee***

The Trust has two Nominations Committees. Responsibility for the appointment of Executive Directors lies with the Board of Directors' Nominations Committee. Responsibility for the appointment of Non-Executive Directors lies with the Council of Governors' Nominations Committee. The Trust's Chairman chairs both of the Nominations Committees.

### ***Executive Director Appointments***

The Trust has two Nominations Committees: the Board of Directors' Nominations Committee is responsible for the appointment of Executive Directors. The Council of Governors' Nominations Committee is responsible for the appointment of Non-Executive Directors. The Trust's Chairman chairs both of the Nominations Committees.

The Committee's terms of reference state that the membership of the Board of Directors' Nomination Committee comprise:

- The Trust's Chair, who chairs the Committee
- Three other Non-Executive Directors; and
- The Interim Chief Executive, who is the Executive Lead

During 2020/21 Martin Havenhand continued to serve as Chair of the Committee, Lynn Hagger served as Vice Chair with Mark Edgell and Runit Shah serving as members of the Committee.

The Committee met three times during the year and attendance is detailed in the table below:

**Attendance at Nominations Committee (Executive Director appointments) 2020/21**

<b>Nominations Committee</b>	<b>Martin Havenhand (Chair)</b>	<b>Mark Edgell</b>	<b>Lynn Hagger</b>	<b>Runit Shah</b>	<b>Richard Jenkins</b>	<b>Steve Ned</b>
<b>2020</b>						
12 May 2020	Y	Y	Y	N	Y	Y
12 August 2020	Y	Y	Y	Y	Y	N
12 October 2020	Y	Y	Y	Y	Y	Y
<b>Attendance</b>	3/3	3/3	3/3	2/3	3/3	2/3

The Board of Directors' Nominations Committee is responsible for the identification of suitable candidates for Executive Director vacancies as they arise. The Committee recommends Executive Director appointments to the Chairman, the other Non-Executive Directors and the Interim Chief Executive (except in the case of the appointment of a Chief Executive).

The Committee considers the balance of qualifications, skills, diversity, knowledge and experience required by the Board of Directors as a whole before recommending a candidate for appointment. The size, composition and structure of the Board of Directors is reviewed on an annual basis by the Nominations Committee to ensure it remains appropriate to deliver its statutory responsibilities.

Throughout 2020/21, the Nomination Committee ensured that arrangements were in place to monitor compliance with statutory responsibilities. This included reviewing, approving, highlighting risks and gaining assurance in the following areas:

- The Committee agreed arrangements for the departure of the Director of Finance
- The Committee approved the appointment of an Interim Director of Finance to cover the above vacancy
- The Committee discussed and agreed an extension to the arrangements in relation to the Interim Chief Executive appointment
- The Committee agreed an initial extension to the Interim Deputy Chief Executive appointment and the subsequent permanent appointment to the substantive role of Deputy Chief Executive
- The Committee conducted an annual review of the outcomes from the Board skills audit
- There was an annual review of the Board structures, ensuring that they were still relevant and fit for purpose.
- The Committee received a report detailing compliance with the Fit and Proper Persons criteria for Directors
- The Committee reviewed its terms of reference, proposed changes and recommended these to the Board of Directors for approval. The most up to date version of the terms of reference were approved at the public Board meeting held in March 2021

The recruitment process undertaken to appoint the first Interim Director of Finance involved the consideration of four possible options with the Committee deciding to use the option of seconding an existing Director of Finance from another NHS provider organisation. Mr Steve Hackett was seconded from Rotherham Doncaster and South Humber (RDASH) NHS Foundation Trust on a part-time basis for an initial three month period from 14 May 2020 which was then extended by a period of up to 6 months at the Nominations Committee meeting in August 2020.

At the October 2020 Nominations Committee meeting it was agreed that the recruitment process to appoint a second Interim Director of Finance should include seeking suitable interim candidates both via a recruitment agency and through the regional Director of Finance at NHS Improvement / England. Mr Stuart Diggles was appointed as Interim Director of Finance from 14 November 2020.

The recruitment process undertaken to appoint the substantive Director of Finance was as follows: The Trust appointed Harvey Nash recruitment agency. The agency managed the appointment process of the Director of Finance role. Four candidates were shortlisted for the role with interviews taking place on the 17 December 2020. A stakeholder group and formal interview process was undertaken as part of the process. Mr Steve Hackett was appointed as substantive Director for Finance with effect from July 2021.

In August 2020 the Committee also approved the extension to the tenure of the Interim Deputy Chief Executive until 30 September 2021. In October 2020 the Nominations Committee reviewed the situation regarding the Interim Deputy Chief Executive's contract. Having weighted up the advantages and risks of Mr Wright continuing to cover the role as an interim, the Committee approved the

recommendation from the Interim Chief Executive that Mr Wright should be appointed as the substantive Deputy Chief Executive from 01 November 2020.

### **Performance Appraisal for Executive Directors**

The performance appraisal of the Interim Chief Executive is undertaken by the Chairman. The performance appraisals of the Executive Directors are undertaken by the Interim Chief Executive.

### ***Non-Executive Director Appointments***

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's Chairman and comprised of at least six Governors (two Public Governors of whom one should be the Lead Governor; two Staff Governors and two Partner Governors). In late 2020 when the Committee's Terms of Reference were reviewed the membership requirements were changed to no more than nine Governors (Public, Staff and Partner), including the Lead Governor.

The Committee met on three occasions during 2020/21.

Following agreement at the July 2020 Council of Governors meeting recruitment was undertaken during quarters three and four to appoint two new Non-Executive Directors to replace Mr Joe Barnes whose term of office concluded in March 2021 and Mr Mark Edgell whose term of office would conclude at the end of May 2021.

Following an analysis by the Committee of the current Board's skills, knowledge and diversity, recruitment was undertaken with the support of an external recruitment agency. The Committee established an Appointments Panel consisting of Governors (Public, Staff and Partner) and the Trust Chairman, who interviewed a total of seven candidates, supported by the recruitment agency in an advisory capacity.

All shortlisted candidates had had the opportunity to meet the Chairman prior to the formal interviews. In addition, stakeholder panels, which included Governors who were not members of the Appointments Panel, Executive Directors and Non-Executive Directors were held. The views from the stakeholder panel formed part of the final decision making process.

Based upon the recommendation from the Appointment Panel and the Committee, the Council of Governors at their February 2021 meeting approved the appointment of Mr Mike Killick for a three year term of office from 01 April 2021, and Dr Joanna Bibby for a three year term of office from 01 June 2021. Remuneration for both would be in accordance with national guidance and was set at £13,000 per annum.

In addition, the Committee took the view that a third candidate, Mr Kamran Malik, should be appointed on a one year term as an Associate Non-Executive Director. This term would commence on 01 April 2021 and be remunerated at £6,500. This appointment was also approved by the Council of Governors.

Other matters considered by the Committee included the annual review of its Terms of Reference, the appointment of the Senior Independent Director and the annual review of the fit and proper person test criteria for each Non-Executive Director, including the Chairman.

The Committee make recommendations as appropriate to the Council of Governors with a report following each meeting, and the Committee's minutes were also routinely provided to all Council members.

### **Performance Appraisal Process for Non-Executive Directors**

The Chair and Non-Executive Directors' annual appraisal and objective setting process was undertaken early in quarter one of 2020/21.

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

In July 2020, the Committee considered the outcome of the appraisal reviews for each Non-Executive Director, including the Chairman, with the Senior Independent Director being present to provide feedback in relation to the Chairman.

The Committee utilised these appraisals as part of their discussions when considering any terms of office for the Non-Executive Directors, including the Chairman. At this meeting support was given, which was later approved by the Council of Governors, to extend Mr Barnes' term of office for a further six months until the end of March 2021. This was to align with Non-Executive Director recruitment.

The July 2020 meeting also supported an extension to the appointment term for the Interim Chief Executive. This was due to the impact of the pandemic on completing the priorities he had been given on his appointment.

At the October 2020 meeting the Committee supported the proposal to offer a further one-year extension to the term of office for Ms Hagger, which would see her concluding her time at the Trust on 30 September 2022.

### **Non-statutory Committees of the Board 2020/21**

Quality Committee

Finance & Performance Committee

People Committee

The annual revision of the Terms of Reference of the non-Statutory Board Committees were approved by the Board of Directors in March 2020.

Self-assessments of the effectiveness of each of the non-statutory committees of the Board were undertaken during January 2021 through anonymous surveys sent to committee members and the results were reported to the Committees at their February 2021 meetings.

### **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's 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 (formerly known as Electoral Reform Services) in accordance with the requirements of the Trust's Constitution.

Although there were four scheduled meetings of the Council of Governors during 2020/21, due to the COVID-19 pandemic the planned April 2020 meeting did not take place. However, an agenda and supporting papers were circulated to enable the Council to remain informed of activities and the 2019/20 year-end outturn position. The same papers were made available on the Trust's internet pages with an opportunity for any member of the general public to send any questions to the Trust.

For the remainder of the financial year, due to the restrictions in place as a result of the pandemic, all Council of Governor meetings, including any informal sessions, were held virtually.

In addition to the scheduled meetings, an extraordinary Council of Governors meeting was held in December 2020.

Although Governor elections were held as scheduled during quarter one, a number of public Governor seats remained vacant following the conclusion of the process. In order to maximise the goodwill being shown to the NHS due to the pandemic, it was agreed that further Public Governor elections would be held during quarter two (summer 2020). From this second phase a further eight Public Governors were elected.

Detailed below are members of the Council of Governors during 2020/21 and their meeting attendance record:

<b>Constituency</b>	<b>Name</b>	<b>Term of Office</b>	<b>Meeting attendance 2020/21<sup>12</sup></b>
Wentworth North (Covering the electoral wards of Hooper, Swinton, Wath)	Vacancy x2	01.04.2020 to 31.10.2020	-
	Tania McGee	01.11.2020 to 31.05.2023	1 of 2
	Vacancy x1	01.11.2020 to 31.03.2021	-
Wentworth South (Covering the electoral wards of Rawmarsh, Silverwood, Valley)	Robert McPherson	01.06.2017 to 31.05.2020 Re-elected 01.06.2020 to 31.05.2023	3 of 4
	Vacancy (x1)	01.04.2020 to 31.10.2020	-
	Neil Redfern	01.11.2020 to 31.05.2023	2 of 2
Wentworth Valley (Covering the electoral wards of Hellaby, Maltby, Wickersley)	Mr Graham Barry Jenkinson	01.06.2011 to 31.05.2014 Re-elected: 01.06.2014 to 31.05.2017 Re-elected 01.06.2017 to 31.05.2020	N/A*
	Vacancy x1	01.04.2020 to 31.10.2020	-

<sup>12</sup> Excludes April 2020 meeting which was not held due to COVID-19

Constituency	Name	Term of Office	Meeting attendance 2020/21 <sup>12</sup>
	Andrew Ball	01.11.2020 to 31.05.2023	2 of 2
	Keith Stringer	01.11.2020 to 31.05.2023	2 of 2
Rotherham South (Covering the electoral wards of Boston Castle, Rotherham East, Sitwell)	Marilyn Gambles	01.06.2019 to 31.05.2022	4 of 4
	Mr A A Zaidi	01.06.2019 to 31.05.2022	3 of 4
Rotherham North (Covering the electoral wards of Keppel, Rotherham West, Wingfield)	Vacancy x2	01.04.2020 to 31.10.2020	-
	Gordon McKenney	01.11.2020 to 31.05.2023 Resigned 31.12.2020	1 of 1
	Vacancy x1	01.01.2021 to 31.03.2021	-
	Anthony Stephan Lowe	01.11.2020 to 31.05.2023	2 of 2
Rother Valley South (Covering the electoral wards of Anston & Woodsetts, Dinnington, Wales)	Gavin Rimmer (Lead Governor)	01.06.2014 to 31.05.2017 Re-elected 01.06.2017 to 31.05.2020 Re-elected 01.06.2020 to 31.05.2023	4 of 4
	Judy Dalton	01.06.2017 to 31.05.2020	N/A*
	Vacancy x1	01.06.2020 to 31.03.2021	-
Rother Valley West (Covering the electoral wards of Brinsworth & Catcliffe, Holderness, Rother Vale)	Mr Dennis Moore	01.06.2018 to 31.05.2021	3 of 4
	Hilda Littlewood	01.06.2017 to 31.05.2020	N/A*
	Vacancy x1	01.06.2020 to 31.03.2021	-
Rest of England	Vacancy x2	01.04.2020 to 31.10.2020	-

<b>Constituency</b>	<b>Name</b>	<b>Term of Office</b>	<b>Meeting attendance 2020/21<sup>12</sup></b>
(Covering those who live outside the borough)	Geoffrey Berry	01.11.2020 to 31.05.2023	2 of 2
	Frank Kler	01.11.2020 to 31.05.2023	2 of 2
Staff Governors (elected x5):	Vacancy x2	01.04.2020 to 31.05.2020	-
	Dr Julian McDonough	01.06.2019 to 31.05.2022	3 of 4
	Mr Christopher Bott	01.06.2019 to 31.05.2022	0 of 4
	Mr Owen Dickinson	01.06.2019 to 31.05.2022	3 of 4
	Clare Denning	01.11.2020 to 31.05.2023	3 of 4
	James Cooper	01.11.2020 to 31.05.2023	3 of 4
<b>Partner Governor Organisations (nominated/appointed):</b>			
Sheffield Hallam University	Dr Joanne Lidster	17.05.2019 to 16.05.2022	3 of 4
Sheffield University	Vacancy	01.04.2020 to 31.03.2021	-
Rotherham Partnership	Vacancy	01.04.2020 to 31.03.2021	-
Voluntary Action Rotherham	Mrs Jean Flanagan	01.09.2017 to 31.08.2020 01.09.2020 to 31.08.2023	4 of 4
Rotherham Metropolitan Borough Council	Cllr Patricia Jarvis	06.02.2017 to 05.02.2020 06.02.2020 to 05.02.2023	3 of 4
Barnsley and Rotherham Chamber of Commerce	Ms Tricia Smith	20.01.2020 to 19.01.2023	4 of 4
Rotherham Ethnic Minority Alliance	Mr Shakoor Adalat	12.02.2019 to 11.02.2022	2 of 4

N/A\* due to April 2020 meeting not being held due to the COVID-19 pandemic

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 views of Governors and Members. Their attendance during 2020/21 is detailed in the table below:

<b>Current Non-Executive Directors</b>	<b>Number of meetings attended</b>
Martin Havenhand	4
Nicola Bancroft	4
Joe Barnes	4
Heather Craven	4
Mark Edgell	4
Lynn Hagger	4
Rumit Shah	4
Michael Smith	2
<b>Current Executive Director</b>	<b>Number of meetings attended</b>
Richard Jenkins	3
George Briggs	1
Stuart Diggles	1
Callum Gardner	3
Steve Ned	0
Angela Wood	2
Michael Wright	3

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](http://www.therotherhamft.nhs.uk)) or by requesting a copy from the Company Secretary.

Company Secretary  
 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 [rg-h-tr.public.governors@nhs.net](mailto:rg-h-tr.public.governors@nhs.net) . Alternatively they may write to the Governor at the following address:

Name of Governor  
 Company Secretary  
 General Management Department, Level D  
 The Rotherham NHS Foundation Trust  
 Moorgate Road  
 Rotherham, S60 2UD

## The Foundation Trust Membership

At the end of 2020/21 there were over 15,115 Members of The Rotherham NHS Foundation Trust (TRFT), which includes public and staff members.

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.

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.

The Rotherham NHS Foundation Trust constituency boundaries are:



Rotherham South (Boston castle, Rotherham East & Sitwell)  
 Rotherham North (Kepple, Rotherham West, Wingfield)  
 Wentworth South (Rawmarsh, Silverwood, Valley)  
 Wentworth North (Hooper, Swinton, Wath)  
 Wentworth Valley (Hellaby, Maltby, Wickersley)  
 Rother Valley West (Brinsworth, Catcliffe, Holderness, Rother Vale)  
 Rother Valley South (Anston and Woodsetts, Dinnington, Wales)  
 Rest of England (covers all areas not within RMBC boundaries)

### Membership composition as at 24 February 2021

<b>Public</b>	
Rother Valley South	951
Rother Valley West	1,199
Rotherham North	1,385
Rotherham South	1,861
Wentworth North	1,095
Wentworth South	1,526
Wentworth Valley	1,565
Rest of England	1,462
<b>Total number of Public Members</b>	<b>11,044</b>
<b>Staff</b>	
Staff Class	4,071
<b>Total number of Staff Members</b>	<b>4,071</b>
<b>Total membership:</b>	<b>15,115</b>

The Trust values the continued support and engagement of its Membership and recognises the importance of a Membership that is representative of all the communities it serves. The Trust strives to ensure that its Membership is representative of the population as much as possible. Detailed below is a breakdown of the relevant information.

As at 24 February 2021 the Trust's membership was composed as follows:

	<b>Public</b>	<b>Staff</b>	<b>Total</b>
<b>Age</b>			
0-16	0	0	0
17-21	2	15	17
22-29	324	408	732
30-39	1,316	934	2,250
40-49	1,368	965	2,333
50-59	1,840	1,202	3,042
60-74	2,788	529	3,317
75+	2,191	12	2,203
Not stated	1,215	6	1,221

	Public	Staff	Total
<b>Gender</b>			
Unspecified	4	3	7
Male	4,335	621	4,956
Female	6,705	3,447	10,152
Transgender	0	0	0
<b>Ethnicity</b>			
White - English, Welsh, Scottish, Northern Irish, British	3,822	2,677	6,499
White - Irish	16	9	25
White - Gypsy or Irish Traveller	0	0	0
White - Other	13	29	42
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	5	15
Asian or Asian British - Indian	33	52	85
Asian or Asian British - Pakistani	166	26	192
Asian or Asian British - Bangladeshi	3	2	5
Asian or Asian British - Chinese	5	6	11
Asian or Asian British - Other Asian	21	18	39
Black or Black British - African	24	20	44
Black or Black British - Caribbean	5	6	11
Black or Black British - Other Black	13	3	16
Other Ethnic Group - Arab	0	0	0
Other Ethnic Group - Any Other Ethnic Group	66	28	94
Not stated	6,843	1,172	8,015
<b>Total numbers of Members</b>	<b>11,044</b>	<b>4,071</b>	<b>15,115</b>

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 were significantly hindered during 2020/21 due to the COVID-19 pandemic.

At the start of the pandemic, in March 2020, the Trust followed national guidance and only engaged with Members on matters relating to the pandemic. However, due to the continued COVID-19 pandemic, for the duration of 2020/21 opportunities to engage with Members and the general public were limited due to the reduction in activities and opportunities for face to face engagement such as the previously established Governors Surgeries.

As the pandemic continued, the Trust ensured Members, and the general public remained informed on relevant non-pandemic matters through media activities and general briefings.

Taking the opportunity to refocus, during the late summer of 2020 a Governor Member Engagement Group was established. The initial focus of this group was to draw upon the support being shown to the NHS as a consequence of the pandemic, and engage where practicable with Members and the general public to hold a second round of Public Governor elections. This positive work resulted in a number of long standing vacancies being filled at the end of October 2020. The knowledge gained would again be harnessed for the annual elections which commenced in March 2021.

This new group developed a Governor Mission statement, which was approved by the Council of Governors:

*'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 group now meet on a quarterly basis and are drawing up plans and strategies and working in collaboration with Trust officers to widen Member engagement in readiness for when the country moves out of the pandemic. However, 2020/21 provided the Governors and the Trust with the opportunity to refresh the approach to engagement and the communication platforms now more frequently used as a means to communicate with Members and potentially build the membership base.

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 2020 was a virtual event. This was well attended and still afforded the opportunity for the Trust to share the Annual Report and Accounts, reflect on the previous year and look forward to the future.

Members continue to be able to contact their Governor by sending an e-mail to: [rgh-tr.public.governors@nhs.net](mailto:rgh-tr.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: [rgh-tr.staffgovernors@nhs.net](mailto:rgh-tr.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](mailto:your.experience@nhs.net) e-mail or the Trust's switchboard.

## Disclosures as set out in the NHS Foundation Trust Code of Governance

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board and Council of Governors	A.1.1	<p>The board of directors should meet sufficiently regularly to discharge its duties effectively. There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. <b>This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved.</b> The annual report should include this schedule of matters <b>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.</b></p> <p>These arrangements should be kept under review at least annually.</p>	<p>Compliant</p> <p>A statement describing how any disagreements between the Board of Directors and Council of Governors would be resolved appears in Annexe 3 of the Trust's Constitution. Schedule of Matters Reserved last reviewed in December 2018 and March 2020. Summary statement included in Accountability Report.</p>
2: Disclose	Board, Nomination Committee (s), Audit Committee, Remuneration Committee	A.1.2	<p>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 remuneration<sup>13</sup> committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.</p> <p><b>Part of this requirement is also contained within paragraph 7.25</b> as part of the directors' report.</p>	<p>Compliant.</p> <p>Included in the Annual Report as follows: Directors' Report, Remuneration Report and Governance &amp; Organisational Structure section (Board of Directors, Audit Committee, Nominations Committee)</p>
2: Disclose	Council of Governors	A.5.3	<p>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. A record should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.</p>	<p>Compliant.</p> <p>Included in Governance &amp; Organisational Structure section (Council of Governors Section) Attendance by individual Governors at Council of Governors' meetings included in the Annual Report in the Governance &amp; Organisational Structure section (Council of Governors section)</p>
Additional requirement of FT ARM	Council of Governors	n/a	<p>The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.</p>	<p>Compliant.</p> <p>Included in Governance &amp; Organisational Structure</p>

<sup>13</sup> This requirement is also contained in paragraph 7.45 as part of the remuneration report requirements. The disclosure relating to the remuneration committee should only be made once.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
				section (Council of Governors Section)
2: Disclose	Board	B.1.1	<p>The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.</p> <p>The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination, including if the director:</p> <ul style="list-style-type: none"> <li>• has been an employee of the NHS foundation trust within the last five years;</li> <li>• has, or has had within the last three years, a material business relationship with the NHS foundation trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the NHS foundation trust;</li> <li>• has received or receives additional remuneration from the NHS foundation trust apart from a director's fee, participates in the NHS foundation trust's performance-related pay scheme, or is a member of the NHS foundation trust's pension scheme;</li> <li>• has close family ties with any of the NHS foundation trust's advisers, directors or senior employees;</li> <li>• holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;</li> <li>• has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or</li> <li>• is an appointed representative of the NHS foundation trust's university medical or dental school.</li> </ul>	<p>Compliant.</p> <p>Statement re: independence of Non-Executive Directors included in Governance &amp; Organisational Structure (Composition of the Board of Directors section, Non-Executive Directors section) Length of service over 6 years included in biographies of current Non-Executive Directors in Governance &amp; Organisational Structure (Composition of the Board of Directors section).</p>
2: Disclose	Board	B.1.4	<p>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. Both statements should also be available on the NHS foundation trust's website.</p>	<p>Compliant.</p> <p>Included in the Governance &amp; Organisational Structure section (Composition of the Board of Directors and Meet the Board of Directors section)</p>
Additional requirement of FT ARM	Board	n/a	<p>The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated</p>	<p>Compliant.</p> <p>Included in the Director's report (Meet the Board of Directors section)</p>

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
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.	Compliant. Included in Governance & Organisational Structure section (Nominations Committee section)
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.	Compliant. Included in Governance & Organisational Structure section (Nominations Committee section)
2: Disclose	Chair / Council of Governors	B.3.1	For the appointment of a chairperson, the nominations committee should prepare a job specification defining the role and capabilities required including an assessment of the time commitment expected, recognising the need for availability in the event of emergencies. 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. No individual, simultaneously whilst being a chairperson of an NHS foundation trust, should be the substantive chairperson of another NHS foundation trust.	Compliant. Included in the Governance & Organisational Structure section (Board of Directors section in the Chairman's biography)
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.	Compliant No formal Council of Governors meeting held in April 2020 (due to COVID-19) however through electric mechanisms the Trust was able to have a dialogue with Governors and facilitate their input into the Trust's strategic and operational planning. In addition, the Operational Priorities, Objectives and financial plan for 2020/21 were included Annual Members Meeting presentation held virtually on 29 September 2020.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
Additional requirement of FT ARM	Council of Governors	n/a	<p>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.</p> <p>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.</p> <p>* 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).</p> <p>** As inserted by section 151 (6) of the Health and Social Care Act 2012)</p>	<p>Compliant</p> <p>During 2020/21 the Governors have not exercised their power under paragraph 10C** of schedule 7 of the NHS Act 2006 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. This is due to the fact that Directors regularly attend the quarterly Council of Governors' meetings.</p>
2: Disclose	Board	B.6.1	<p>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, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.</p>	<p>Compliant.</p> <p>Included in Governance &amp; Organisational Structure section: Composition of Board of Directors (re: evaluation of Board) Nominations Committee (for Board members' evaluation). Also in 'Non-statutory Committees of the Board of Directors' section for Board committee evaluation.</p> <p>At the end of each Board meeting one of the Executive or Non-Executive Directors feeds back their evaluation of the meeting.</p>
2: Disclose	Board	B.6.2	<p>Evaluation of the boards of NHS foundations trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. 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.</p>	<p>Compliant.</p> <p>Included in Governance &amp; Organisational Structure section: Composition of Board of Directors (re: evaluation of Board) And in 'Non-statutory Committees of the Board of Directors' section (re: evaluation of Board committees)</p> <p>During 2018/19 The Governance Forum / RSM were commissioned by the Trust to undertake an external well-led review. In addition, NHS Improvement undertook their Use of Resources assessment of the Trust in September 2018 and the</p>

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
				CQC assessed the Trust against its 'well-led' domain at its inspection also in September 2018. Both NHSI and the CQC are regulators of the Trust.
2: Disclose	Board	C.1.1	<p>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.</p> <p>There should be a statement by the external auditor about their reporting responsibilities</p> <p>Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 7.92.</p>	Compliant. Included in the Directors' Report and Annual Governance Statement sections Statement from the External Auditor is included in their opinion on the Accounts
2: Disclose	Board	C.2.1	<p>The board of directors should maintain continuous oversight of the effectiveness of the NHS foundation trust's risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls. The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.</p>	Compliant. Included in the Annual Governance Statement section
2: Disclose	Audit Committee / control environment	C.2.2	<p>A trust should disclose in the annual report:</p> <p>(a) if it has an internal audit function, how the function is structured and what role it performs; or</p> <p>(b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.</p>	Compliant. Included in Governance & Organisational Structure section (Audit Committee section)
2: Disclose	Audit Committee / Council of Governors	C.3.5	<p>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.</p>	Not applicable.
2: Disclose	Audit Committee	C.3.9	<p>A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include:</p>	Compliant. <ul style="list-style-type: none"> <li>Included in Governance &amp; Organisational Structure section (Audit Committee section)</li> </ul>

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
			<ul style="list-style-type: none"> <li>the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;</li> <li>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</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>Included in Governance &amp; Organisational Structure section (Audit Committee section)</li> <li>Not applicable no non-audit services provided by Mazars to the Trust during 2020/21.</li> </ul>
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, <b>the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.</b>	Compliant. None of the Trust's Executive Directors were released, for example to serve as a Non-Executive Director elsewhere, during 2020/21
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.	Website: Compliant Annual Report: Compliant, included in Governance & Organisational Structure section: Council of Governors section, FT membership section and Board of Directors section
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.	Compliant. Included in the Governance & Organisational Structure section (Council of Governors section)
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. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector.	Compliant. Included in FT Membership section of Governance & Organisational Structure section.
Additional requirement of FT ARM	Membership	n/a	The annual report should include: <ul style="list-style-type: none"> <li>a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership;</li> </ul>	Compliant. Included in FT Membership section of Governance & Organisational Structure section

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			<ul style="list-style-type: none"> <li>information on the number of members and the number of members in each constituency; and</li> <li>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.</li> </ul>	
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. See also ARM paragraph as directors' report requirement.	Compliant. Included in Governance & Organisational Structure section: <ul style="list-style-type: none"> <li>Board of Directors section</li> <li>At end of Council of Governors section.</li> </ul>
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.  The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives	Compliant.
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.  Where appropriate and, in particular, in high risk or complex areas, independent advice, for example, from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	Compliant.
6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where, within the structure of the	Compliant.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			organisation, consideration of clinical governance matters occurs.	
6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity, and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	Compliant.
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 which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles)	Compliant.
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. The board of directors should follow a policy of openness and transparency in its proceedings and decision-making unless this is in conflict with a need to protect the wider interests of the public or the NHS foundation trust (including commercial-in-confidence matters) and make clear how potential conflicts of interest are dealt with.	Compliant.
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. Assuming the governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	Compliant
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	Compliant.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			to be the chairperson of the same NHS foundation trust.	
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 to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	Compliant.
6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.  Led by the senior independent director, the non-executive directors should meet without the chairperson present, at least annually, to appraise the chairperson's performance, and on other such occasions as are deemed appropriate	Compliant.
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.  On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	Compliant.
6: Comply or explain	Council of Governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.  Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	Compliant.
6: Comply or explain	Council of Governors	A.5.2	The council of governors should not be so large as to be unwieldy.  The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and	Compliant.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			procedures of the council of governors should be reviewed regularly as described in provision B.6.5.	
6: Comply or explain	Council of Governors	A.5.4	<p>The roles and responsibilities of the council of governors should be set out in a written document.</p> <p>This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.</p>	Compliant
6: Comply or explain	Council of Governors	A.5.5	<p>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.</p> <p>In these meetings other members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant director present at the meeting about the affairs of the NHS foundation trust.</p>	Compliant.
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 about the performance of the board of directors, compliance with the new provider licence or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director (see A.4.1).	Compliant.
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. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Compliant.
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. The council should raise any issues with the chairperson with the senior independent director in the first instance.	Compliant.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
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, for example clinical statistical data and operational data	Compliant.
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.	Compliant
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.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.1	<p>The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.</p> <p>The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board of directors to meet them.</p>	Compliant.
6: Comply or explain	Board / Council of Governors	B.2.2	<p>Directors on the board of directors and governors on the council should meet the “fit and proper” persons test described in the provider licence.</p> <p>For the purpose of the licence and application criteria, “fit and proper” persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations.</p>	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.3	<p>There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson).</p> <p>The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.</p> <p>In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors and, in the light of this</p>	Compliant.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	
6: Comply or explain	Nomination Committee(s)	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).  At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chairman.	Compliant
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 non-executive directors.  Once suitable candidates have been identified the nominations committee should make recommendations to the council of governors.	Compliant.
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.  If only one nominations committee exists, when nominations for non-executives, including the appointment of a chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	Compliant.
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.	Compliant.
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 non-executive directors.	Compliant.
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).	Compliant.
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	Compliant.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			comparable size and complexity, nor the chairpersonship of such an organisation.	
6: Comply or explain	Board / Council of Governors	B.5.1	<p>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.</p> <p>The board of directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.</p>	Compliant.
6: Comply or explain	Board	B.5.2	<p>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.</p> <p>When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.</p>	Compliant.
6: Comply or explain	Board	B.5.3	<p>The board should ensure that directors, especially non-executive 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.</p> <p>Decisions to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.</p>	Compliant.
6: Comply or explain	Board / Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.	Compliant.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			The board of directors should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	
6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson, within a framework agreed by the council of governors and taking into account the views of directors and governors	Compliant
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.	Compliant
6: Comply or explain	Chair / Council of Governors	B.6.5	<p>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 including their impact and effectiveness on:</p> <ul style="list-style-type: none"> <li>• holding the non-executive directors individually and collectively to account for the performance of the board of directors.</li> <li>• communicating with their member constituencies and the public and transmitting their views to the board of directors; and</li> <li>• contributing to the development of forward plans of NHS foundation trusts.</li> </ul> <p>The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Monitor's publication: <i>Your statutory duties: A reference guide for NHS foundation trust governors</i></p>	Compliant
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.	Compliant.

Part of schedule A (see above)	Relating to	CoG ref	Summary of requirement	Self-assessment
			This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	
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 <b>service of their full notice period and/or material reductions in their time commitment to the role</b> , without the board first having completed and approved a full risk assessment.	Compliant
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.  See also ARM paragraph 7.15.	Compliant.
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.	Compliant.
6: Comply or explain	Board	C.1.4	a) The board of directors must notify Monitor 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.	Compliant

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			<p>b) The board of directors must notify Monitor 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:</p> <ul style="list-style-type: none"> <li>• the NHS foundation trust's financial condition;</li> <li>• the performance of its business; and/or</li> <li>• 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. 1</li> </ul>	
6: Comply or explain	Board / Audit Committee	C.3.1	<p>The board should establish an audit committee composed of at least three members who are all independent non-executive directors.</p> <p>The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively, including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.</p>	Compliant.
6: Comply or explain	Council of Governors / Audit Committee	C.3.3	<p>The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.</p> <p>The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.</p>	Compliant.
6: Comply or explain	Council of Governors / Audit Committee	C.3.6	<p>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. The current best practice is for a three- to five-year period of appointment.</p>	Compliant.
6: Comply or explain	Council of Governors	C.3.7	<p>When the council ends an external auditor's appointment in disputed circumstances, the</p>	Compliant.

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			chairperson should write to Monitor informing it of the reasons behind the decision.	
6: Comply or explain	Audit Committee	C.3.8	<p>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.</p> <p>The audit committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions</p>	Compliant.
6: Comply or explain	Remuneration Committee	D.1.1	<p>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.</p> <p>In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions:</p> <p>i) The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.</p> <p>ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate.</p>	Compliant.

<i>Part of schedule A (see above)</i>	<i>Relating to</i>	<i>CoG ref</i>	<i>Summary of requirement</i>	<i>Self-assessment</i>
			<p>iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed.</p> <p>iv) The remuneration committee should consider the pension consequences and associated costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.</p>	
6: Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	Compliant.
6: Comply or explain	Remuneration Committee	D.1.4	<p>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.</p> <p>The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.</p>	Compliant
6: Comply or explain	Remuneration Committee	D.2.2	<p>The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.</p> <p>The committee should also recommend and monitor the level and structure of remuneration for <b>senior management</b>. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.</p>	Compliant
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 non-executive.	Compliant
6: Comply or explain	Board	E.1.2	The board should <b>clarify in writing</b> how the public interests of patients and the local community will be represented, including its	Compliant

<b>Part of schedule A (see above)</b>	<b>Relating to</b>	<b>CoG ref</b>	<b>Summary of requirement</b>	<b>Self-assessment</b>
			approach for addressing the overlap and interface between governors and any local consultative forums (e.g., Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups).	
6: Comply or explain	Board	E.1.3	<p>The chairperson should ensure that the views of governors and members are communicated to the board as a whole.</p> <p>The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested by governors. The senior independent director should attend sufficient meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.</p>	Compliant.
6: Comply or explain	Board	E.2.1	<p>The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.</p> <p>The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.</p>	<p>Compliant:</p> <p><i>Schedule of third parties with whom the Trust has a duty of cooperation</i> on Trust website here:  <a href="http://www.therotherhamft.nhs.uk/key_documents/">http://www.therotherhamft.nhs.uk/key_documents/</a></p>
6: Comply or explain	Board	E.2.2	<p>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.</p> <p>The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.</p>	Compliant

## NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

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

### Segmentation

The Rotherham NHS Foundation Trust is in segment 3. This means that the Trust is in receipt of mandated and targeted support from NHS Improvement which has identified support needs in relation to quality of care, finance and use of resources and operational performance.

This segmentation information is the Trust's position as at 30 March 2021.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website<sup>14</sup>.

During 2020/21, the breaches against the Trust's Provider Licence remained in place. These breaches resulted from Enforcement Action taken against the Trust by Monitor in April 2013. The Trust was required to take specific actions, pursuant to section 106 of the Health and Social Care Act 2012, relating to financial planning, governance breaches, and breaches relating to the Electronic Patient Record (EPR) system.

Two of the breaches (those relating to governance and the EPR system) were lifted during 2014/15 because NHS Improvement (then Monitor) considered that the Trust had taken all of the actions required of it.

Progress in relation to the outstanding financial and strategic planning breaches has also been made by the Trust in terms of being able to evidence its compliance with the required actions. During the year the Trust's Executive Team has clarified with the regulator the actions which need to be taken and the evidence required in order for the outstanding licence breach to be lifted.

<sup>14</sup> Source of latest segmentation information dated 29 March 2021: <https://improvement.nhs.uk/resources/single-oversight-framework-segmentation/> last accessed on 30 March 2021

Consequently, the following breaches against the Trust's Licence remained in place throughout 2019/20: Licence conditions FT4(5)(a), FT4(5)(b), FT4(5)(d), FT4(5)(e), FT4(5)(f), FT4(5)(g) and CoS3(1).

The Trust's segment 3 rating allocated by NHS Improvement in October 2016, reflected the Trust's regulatory position at that time. Further details are provided in the Annual Governance Statement section of this Annual Report in the 'Future Risks' section.

Accountability Report signed by the Chief Executive in his role as Accounting Officer:



**Dr Richard Jenkins**  
**Interim Chief Executive**  
**11 June 2021**

## Statement of Accounting Officer's Responsibilities

### 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 The Rotherham 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 The Rotherham 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 outlined 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

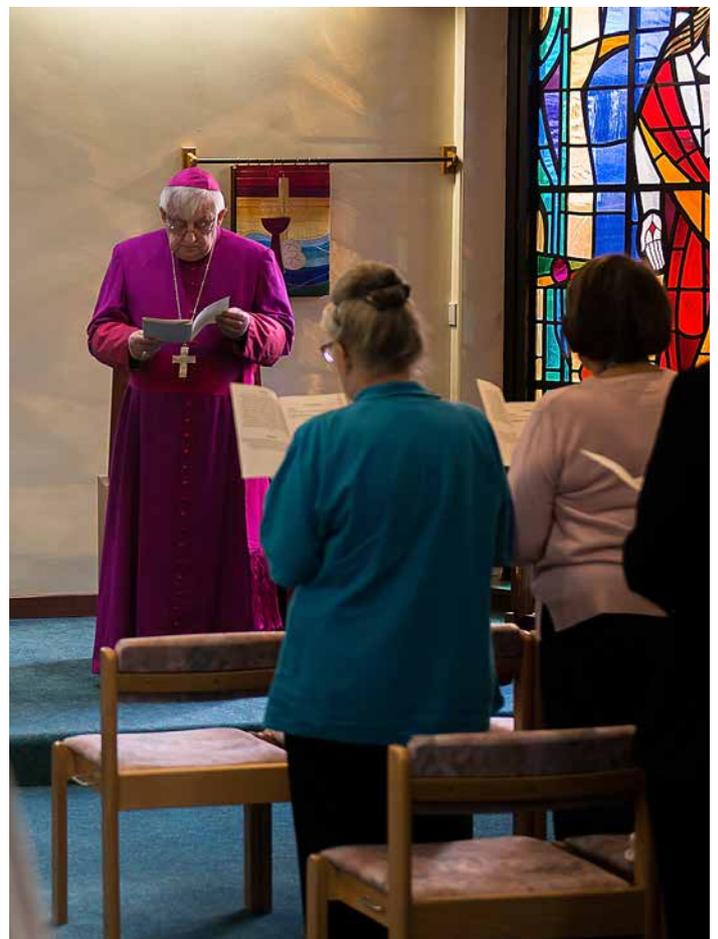
make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

*R. Jenkins*

**Dr Richard Jenkins**  
**Interim Chief Executive**  
**11 June 2021**





## Annual Governance Statement

### Scope of responsibility

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

### The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2021 and up to the date of approval of the annual report and accounts.

### Capacity to handle risk

The Trust Board of Directors ("the Board") has overall responsibility for the activity, integrity and strategy of the Trust and is accountable through its Chair, to NHS England/Improvement (NHSE/I). It provides leadership on the overall governance agenda, including risk management. It is supported by a number of committees that scrutinise and review assurances on internal control. These include:

- Audit Committee
- Quality Committee
- Finance and Performance Committee
- People Committee

The Board brings together the clinical, operational, financial, workforce, corporate and risk agendas and is responsible for the periodic review of the overall governance arrangements, both clinical and non-clinical to ensure they remain effective.

As Interim Chief Executive and designated Accounting Officer, I have overall responsibility for ensuring there are effective risk management and integrated governance systems in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by NHS Improvement in respect of governance and risk management.

To support me, I have delegated specific areas of risk management activity to each member of the executive team in accordance with their portfolios and as reflected in their job descriptions, for example, as follows:

- The Chief Nurse is the executive lead for ensuring a fully integrated and joined-up system of risk and control management is in place on behalf of the Board. This involves having day-to-day responsibility for the strategic development and implementation of organisational risk management;
- The Medical Director who is the Caldicott Guardian and the Chief Nurse are jointly responsible for clinical risk management. Whilst each has been allocated specific duties and responsibilities, there are clear lines of accountability;
- The Chief Nurse is also responsible for infection prevention and control, and safeguarding children and adults;
- The Medical Director has responsibility for the management of clinical standards;
- The Chief Operating Officer is responsible for risks to achieving overall operational performance;
- The Director of Finance provides the strategic lead for financial risk and the effective coordination of financial control throughout the Trust;
- The Director of Workforce and Organisational Development is responsible for staffing and workforce risks;
- The Deputy Chief Executive is the Senior Information Risk Officer (SIRO), for risks relating to information; and
- The Director of Corporate Affairs is responsible for the management of the Board Assurance Framework (BAF) and ensuring that strategic risks are identified and reported to the Board of Directors.

Over the past two years the Risk Management Strategy, Policy and guidance have been reviewed and updated with identification of risk appetites and risk tolerances. In addition, there are clear responsibilities for risk identified across the Trust. Day to day management of risk is undertaken by operational management who are charged with ensuring risk assessments are undertaken proactively throughout their area of responsibility and remedial action is carried out where problems are identified. There is a process of escalation to executive directors, relevant committees and governance groups for risks where there are difficulties in implementing mitigations.

The process of identification, assessment, analysis and management of risks (including incidents) is the responsibility of all staff across the Trust and particularly all managers. Staff receive appropriate training to equip themselves to manage risk in a way appropriate to their authority and duties, primarily through:

- Awareness of risk assessments which have to be carried out in their place of work and to compliance with control measures introduced by these risk assessments;
- Compliance with all legislation relevant to their role, including information governance requirements set locally by the Trust;
- Following all Trust policies and procedures;
- Reporting all adverse incidents and near misses via the Trust incident reporting system;
- Attending regular training as required ensuring safe working practices;

- Awareness of the Trust's Risk Management Strategy and their own patient safety and risk management processes; and
- Knowing their limitations and seeking advice and assistance in a timely manner when relevant.

The Trust recognises the importance of supporting staff through appropriate training, development and access to systems. The Board has set out the minimum requirements for staff to training to control key risks through a clear mandatory training programme including infection control, fire safety, safeguarding adults and children, information governance and manual handling. During 2020/21 we achieved 92.0% compliance against this programme. In addition there is training in incident investigation including documentation, root cause analysis, serious incidents and steps to prevent or minimise recurrence and reporting requirements.

Prior to the COVID-19 pandemic, the Trust delivered face to face risk management training for all staff of band 8a or equivalent, or above, and to anyone else who felt that it would be beneficial to their role. Due to COVID, this is now delivered online and has recently been opened up to all divisional governance group members. The training supports staff in identifying, recording and managing risks. Procedures and guides are sent to all staff who complete the training.

Incident, complaints, claims and patient feedback are routinely analysed to identify lessons learned and to help improve internal control and are reported to the Board through the Quality Committee. The Trust monitors the Duty of Candour and our obligation to be open, transparent and accountable to the public and our patients for our actions and commissions leading to episodes of poor care. This is reported and monitored by the Quality Committee.

The Trust has in place counter fraud arrangements through 360 Assurance Anti-Crime Services and has a named Counter Fraud Specialist. In order to ensure counter fraud resources are effectively managed there is a Counter Fraud Plan and Annual Counter Fraud Report which outlines the proactive, reactive and strategic counter fraud work undertaken for the Trust in 2020/21.

The Trust has recently agreed to appoint a health and safety lead who will deliver detailed risk assessor training during 2021/22.

### **The risk and control framework**

The Trust's risk management strategy provides a framework for managing risk across the organisation. It also provides a clear systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The Strategy sets out the role of the Board and its assurance committees together with individual responsibilities of the Interim Chief Executive, executive directors, other senior managers and all staff in managing risk. It assigns responsibility for the ownership and management of risks to all levels and individuals to ensure that risks which cannot be managed locally are escalated through the organisation. All risks are evaluated

against a common grading matrix to ensure that all risks are considered alike. The control measures, designed to mitigate and minimise risks, are recorded within the corporate risk register (CRR) and BAF.

The Risk Management Strategy works alongside the Trust-wide Operational Plan and Trust-wide Supporting Strategies to achieve the Risk Management Actions for the next five years.

Risk Management is an integral part of the Trust's quality, governance and performance framework. Colleagues have a role in considering risk, mitigating and managing risk, to ensure the delivery of safe, effective and high quality services.

The Trust has taken a proactive approach in improving its risk management and control framework over the past year through enhancing its governance structure and risk management arrangement. The strategy is reviewed on an ongoing basis as opportunities for improvement are identified and not less than once every three years. It is formally approved by the Board and includes an annual review of the Trust's risk appetite statement and thresholds for each of the BAF's individual risks items (risk tolerance levels) that are deemed acceptable. The purpose of the risk appetite statement is to articulate what risks the Board is willing or unwilling to take in order to achieve the Trust's strategic objectives. The Board last reviewed its risk appetite in June 2020 and this will be revisited in summer/early autumn 2021 to align with the newly approved Trust strategy.

The Board of Directors, with the support of the assurance committees, have a key role in ensuring there is a robust risk management system in place that is effectively managed and supports the development of a culture, where risk management is embedded across the organisation. Each committee receives a quarterly report on the strategic risks relating to their particular area of oversight and also undertakes periodic 'deep dives' into specific risk areas as a means of gaining further assurance. This enables the Board to focus on matters of strategic importance or those requiring escalation.

The Trust's Standing Orders and Scheme of Delegation outline the accountability arrangements and scope of responsibility of the Board of Directors, executive directors and the organisation's officers. The unitary Board was fully involved in agreeing the strategic priorities and annual objectives of the Trust, with the most important priorities being those set out in the Trust's annual plan, against which the Board submits regular reports to the Council of Governors.

The Board receives regular minutes and assurance logs from each of the board committees that report to it. The terms of reference of the committees of the Board have been reviewed to ensure that governance arrangements continue to be fit for purpose.

Effective risk management is the responsibility of every colleague, either permanent, temporary or of those contracted to work within, or for, the Trust.

This Strategy is based on the implementation and sustainability of the three actions detailed below. From November 2020 to October 2025, the Trust will aim to achieve the following Risk Management 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.

A number of tools are used to identify and control risks, including:

- The monthly Integrated Performance Reports, including serious incidents requiring investigations (SIRIs)
- Review of adverse incidents and accidents reports
- Reviews of claims and complaints
- Workforce engagement and leadership walk-arounds
- Annual fire inspection checks
- Health and safety risk assessments
- Self-assessment against the Care Quality Commission essential standards of quality and safety

The high level Board committee structure discharging overall responsibilities for risk management is summarised below:

- Audit Committee (AC), on behalf of the Board, reviews 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.
- Quality Committee (QC) 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 to ensure that their experience of our services and outcomes are as expected. This includes the CQC action plans.
- Finance and Performance Committee (FPC) is responsible for scrutinising aspects of financial and operational performance as requested by the Board, as well as conducting scrutiny of major business cases, proposed investment decisions and regular review of contracts with key partners.
- The People Committee (PC) is 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.

Operationally, risk management is delegated through the Risk Management Committee (RNC) , chaired by the Chief Nurse. This Committee provides assurance to the Board on the functioning of systems of risk management, and is supported by the Risk Analysis Group, the attendees of which, are taken from across the organisation. The agenda of the weekly executive team meetings, which are chaired

by the Interim Chief Executive, includes a standing item to consider any new organisational risks scoring 15 and above.

The RMC ensures that effective risk management processes encompass the following:

- Improvement to risk response: good risk management should provide the rigor to identify appropriate responses to risks (avoid, mitigate, share or accept).
- Reduction of operational surprises: the Committee should be able to identify potential issues that might adversely affect the organisation and be better able to respond in the event of a crisis.
- The identification and management of multiple and cross organisational risks: effective risk management should determine the scope of cross organisational risks and facilitate response to inter-related risks across the organisation.
- Improve deployment of resources: the Committee should ensure that the Trust has robust information on risk to allow the Board and the Executive Team Meeting to effectively assess the needs for capital and appropriate allocation of resources.

The Risk Analysis Group meets monthly to review and agree divisional risks of 15 and above which are then referred to monthly RMC for approval. The Chief Nurse chairs the Committee and quoracy requires two Executive Directors to be present. Risks are discussed at length to ensure new risks are appropriately assessed and current risks are reviewed and changed as required. Each of the risks is allocated to an Assurance Committee and reviewed quarterly which once agreed and supported are presented to the Trust Board. Any new risks identified as 15 and above are presented to the Executive Team Meeting with rationale for their allocation and to highlight current issues.

The Senior Information Risk Owner (SIRO), generally an Executive Director or other senior member of the board, has key responsibilities for acting as an advocate for information risk on the board advising on information risk issues, overseeing the development and implementation of an Information Risk Policy within the Information Governance Framework and providing leadership and guidance to a number of Information Asset Owners (IAOs).

The SIRO will take ownership of the risk assessment process for information and cyber security risk and review and agree action, in respect of identified risk and ensure all care systems have an assigned Information Asset Owner.

The SIRO will be expected to understand how the business goals of the organisation may be impacted by information risk.

The Caldicott Guardian is responsible for overseeing the use and sharing of patient information and the role was mandated within the NHS in 1999.

The role acts as the 'conscience' for the Trust and plays a key role in ensuring the organisation maintains the highest practical standards for handling patient information, whilst actively supporting work to share information where it is appropriate, advising

on options for lawful and ethical processing of the data. This is supported by the eight Caldicott Principles.

The Guardian should be an existing member of the senior management team and a healthcare professional with responsibility for clinical governance, championing confidentiality and information sharing at a senior and strategic management level.

The Guardian must be registered on the publicly available National Register of Caldicott Guardians and is encouraged to work with the SIRO and other Caldicott Guardians, to resolve conflicts of interest.

The Caldicott Guardian will ensure compliance with the 'Confidentiality: NHS Code of Practice and identify and address, any barriers to sharing for care.

The Data Protection Officer (DPO) is responsible for ensuring that the application of data protection and confidentiality legislation is consistently observed and any weaknesses in current practices are identified and remedied where possible. The DPO must have expert knowledge of data protection law and practices and the ability to acquire detailed understanding of the organisation's business, the purposes for which it processes, or intends to process personal data.

This is the principal officer with contact between the Trust and ICO, and has a statutory function under the Data Protection Act 2018 which means that they must be independent, and must not be fettered by organisational management.

The Information Governance Committee (IGC), of which the DPO is an attending member, meets on a regular basis to assess risks to security and integrity of information, and management of confidential information. The Committee monitors the completion of the Data Protection Security Toolkit submission, data flow mapping, information risks, and information asset registers, also ensuring the Trust has an effective framework with up to date policies, processes and management arrangements in place. There have been no escalations to the Audit Committee from April 2020 to the present date.

The framework aims to ensure that each information asset has a clearly defined administrator/manager who is responsible for that as set on a day to day basis. That manager implements the Information Governance policies, procedures and instructions to manage that asset and provides regular reports to the Information Asset Owner (IAO) for that asset, who is responsible and accountable for ensuring that information assets within their area are managed.

Health Informatics representatives provide system updates to the committee as well as providing the IT Security Group minutes. The DPO is also an attending member of the IT Security Group.

The Information Governance Committee is accountable to the Trust's Executive Team Meeting (ETM), and the Committee Chair will report as required on the Committee's proceedings.

The Digital Transformation Committee (DTC) meets monthly and reports to the Finance and Performance Committee. The Trust Board receives quarterly digital strategy updates.

In addition, clinical directors, operational managers, senior nursing colleagues all have delegated responsibility for ensuring effective risk management within their own areas.

The BAF is the mechanism which is used to identify and monitor risks which may affect achieving the Trust's strategic objectives and manage the associated risks that may compromise their achievement. Each BAF risk is assigned to an accountable board committee and lead executive director and is mapped to corresponding controls and assurances, both internal and external.

The BAF is reviewed on a monthly basis by the Executive Directors and formally reviewed quarterly by Board assurance committees and the Board of Directors to ensure that appropriate mitigating action is taken against the key risks. Operational and other corporate risks with scores of 15 and above, are also reviewed by the relevant Board assurance committees and the Board of Directors as part of its regular monitoring of risk management.

The Audit Committee oversees and monitors the performance of the risk management system and internal auditors (360 Assurance) and external auditors (Mazars) work closely with the Committee. The Chairs of each board committee have a standing invitation to attend the Audit Committee, ensuring the Committees of the Trust Board are aligned and have no gaps in assurance. The end of year BAF was received by the Audit Committee and the Trust Board in April 2021. It is the key document that underpins the Annual Governance Statement (AGS).

## **Provider Licence**

The NHS Provider Licence is the main tool for regulating providers of NHS services. The Board of Directors is responsible for ensuring compliance against the provider licence, mandatory guidance issued by NHS Improvement and other statutory requirements. There is a robust horizon scanning process in place which tracks legislative changes and changes in sector guidance. This is led by the Director of Corporate Affairs and reported to the Board along with an assessment of potential impact on the Trust.

During the year, the Trust retained breaches against its Licence, resulting from Enforcement Action taken by Monitor against the Trust in April 2013. Outstanding financial planning breaches, i.e. those relating to Licence conditions FT4(5)(a), FT4(5)(b), FT4(5)(d), FT4(5)(e), FT4(5)(f), FT4(5)(g) and CoS3(1), remain in place, as does an overall section 111 breach.

The NHS Oversight Framework (last published in 2019/20) outlines the joint approach NHS England / Improvement (NHSEI) take to oversee organisational performance and identify where commissioners and providers may need support. In 2019/20 NHSEI determined that the Trust should be put into Segment 3, specifically for support needs identified in quality of care, finance and use of resources and operational performance. There has been no change to this assessment by NHSEI in 2020/21.

Under the NHS Foundation Trust condition FT4(8)(b) the Board of Directors is required to assure itself of the validity of its Corporate Governance Statement. The Board of Directors reviews the Corporate Governance Statement every year to ensure that declarations being made can be supported with evidence. It considers the risks and mitigating actions that management provided to support the Statements and determine, both from its own work throughout the year - particularly the testing of the controls set out in the Assurance Framework - and assurances provided from the work of the Trust's internal auditors, external auditor and other external audits or reviews, whether the Statements are valid.

The annual self-certification for 2020/21 was considered and approved at the Board meeting in June 2021. This document states compliance with a number of licence conditions but non or partial compliance with FT 4(5) (a) – (d). Progress against items FT 4(5) (a) – (d) has been made and is monitored by the Board of Directors on a quarterly basis. The self-certification is available on the Trust's website.

### **CQC Registration Requirement and Well-Led Framework**

The Trust is registered and licensed by the Care Quality Commission (CQC) and is currently **fully compliant** with the registration requirements.

In October 2018, the CQC served a condition on the Trust registration relating to mitigating the risks within paediatric Urgent and Emergency Care Centre with a focus on medical and nursing staffing levels.

The CQC has taken enforcement action against the Rotherham NHS Foundation Trust during 2020/21.

During 2020/21 the Trust received two inspections/reviews by the CQC. In July 2020, concerns were raised about the safeguarding children pathway and in November 2020 in relation to quality of health in the Acute Medical Unit (AMU) and learning throughout the organisation. A Section 29A of the Health and Social Care Act warning notice was issued. In addition the Trust received a letter indicating CQC's intent to issue a warning notice under Section 31 of the Health and Social Care Act 2008. However, having addressed the issues raised by the CQC no further action was taken under Section 31. Immediate actions were undertaken in response to both inspections and an ongoing action plan was developed for each issue. Assurance continues to be provided to the CQC in relation to addressing the concerns identified on a regular basis.

A comprehensive action plan was created as a result of the inspection findings for the regulation breaches which was approved by the Board of Directors on 26th February 2018. The plan aimed for all actions to be in place by 31 October 2018, with the audits to confirm this completed by 31 March 2020.

Following the August 2019 inspection of the Urgent and Emergency Care Service, an additional action plan was developed and approved by the Board of Directors on 4 February 2020.

Following the July 2020 Safeguarding inspection, an additional action plan was developed and submitted to the CQC on the 14<sup>th</sup> July 2020 and received at the following Board of Directors meeting on the 4<sup>th</sup> August 2020.

Following the November 2020 review in relation to the quality of health provision in the AMU and learning throughout the organisation, an additional action plan was developed and received by the Board of Directors on 5 March 2021.

Throughout the course of the year the Trust has maintained contact with the CQC through regular conversations and correspondence with the Trust's lead CQC Inspector and quarterly engagement meetings.

To ensure robust implementation of the must and should do actions identified by the CQC, the Trust put in place specific governance arrangements based on NHS Improvement methodology for challenged Trust's whereby all actions are monitored through a Blue, Red, Amber, Green (BRAG) rating. In order for an action to become green, robust evidence will be required as assurance that:

- The action has been completed
- The action will achieve the intended impact
- Any identified risks are captured on a risk register
- There is a plan in place to monitor the effectiveness of the actions, including the impact for patients/staff.

In order for an action to become blue, a period of monitoring/measuring must be completed which demonstrates a sustained delivery of the expected outcome. This is a proven system of assurance of sustained improvement in the quality of care provided to patients and ensures the Board of Directors has a clear line of sight of the improvement changes in the organisation.

In compliance with NHS Improvement's publication '*Development Reviews of Leadership and Governance using the well-led framework: guidance for NHS Trusts and NHS Foundation Trust's - June 2017*', the Trust Board is committed to undertaking Well-Led Development Reviews every three years. An externally facilitated review was commissioned during 2019/20, in alignment with the guidance. The report highlighted a number of strengths and good practice. There were a few areas identified for development, all of which have been addressed.

The Trust has included the requirement for members of the Trust Board to make a declaration against the Fit and Proper Persons Test and following review, has robust arrangements in place for new appointments to the Board (whether non-executive or executive). The Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy monitoring and managing performance, and ensuring management capacity and capability.

## **Performance Information**

The Board reviews performance data each month against NHS Improvement and CQC standards via its Integrated Performance Report (IPR) focusing on key performance indicators, quality, operational, patient safety, patient experience and clinical outcomes; people and organisational development; and finance. The report highlights performance against agreed national, local or benchmark targets, and includes escalation reports for the some of the most significant areas of under delivery. Statistical process control charts are included for many key performance metrics. Each of the Board assurance committees receive the relevant elements of the integrated performance report for further scrutiny, challenge and assurance , with each Executive Director approving the content for their domain. The Deputy Chief Executive is the lead Executive for reporting on the performance of the organisation via the IPR.

## **Summary of major organisational risks**

At the time of publishing the Annual Governance Statement the key strategic risks to the delivery of the Trust's objectives, as described in the BAF are detailed below:

- Standards and 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
- 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 plan
- Inability to recruit and retain staff within the organisation leading to impaired ability to deliver the Trust plan and increased temporary staffing costs
- The lack of development of new roles within the organisation leads to continued workforce gaps impacting on the Trust's ability to deliver its plan
- Insufficiently robust Trust-wide quality and clinical governance arrangements impede the delivery of a number of Trust plans / objectives
- There is a risk that the delivery of a number of (non-clinical / quality focused) Trust plans / objectives may be at risk due to there being insufficiently robust governance arrangements in place across the Trust e.g. financial governance arrangements
- The financial plan is not delivered
- The lack of capital investment may affect the delivery of some services

- Misaligned governance and decision-making may arise from divergent Trust and ICS interests and objectives
- Ineffective relationships with key partners may lead to a lack of integrated working and poor service configuration across the Rotherham Place

### **COVID-19 Pandemic**

A further risk to delivery of the Trust's strategic objectives emerged in early 2020 with the outbreak of the Coronavirus COVID-19 pandemic which quickly escalated into a Level 4 National Major Incident. Due to the effectiveness of the Trust's governance structures and clear lines of leadership and accountability, in response to national guidance issued by NHS England / Improvement, the Trust's governance structures were dynamically reviewed and enhanced to be able to respond to the impacts of the pandemic. In February 2020, the Trust activated its Incident Management Room and Command and Control structures in response to the Coronavirus pandemic and all services across the organisation reviewed, enhanced and implemented their Business Continuity Plans in light of the extended nature of the incident.

The Board also reviewed the frequency, delegated authority and quoracy of the Trust Board, Assurance Committee and Council of Governor meetings in response to national NHS guidance to reduce the burden of meetings during this unprecedented period.

### **Stakeholder Involvement**

Established and effective arrangements are in place for working with key public stakeholders across the local health economy, including:

- Rotherham Clinical Commissioning Group
- Rotherham Metropolitan Borough Council
- Health Select Commission (RMBC)
- HealthWatch Rotherham
- Rotherham and Barnsley Chamber of Commerce
- Rotherham College / University College Rotherham
- Rotherham Place Board
- Voluntary Action Rotherham
- Yorkshire Ambulance Service
- South Yorkshire Police
- South Yorkshire Fire and Rescue Services
- South Yorkshire and Bassetlaw Integrated Care System
- NHS England
- NHS Improvement
- The Trust's Council of Governors, Trust members, and members of the public.

Gathering feedback from external stakeholders as well as using patients' and carers' views is important and also undertaken. This process enables these groups to feedback and scrutinise the Trust's activity ensuring that the patient and carer view is incorporated into our systems.

The organisation also has a number of patient experience groups, where patients and carers are members, which oversee and monitor involvement and patient experience activity in the Trust. Our patient experience team provides central reporting of low level concerns and issues raised by patients and the public. It is fully integrated with the complaints management process. These and other patient experience issues are considered at the patient experience group and then ultimately into the quality governance committee. This, along with other quality data, is reported in a quality dashboard that is presented to the Quality Committee.

Patients, service users, carers and visitors are encouraged to report any issue of concern, or suggest areas for improvement using leaflets, comment cards (positioned in patient areas), and through discharge patient surveys. The Trust actively takes part in the national Friends and Family Test model.

### **Conflicts of Interest**

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 NHS23* guidance.

[www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/](http://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/)

### **Pension Membership**

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

### **Equality, Diversity and Inclusion**

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with including development of action plans to address information arising from our Workforce Race Equality Standard and the Workforce Disability Equality Standard.

The Equality Impact Assessment Tool (EIA) is utilised to assess all policies. The Incident Reporting Patient Safety Team, actively encourage reporting. The Harm Free Care Meeting meets weekly to review incidents with a risk rating of moderate or above and discuss patient issues e.g. pressure sores. Items are reported into the weekly Serious Incident Panel chaired by the Chief Nurse or Medical Director or deputies.

## **Carbon Reduction Delivery Plans**

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

## **Review of economy, efficiency and effectiveness of the use of resources**

The Board, on a monthly basis, keeps under review the Trust's use of resources, financial performance and cost effectiveness through extracts of the monthly finance report and integrated performance report, reviewed in detail by the Finance and Performance Committee (FPC) and also received monthly by the Board. Where key risks and issues in relation to the Trust's use of resources are identified, reviews are presented to the FPC to ensure that a sufficient degree of assurance is obtained. Divisional performance and finance reviews are also held monthly and report into FPC through the Operations Directorate.

The oversight role of the Board and the FPC is supplemented by the annual internal audit programme which includes a comprehensive review of the Trust's financial systems and controls.

External auditors carry out the audit of financial systems and comment specifically on the use of resources, going concern and value for money in their reports to the Audit Committee and the Board.

The governance structure at Executive level and below provide opportunities for specific divisions, service lines and departments to be challenged on their use of resources within the respective services which they provide. All budget holders are provided with monthly financial information to help them ensure resources are used economically, efficiently and effectively. All divisions and corporate areas are set cost improvement targets as part of the operational and financial planning processes, delivery against these targets are reviewed at a monthly improvement board which reports through to FPC.

The Trust underwent a Use of Resources Assessment, led by NHS Improvement, in September 2018, the outcome of which was rated as 'requires improvement'. Further reviews have not yet taken place due to the COVID-19 pandemic, based on additional processes which have been put in place since the last assessment and improvements to governance arrangements across the Trust, it is expected that future assessments will show improvement.

## **Financial Sustainability**

In another financially challenging year for the Trust, the Trust delivered a surplus against a planned deficit position for 2020/21.

By the end of the year, the Trust's clinical income was favourable to plan by £18,096k, due in part to additional income to respond to the COVID-19 pandemic. Full year outturn pay costs were adverse to plan by £11,153k with 42% of this cost linked to the

management of the COVID19 pandemic, the remainder mainly due to superannuation costs funded through additional clinical income.

COVID-19 led to the national suspension of usual NHS planning processes for the first six months of the financial year 2020/21. A separate financial plan was set for the second half of 2020/21. The Trust has moved into 2021/22 with a financial plan covering the first six months of the year, this plan achieves a break even position. At this stage, it is unclear what will happen after this period and whether interim financial arrangements will continue longer than originally advised. However, it is clear that at some point, arrangements will be put in place to transition back to business as usual.

## **Information governance**

Information governance provides the framework for handling information in a secure and confidential manner. Covering 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.

Any serious incidents relating to information governance, data loss, confidentiality and data security are reviewed and monitored and the Caldicott Guardian and Senior Information Risk Officer (SIRO) are alerted in the case of any significant breach.

During the period 2020/21, there were two reportable incidents to the ICO using the Data Security Incident Reporting Tool which uses an algorithm to calculate whether the incident requires further investigation by the ICO.

The first incident (September 2020) was determined by the tool as 'non-reportable' to the ICO. This was concerned with a previous GP Registrar not having access to Trust clinical records removed, when employment with the Trust ended. After discussion with the Registration Authority (RA) Manager, additional internal measures are now in place to prevent a further occurrence.

The second incident (November 2020) was determined by the tool to be reportable to the ICO. This was concerned with a Subject Access Request (SAR) response being sent to a previous address (the Parent's address). An investigation was completed by the DPO, Information Governance Manager and the Patient Access Manager and additional checking procedures have been made to the Standard Operating Procedure (SOP). The ICO was satisfied with the actions taken by the Trust and communication with the data subject and no further action was taken.

The Trust carries out an annual assessment of its position against the Data Security and Protection Standards published by the Department of Health and Social Care. The most recent review was submitted on 31 March 2021.

## **Workforce Safeguards**

In line with the NHS 'Developing Workforce Safeguards' best practice guidance document, the Trust continues to improve its workforce reporting by interrogating and triangulating the workforce data in greater detail to manage workforce risks more effectively. This approach will include utilising evidence based tools, e.g.

establishment reviews, roster information together with professional judgement and patient outcome measures.

The Board of Directors and its Board assurance committees (Quality, Finance & Performance and People) receive regular reports detailing the staffing arrangements in place to provide assurance in respect of quality, safety, sustainability and effectiveness. The reports detail areas of risk and mitigation strategies in relation to workforce. Workforce assurance is also provided through the People Committee in respect of key workforce metrics, e.g. establishment data, sickness absence, statutory and mandatory training and turnover.

The Board has also approved a 'People Plan' which has a key objective to support and enable Clinical Divisions and Corporate Services to develop robust workforce planning strategies. The 'People Plan' also sets out our approach to people and skills, specifically to:

**Build** How we will build our workforce;

**Engage** How we will engage with all our people;

**Lead** How we will develop our leadership culture and nurture talent and,

**Learn** How we will ensure there are learning opportunities for all

## Data Quality and Governance

The Trust has arrangements in place to ensure its processes data that is accurate, reliable, timely, complete and sufficient, facilitating translation into meaningful information whenever and wherever required. Our Data Quality Team has continued to work with heads of service, line managers and health professionals across the Trust to ensure that all of our colleagues are supported to enable accurate and complete input of data and to have an understanding of the importance of data quality.

The annual review of all performance indicators (including constitutional KPIs, of which the size of the elective care waiting list is one), was carried out in Q3 2020/21, with updated data quality assurance statements being written and signed off for each indicator. Our system rates the 6 elements of granularity, contemporaneousness, completeness, sign-off, system / data source and audit to provide a grading of data quality ranging from 'No Assurance' to 'Substantial Assurance'. There were no elements of the Elective Care Waiting List data quality assessment which were rated as red – all were either reasonable or suitable.

The process supports the Data Protection and Security Toolkit assertion 1.7 and is acknowledged by the Trust's internal auditors and NHS Digital as an example of best practice nationally.

A quarterly report is presented to the Board providing assurance on progress against our digital strategy and data quality processes. In addition to this a Quarterly update of Data Quality matters are presented to the Trust Digital Transformation Committee to highlight areas that require attention at a Divisional / Service level.

## Significant Internal Control Issues

There are a number of significant issues facing the Trust in 2020/21

- *Improving the quality of care required to meet required standards*  
The CQC took enforcement action against the Trust during 2020/21. In July 2020, concerns were raised about the safeguarding children pathway and in November 2020 in relation to quality of health in the Acute Medical Unit (AMU) and learning throughout the organisation. A Section 29A of the Health and Social Care Act warning notice was issued. In addition the Trust received letter indicating CQC's intent to issue a warning notice under Section 31 of the Health and Social Care Act 2008. However, having addressed the issues raised by the CQC no further action was taken under Section 31. These issues are evidence of significant weaknesses in relation to:
  - Governance, and how the Trust ensures that it makes informed decisions and properly manages risks, and
  - Improving economy, efficiently and effectiveness, and how the Trust uses information about its costs and performance to improve the way it manages and delivers its services
- *Continuing to improve financial governance*  
In the first half of 2020/21, a number of financial governance issues were identified concerning the previous 2019/20 financial year in relation to the inception and approval of the Carbon Energy Fund project which called into question the basis for the project, the financial monitoring and reporting in the previous financial year which resulted in a worse than expected financial position, and a breach in standing financial instructions in relation to the Greenoaks project.

This highlights weaknesses in arrangements in relation to financial sustainability and governance.

- *Failure to address licence conditions*  
The Trust continues to have outstanding licence conditions in relation to financial breaches arising from enforcement action by NHS Improvement (formerly Monitor) between 2013 and 2015. This suggests the Trust has failed to achieve sufficient progress for these conditions to be lifted over a protracted period and is evidence of a significant weakness in arrangements in relation to financial sustainability.

Robust action plans have been proactively implemented during year to address and embed the identified areas of improvement.

## Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.

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.

This includes, but is not limited to the following:

- The Board has been actively involved in developing and reviewing the Trust's risk management processes including receiving and reviewing reports from the Risk Analysis Group and Audit Committee. The Board has also reviewed the Board Assurance Framework as well as monitoring performance objectives via the Board's Integrated Performance Report and tracking of the annual plan objectives.
- The Audit Committee has been a directing force in relation to reviewing the system of internal control particularly with regard to corporate risk and counter fraud. The Audit Committee and Finance and Performance Committees have key roles in the oversight of the Trust's key financial challenges.
- Executive Directors have ensured that key risks have been highlighted, monitored and the necessary action taken to address them. Executive Directors were also directly involved in producing and reviewing the Board Assurance Framework.
- Clinical Effectiveness & Research Group (CERG). This plan is informed by Trust priorities for quality improvement and developed by taking into account the NHS England Quality Accounts list 2020-21, which lists the National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement projects for prioritisation, along with locally agreed audits. The department facilitates, supports, and oversees delivery of Audit Plan and reports on the clinical effectiveness activities that have supported clinicians and healthcare professionals to examine and improve the quality of care. This activity has provided assurance of the standards of care and identification of areas for quality development, in line with national and local guidelines, with progress reported and any concerns on delivery on any part of the Audit Plan highlighted through CERG and the Clinical Governance Committee. The COVID pandemic has had an impact on national audits with some being cancelled and national guidance issued stating that 'data collection can be suspended'. Clinical time for work on audits has also been affected by the pandemic, reducing the audit activity possible. Local audits and quality improvement projects across the Trust have been carried out in response to the pandemic, in order to optimise the quality of care delivered with results and recommendations discussed and agreed at local Clinical Effectiveness and Governance meetings, and reported to CERG.

- Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan for 2020/21 approved by the Audit Committee. This work included identifying and evaluation controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards. Recommendations were made where scope for improvement was found, and actions agreed with management. The Head of Internal Audit has provided a moderate assurance opinion on the effectiveness of risk management, internal control and governance processes that are designed to support achievement of the Trust's objectives which is the same as the previous year.
- Perfect Ward is a digital audit tool that assesses if areas are meeting quality standards by asking a series of questions. It takes the form of an Application (App) that is operated on a smart phone or an electronic tablet. Audit questions are customised to meet the Trust's specific needs in terms of the areas to be assessed, the subjects to be assessed and the questions to be asked. It is designed to reduce the burden of staff carrying out paper based audits and audit results are immediately available on the App. Results can be analysed at area, division and Trust level.

Perfect Ward will be used in all areas of the Trust, both acute and community. Nine Perfect Ward audits will be implemented in 40 areas of the Trust. The questions for each audit will be tailored to each area.

Perfect Ward was purchased in April 2020 but due to the COVID-19 pandemic the implementation of the audit programme was delayed and progress has been slower than anticipated. However, this is now in use throughout the Trust and there has been good engagement from staff.

## Internal Audit

External Auditors (Mazars ) and Internal Auditors (360 Assurance) work closely with the Audit Committee, with Internal Audit undertaking reviews and providing assurance to the Committee on systems of control operating within the Trust. The Audit Committee considers the Board Assurance Framework and the Corporate Risk Register when setting Internal Audit's annual plan. The results of internal audits are reported to the Audit Committee, as well as the relevant assurance committee. Procedures are in place to monitor the implementation of control improvements and to undertake follow-up reviews if systems are deemed less than adequate. Internal Audit recommendations are robustly tracked via reports to the Audit Committee.

During the year the Trust identified no significant control weaknesses through its Internal Audit programme. This is reflected in the Head of Internal Audit Opinion of **Moderate Assurance** - that there is a generally sound framework of governance, risk management and control, however inconsistent application of controls puts achievement of the organisation's objectives at risk.

The opinion reflects the following third party assurances received in the year to date.

- The Trust's staff survey results were the fifth most improved in the country, demonstrating above average benchmark results across eight out of ten themes, and year-on-year improvements across all themes.
- Financial Governance Report and Measured Term Contract review report incorporating Greenoaks Development, both relating to 2019/20 and raising significant issues. Action plans are in place to address the issues
- CQC – the Trust is rated Requires Improvement. Three actions remain open from historic CQC inspections. This year, the Trust was inspected on the Children's Pathway and Safeguarding and concerns were raised about the safety of children in the Trust's care. The Trust has also been issued a Section 29a warning notice and at the time of writing, a further inspection is underway

The Trust took the opportunity through its Audit Plan to focus resource on areas where Internal Audit could add the most value to the Trust in its drive to provide the best services to its patients. A decision was made to defer two scheduled audits to allow for internal work to progress in those areas.

The summary of the audits and their associated assurance ratings for 2020/21 is as follows:

Audit assignment	Core audit	Status	Assurance level/comment
<b>2019/20 audits concluded in-year</b>			
Payroll	✓	Complete	Significant
Learning from Deaths – Stage 1 Mortality Reviews		Complete	Limited
<b>Outturn from 2020/21 audit plan</b>			
Policy management framework	✓	Complete	Limited
Leases		Complete	Advisory
eRostering	✓	Complete	Limited
CSU-level risk management	✓	Complete	Significant
NHSP and eRoster data analytics review		Complete	Advisory
Data quality framework – cancer two week waits	✓	Complete	Significant
Data security and protection toolkit	✓	Complete	Substantial (NHSD rating)
Learning from deaths governance		Complete	Limited
Integrity of the general ledger and financial reporting	✓	Complete	Significant
Procurement	✓	Complete	Significant
Quality governance	✓	Draft report	Indicative opinion - Significant
Learning from incidents		Deferred	
Consultant job planning		Deferred	

The following reviews have identified five high risk actions:

- eRostering: High risk issues were identified relating to non-compliance with the Trust's Rostering Policy/expectations, and a lack of staff engagement in eRostering resulting in a failure to ensure efficient, effective and safe rosters.

The three actions relating to these risk areas have now been implemented. There is a planned revisit audit in the 2021/22 plan.

- Learning from deaths governance: This identified that the processes for ensuring that learnings are identified, escalated, and disseminated are not embedded or consistently applied within the Division of Integrated Medicine. Two actions were agreed to mitigate this risk area which are due for completion by 30 June 2021. There is a planned revisit audit in the 2021/22 plan.

The Trust has responded positively to internal audit findings and has, or is in the process of taking appropriate actions to mitigate the risks identified during the year. From the 50 recommendations made within the scope of the work plan, 39 have been implemented within the original due date, nine have been implemented beyond their original due date and two remain in progress. This equates to an overall implementation rate of 96%.

In response to the impact of COVID-19, the organisation involved the Internal Audit team in its plan to develop and enhance its governance structures for the duration of the pandemic and has ensured that internal audit findings remain a core part of our quality, safety and risk considerations. The Head of Internal Audit Opinion has not been affected by the impact of COVID-19. However, the Internal Audit work plan for 2020/21 has been affected, and audits planned for the initial quarter were re-ordered due to social distancing rules, where auditors would need to be visiting clinical services in order to complete assessment.

## **External Audit**

External Audit provides independent assurance on the accounts, annual report and Annual Governance Statement. These documents and internal and external audits of specific areas of internal control provide the Board of Directors with the information it requires to gain assurance that the Trust is meeting its obligations to protect patients, staff, the public and other stakeholders against risks of any kind: which allows the Board to support me signing this Annual Governance Statement. The Auditor provided a clean unqualified audit opinion on 11 June 2021.

Review and assurance mechanisms are in place and the Trust continues to develop arrangements to ensure that:

- Management, including the Board regulatory reviews the risks and controls for which it is responsible
- Reviews are monitored and reported to the next level of management
- Changes to priorities or controls are recorded and appropriately referred or actioned
- Lessons which can be learned, from both successes and failures, are identified and circulated to those who can gain from them
- Appropriate level of independent assurance is provided on the whole process of risk.

## Conclusion

The Board is committed to continuous improvement of its governance arrangements to ensure that systems are in place to identify and manage risks and to ensure that Serious Incidents and incidents of non-compliance with standards and regulatory requirements are escalated and are subject to prompt and remedial action, so that patients, service users, staff and stakeholders of The Rotherham NHS Foundation Trust can be confident in the quality of the service we deliver and the effective, economic and efficient use of resources.

In summary, I am assured that the Trust has an overall sound system of internal controls in place, which is designed to manage the key organisational objectives and minimise exposure to risk. However, as Accounting Officer, I am reporting that a number of **significant internal control issues** have been noted for the year ended 31 March 2021. These are described above and relate primarily to:

- Quality of care for patients
- Governance and financial management
- Regulatory compliance

These issues have been disclosed to our regulators and formal action plans have been agreed and implemented to address control weaknesses in these areas where these have been identified. Progress is routinely reported to the Board of Directors and Board assurance committees.

I am assured that:

- The Board, executive directors and senior management have identified and are managing risks facing the Trust, with the escalations of risk events, an effective process for keeping risk scores up to date and flagging any risk and control concerns;
- There is an appropriate risk management framework embedded in the Trust; and
- The internal auditors and other independent assurance providers to the Trust, including external audit, have identified no major concerns from their risk focussed programme of independent assurance.

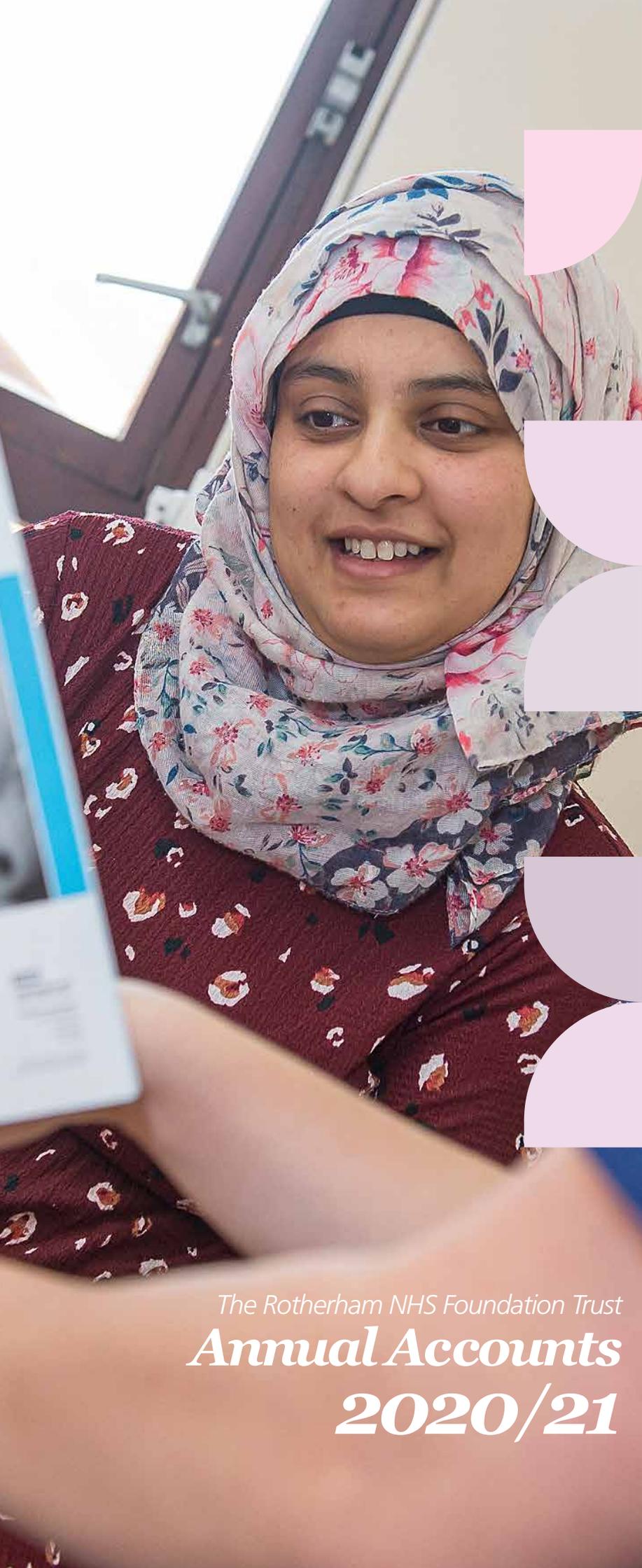
My review therefore confirms that sound systems of internal control have been in place in the Rotherham NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Finally, I would like to conclude my statement by outlining that the Trust, in common with other NHS providers, began its response to the outbreak of COVID-19 in the final quarter of 2019/20. Governance was a key element of our response, as well as underpinning all other aspects of our arrangements (for example, through

maintenance of a COVID-19 risk register). Arrangements for decision-making were reviewed and refined not only in order to support our response but also to retain the principles of good governance. Working with the Board, governors and all staff, I am fully committed to addressing the significant control issues highlighted above and to providing sustainable high quality care for the population of Rotherham.

*R. Jenkins*

**Dr Richard Jenkins**  
**Interim Chief Executive**  
11 June 2021



*The Rotherham NHS Foundation Trust*  
***Annual Accounts***  
***2020/21***

The Rotherham NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

**Foreword to the accounts**

**The Rotherham NHS Foundation Trust**

These accounts, for the year ended 31 March 2021, 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.

*R. Jenkins*

**Signed** .....

**Name** Dr Richard Jenkins  
**Job title** Interim Chief Executive  
**Date** 11 June 2021

## Statement of Financial Position

		31 March 2021 £000	31 March 2020 £000
<b>Non-current assets</b>			
Intangible assets	15	8,290	8,927
Property, plant and equipment	16	151,391	122,300
Receivables	24	52	54
<b>Total non-current assets</b>		<b>159,733</b>	<b>131,281</b>
<b>Current assets</b>			
Inventories	23	3,916	3,992
Receivables	24	8,760	26,002
Cash and cash equivalents	27	30,910	1,367
<b>Total current assets</b>		<b>43,586</b>	<b>31,361</b>
<b>Current liabilities</b>			
Trade and other payables	28	(39,400)	(27,911)
Borrowings	30	(2,257)	(59,455)
Provisions	33	(154)	(196)
Other liabilities	29	(815)	(1,425)
<b>Total current liabilities</b>		<b>(42,626)</b>	<b>(88,987)</b>
<b>Total assets less current liabilities</b>		<b>160,693</b>	<b>73,655</b>
<b>Non-current liabilities</b>			
Borrowings	30	(28,142)	(29,015)
Provisions	33	(1,002)	(986)
<b>Total non-current liabilities</b>		<b>(29,144)</b>	<b>(30,001)</b>
<b>Total assets employed</b>		<b>131,549</b>	<b>43,654</b>
<b>Financed by</b>			
Public dividend capital		161,872	80,038
Revaluation reserve		47,681	41,676
Income and expenditure reserve		(78,004)	(78,060)
<b>Total taxpayers' equity</b>		<b>131,549</b>	<b>43,654</b>

Signed

*R. Jenkins*

Name

Dr Richard Jenkins

Position

Interim Chief Executive

Date

11 June 2021

## Statement of Comprehensive Income

	2020/21	2019/20
Note	£000	£000
Operating income from patient care activities	3 274,972	242,465
Other operating income	4 49,127	46,149
Operating expenses	6, 8 (323,421)	(285,195)
<b>Operating surplus/(deficit) from continuing operations</b>	<b>678</b>	<b>3,419</b>
Finance income	11 3	80
Finance expenses	12 (597)	(2,639)
PDC dividends payable	(1,796)	(832)
<b>Net finance costs</b>	<b>(2,390)</b>	<b>(3,391)</b>
Other gains / (losses)	13 -	(19)
<b>Surplus / (deficit) for the year from continuing operations</b>	<b>(1,712)</b>	<b>9</b>
<b>Surplus / (deficit) for the year</b>	<b>(1,712)</b>	<b>9</b>
<b>Other comprehensive income</b>		
<b>Will not be reclassified to income and expenditure:</b>		
Revaluations	18 7,773	11
Other reserve movements	-	2
<b>Total comprehensive income / (expense) for the period</b>	<b>6,061</b>	<b>22</b>
<b>Adjusted financial performance (control total basis):</b>		
Surplus / (deficit) for the period	(1,712)	9
Remove net impairments not scoring to the Departmental expenditure limit	7,022	-
Remove I&E impact of capital grants and donations	(4,254)	41
Remove net impact of inventories received from DHSC group bodies for COVID response	(583)	-
<b>Adjusted financial performance surplus / (deficit)</b>	<b>473</b>	<b>50</b>

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' and others' equity at 1 April 2020 - brought forward</b>	<b>80,038</b>	<b>41,676</b>	<b>(78,060)</b>	<b>43,654</b>
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
<b>Taxpayers' and others' equity at 31 March 2021</b>	<b>161,872</b>	<b>47,681</b>	<b>(78,004)</b>	<b>131,549</b>

**Statement of Changes in Taxpayers Equity for the year ended 31 March 2020**

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
<b>Taxpayers' and others' equity at 1 April 2019 - brought forward</b>	<b>76,809</b>	<b>43,136</b>	<b>(79,541)</b>	<b>40,403</b>
Surplus/(deficit) for the year	-	-	9	9
Other transfers between reserves	-	(1,472)	1,472	-
Revaluations	-	11	-	11
Public dividend capital received	3,229	-	-	3,229
Other reserve movements	-	1	1	2
<b>Taxpayers' and others' equity at 31 March 2020</b>	<b>80,038</b>	<b>41,676</b>	<b>(78,060)</b>	<b>43,654</b>

## **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

	2020/21	2019/20
Note	£000	£000
<b>Cash flows from operating activities</b>		
Operating surplus / (deficit)	678	3,419
<b>Non-cash income and expense:</b>		
Depreciation and amortisation	6.1 8,844	7,621
Net impairments	7 7,022	-
Income recognised in respect of capital donations	4 (4,370)	-
(Increase) / decrease in receivables and other assets	17,324	(11,983)
(Increase) / decrease in inventories	76	(415)
Increase / (decrease) in payables and other liabilities	6,529	3,137
Increase / (decrease) in provisions	(16)	(293)
Other movements in operating cash flows	-	2
<b>Net cash flows from / (used in) operating activities</b>	<b><u>36,087</u></b>	<b><u>1,488</u></b>
<b>Cash flows from investing activities</b>		
Interest received	3	80
Purchase of intangible assets	(1,027)	(806)
Purchase of PPE and investment property	(15,020)	(6,613)
Sales of PPE and investment property	-	12
<b>Net cash flows from / (used in) investing activities</b>	<b><u>(16,044)</u></b>	<b><u>(7,327)</u></b>
<b>Cash flows from financing activities</b>		
Public dividend capital received	81,834	3,229
Movement on loans from DHSC	(68,709)	6,497
Capital element of finance lease rental payments	(737)	(281)
Interest on loans	(773)	(2,484)
Other interest	(1)	-
Interest paid on finance lease liabilities	(242)	(169)
PDC dividend (paid) / refunded	(1,876)	(1,047)
Cash flows from (used in) other financing activities	4	-
<b>Net cash flows from / (used in) financing activities</b>	<b><u>9,500</u></b>	<b><u>5,745</u></b>
<b>Increase / (decrease) in cash and cash equivalents</b>	<b><u>29,543</u></b>	<b><u>(94)</u></b>
<b>Cash and cash equivalents at 1 April - brought forward</b>	<b><u>1,367</u></b>	<b><u>1,461</u></b>
<b>Cash and cash equivalents at 31 March</b>	27.1 <b><u><u>30,910</u></u></b>	<b><u><u>1,367</u></u></b>

## **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 NHS Foundation Trust shall meet the accounting requirements of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

Consequently, the following financial statements have been prepared in accordance with the GAM issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

#### **1.1.2 Accounting convention**

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

### **1.3.1 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 Rotherham NHS Foundation Trust's 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.

### **1.3.2 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. Included in the income figure is an estimate for open spells: patients undergoing treatment that is only partially complete at twelve midnight on 31 March. The number of open spells for each specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which belongs to the current 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 Income (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).

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

- as per paragraph 121 of the Standard the Trust will not 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 paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date
- the Financial Reporting Manual (FRm) has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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 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 a provision 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**

### **1.6.1 Short-term employee benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave 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.

### **1.6.2 Retirement Benefit Costs**

#### **NHS Pension Scheme**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

#### **b) Full actuarial (funding) valuation**

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced 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.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

#### **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**

### **1.8.1 Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and either
- 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, for example, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

### **1.8.2 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.

All assets are measured subsequently at valuation. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus, with no plan to bring them back into use and where there are no restrictions preventing access to the market at the reporting date, are valued at fair value under IFRS 13.

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

- Land and non-specialised buildings - market value for existing use
- Specialised buildings - depreciated replacement cost, modern equivalent asset basis

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, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

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

### **1.8.3 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.

### **1.8.4 Depreciation**

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

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position Public Finance Initiative (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.

### **1.8.5 Revaluation gains and losses**

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

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

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

### **1.8.6 Impairments**

In accordance with the DHSC 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 income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

### **1.8.7 De-recognition**

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable, 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 '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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

#### **1.8.8 Donated, government grant and other 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.

### 1.8.9 Useful Economic 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:

	<b>Min life Years</b>	<b>Max life Years</b>
Land	-	-
Buildings, excluding dwellings	3	90
Plant & machinery	5	15
Transport equipment	7	9
Information technology	2	20
Furniture & fittings	10	10

#### 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

##### 1.10.1 Recognition

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

##### 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.

#### **1.10.2 Measurement**

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

#### **1.10.3 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.

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

#### **1.10.4 Amortisation**

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

#### **1.10.5 Useful economic life of intangible assets**

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

	<b>Min life Years</b>	<b>Max life Years</b>
Software licences	2	20

### **Note 1.11 Revenue government and other grants**

Government grants are grants from government bodies other than income from commissioners or NHS 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.

### **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, 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.

### **1.14.1 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.

### **1.14.2 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.

### **1.14.3 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.

### **1.14.4 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.

#### **1.14.5 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.

#### **1.14.6 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.

#### **1.14.7 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.

## **Note 1.15 Leases**

### **Finance leases**

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

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

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

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 and building components are separated and individually assessed as to whether they are operating or finance leases.

### **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 capitalised 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.

### **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 at the end of the reporting period. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. This applies to early retirements and injury benefits provisions.

### **Clinical negligence costs**

NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in the notes to the Accounts but is not recognised within 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 NHSR 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.

### **Early Retirement Provisions**

Early retirement provisions are discounted using the HM Treasury's pension discount rate of negative 0.95% (negative 0.5% in 2019/2020) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

A nominal short-term rate of minus 0.02% (positive 0.51% in 2019/2020) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

A nominal medium-term rate of positive 0.18% (positive 0.55% in 2019/2020) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

A nominal long-term rate of positive 1.99% (positive 1.99% in 2019/2020) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term date of positive 1.99% (positive 1.99% in 2019/2020) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

## **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 Trust'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, 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 Trust's control
- 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 (PDC) and PDC dividend**

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 Trust. It represents the DHSC investment in the Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as PDC dividend. The charge is calculated at the real rate set by the Secretary of State with the consent of HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility
- assets under construction for nationally directed schemes
- any PDC dividend balance receivable or payable
- Approved expenditure on COVID-19 capital assets

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts.

The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts. PDC dividend calculation is based upon the Trust's group accounts (that is, including subsidiaries), but excluding consolidated charitable funds.

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 (VAT)**

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 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 currencies of the Trust are 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 (other than financial instruments measured at "fair value through profit and loss") 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
- 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 (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

### **Note 1.23 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 or local government body, the assets and liabilities transferred are recognised in the accounts 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 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 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2020/2021.

## **Note 1.27 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 2020/2021. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020/21, 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 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 a rate defined by HM Treasury. Currently this rate is 0.91% (1.27% in 2020/2021) but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/2023, 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 implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

## 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.

	<b>Healthcare</b>		<b>Total</b>	
	<b>2020/21</b>	2019/20	<b>2020/21</b>	2019/20
	<b>£000</b>	£000	<b>£000</b>	£000
Income	<b>324,099</b>	<b>288,614</b>	<b>324,099</b>	288,614
Retained Earnings / (Accumulated Deficit)	<b>(1,712)</b>	<b>9</b>	<b>(1,712)</b>	9
Segment net assets	<b>131,549</b>	<b>43,654</b>	<b>131,549</b>	43,654

### Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.1

#### Note 3.1 Income from patient care activities

	2020/21 £000	2019/20 £000 (Restated)	2019/20 £000
<b>Acute services</b>			
Elective income	-	-	33,938
Non elective income	-	-	61,985
First outpatient income	-	-	17,454
Follow up outpatient income	-	-	15,777
A & E income	-	-	12,911
Block contract / system envelope income*	253,921	142,065	-
High cost drugs income from commissioners (excluding pass-through costs)	114	10,833	10,833
Other NHS clinical income	3,696	36,611	36,611
<b>Community services</b>			
Block contract / system envelope income*	8,554	42,303	42,303
Income from other sources (e.g. local authorities)	-	2,080	2,080
<b>All services</b>			
Additional pension contribution central funding**	7,996	7,646	7,646
Other clinical income	691	927	927
<b>Total income from activities</b>	<b><u>274,972</u></b>	<b><u>242,465</u></b>	<b><u>242,465</u></b>

\*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

\*\*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)**

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
<b>Income from patient care activities received from:</b>		
NHS England	31,648	28,797
Clinical commissioning groups	234,148	201,915
Other NHS providers	-	255
NHS other	61	70
Local authorities	8,439	10,487
Non-NHS: overseas patients (chargeable to patient)	110	87
Injury cost recovery scheme	544	776
Non NHS: other	22	78
<b>Total income from activities</b>	<b><u>274,972</u></b>	<b><u>242,465</u></b>
<b>Of which:</b>		
Related to continuing operations	274,972	242,465
Related to discontinued operations	-	-

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

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
Income recognised this year	110	87
Cash payments received in-year	6	3
Amounts added to provision for impairment of receivables	100	53
Amounts written off in-year	-	-

#### Note 4 Other operating income

	2020/21		2019/20	
	Contract income £000	Non- contract income £000	Contract income £000	Non- contract income £000
Research and development	295	-	286	286
Education and training	10,135	656	9,483	9,934
Non-patient care services to other bodies	6,254	-	8,049	8,049
Provider sustainability fund (2019/20 only)	-	-	2,769	2,769
Financial recovery fund (2019/20 only)	-	-	16,972	16,972
Marginal rate emergency tariff funding (2019/20 only)	-	-	1,434	1,434
Reimbursement and top up funding	20,992	-	-	-
Income in respect of employee benefits accounted on a gross basis	1,707	-	2,051	2,051
Receipt of capital grants and donations	-	4,370	-	-
Charitable and other contributions to expenditure	-	2,365	-	5
Rental revenue from operating leases	-	427	-	555
Other income	1,926	-	4,094	4,094
<b>Total other operating income</b>	<b>41,309</b>	<b>7,818</b>	<b>45,138</b>	<b>1,011</b>
<b>Of which:</b>				
Related to continuing operations		49,127		46,149
Related to discontinued operations		-		-

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

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	1,425	1,353
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:

	2020/21 £000	2019/20 £000
Income from services designated as commissioner requested services	274,281	241,538
Income from services not designated as commissioner requested services	49,818	47,076
<b>Total</b>	<b>324,099</b>	<b>288,614</b>

### 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, for example: dental and prescription charges and other income generation activities. This disclosure is of income from charges to service users where full cost for that service exceeds £1,000k and/or is otherwise material to the Accounts. It is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

In 2020/21 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

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
Purchase of healthcare from non-NHS and non-DHSC bodies	2,581	1,088
Staff and executive directors costs	220,150	200,161
Remuneration of non-executive directors	176	182
Supplies and services - clinical (excluding drugs costs)	26,140	25,418
Supplies and services - general	6,260	4,148
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	16,847	16,839
Inventories written down	343	17
Consultancy costs	199	208
Establishment	2,955	1,773
Premises	14,429	11,660
Transport (including patient travel)	2,689	2,712
Depreciation on property, plant and equipment	7,414	6,287
Amortisation on intangible assets	1,430	1,334
Net impairments	7,022	-
Movement in credit loss allowance: contract receivables / contract assets	481	(372)
Movement in credit loss allowance: all other receivables and investments	20	(1)
Change in provisions discount rate(s)	30	39
Audit fees payable to the external auditor:		
audit services- statutory audit*	121	84
other auditor remuneration (external auditor only)	-	5
Internal audit costs	87	91
Clinical negligence	7,962	7,041
Legal fees	105	104
Insurance	252	217
Research and development	307	328
Education and training	1,613	857
Rentals under operating leases	2,021	2,511
Losses, ex gratia & special payments	19	119
Other services, eg external payroll	1,092	1,624
Other	676	721
<b>Total</b>	<b><u>323,421</u></b>	<b><u>285,195</u></b>
<b>Of which:</b>		
Related to continuing operations	323,421	285,195
Related to discontinued operations	-	-

\* Statutory Audit fees shown above are inclusive of VAT. The Audit fee for 2020/21 includes £13k which is for work carried out relating to the 2019/20 financial year by the Trust's previous Auditors.

## Note 6.2 Nightingale hospital

During 2020/21 the Trust supported the setting up of the Harrogate Nightingale facility as part of the regional coronavirus pandemic response.

The costs incurred by the Trust in supporting the setting up of the facility have been included within the operating expenses note in these accounts. The costs shown below are disclosed below for information. Incremental costs associated with operating the facility have been reimbursed by NHS England.

	<b>Gross 2020/21 £000</b>
<b>Set up costs:</b>	
Staff costs	13
<b>Total gross costs</b>	<b>13</b>

## Note 6.3 Other auditor remuneration

	<b>2020/21 £000</b>	<b>2019/20 £000</b>
<b>Other auditor remuneration paid to the external auditor:</b>		
Audit-related assurance services	-	5
<b>Total</b>	<b>-</b>	<b>5</b>

## Note 6.4 Limitation on auditor's liability

During the 2020/21 financial year the Trust appointed Mazars LLP to carry out the role of External Auditor; their limitation of liability is unlimited. There was a £1,000k limitation for the previous Auditors in 2019/2020.

## Note 7 Impairment of assets

	<b>2020/21 £000</b>	<b>2019/20 £000</b>
<b>Net impairments charged to operating surplus / deficit resulting from:</b>		
Changes in market price	7,022	-
<b>Total net impairments charged to operating surplus / deficit</b>	<b>7,022</b>	<b>-</b>
Impairments charged to the revaluation reserve	-	-
<b>Total net impairments</b>	<b>7,022</b>	<b>-</b>

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

## Note 8 Employee benefits

	<b>2020/21</b>	<b>2019/20</b>
	<b>Total</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
Salaries and wages	165,265	150,632
Social security costs	15,532	14,651
Apprenticeship levy	767	718
Employer's contributions to NHS pensions	26,255	25,091
Pension cost - other	87	83
Temporary staff (including agency)	12,752	9,830
<b>Total staff costs</b>	<b>220,658</b>	<b>201,005</b>
<b>Of which</b>		
Costs capitalised as part of assets	221	524
Research and Development staffing costs	287	320
<b>Total</b>	<b>220,150</b>	<b>200,161</b>

### Note 8.1 Retirements due to ill-health

During 2020/21 there were 3 early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £165k (0k in 2019/20).

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

### Note 8.2 Directors' remuneration and other benefits

The requirements under section 412 of the Companies Act 2006 to disclosure information on directors' remuneration are considered to be satisfied by the disclosures made in the notes to the accounts above and in the Remuneration Report. Directors' other benefits, where relevant are disclosed here.

In 2020/21 no advances or credit were granted by the Trust to any of the directors of the Trust. No guarantees were entered into on behalf of the directors of the Trust.

## **Note 9 Pension costs**

The default scheme is the NHS pension scheme, however some employees are not eligible to join and therefore to meet auto enrolment legislation an alternative pension scheme must be provided. Like most NHS providers this Trust procured the government backed, defined contribution, National Employment Savings Trust ("NEST") as the alternative pension scheme.

## Note 10 Operating leases

### Note 10.1 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.

	2020/21 £000	2019/20 £000
<b>Operating lease revenue</b>		
Minimum lease receipts	427	555
<b>Total</b>	<u>427</u>	<u>555</u>
	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Future minimum lease receipts due:</b>		
- not later than one year;	457	481
- later than one year and not later than five years;	1,672	1,671
- later than five years.	5,999	6,140
<b>Total</b>	<u>8,128</u>	<u>8,292</u>

### Note 10.2 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.

	2020/21 £000	2019/20 £000
<b>Operating lease expense</b>		
Minimum lease payments	2,021	2,511
<b>Total</b>	<u>2,021</u>	<u>2,511</u>
	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Future minimum lease payments due:</b>		
- not later than one year;	2,021	2,071
- later than one year and not later than five years;	6,063	6,474
- later than five years.	-	123
<b>Total</b>	<u>8,084</u>	<u>8,668</u>
Future minimum sublease payments to be received	-	-

## Note 11 Finance income

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

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
Interest on bank accounts	3	79
Interest on other investments / financial assets	-	1
<b>Total finance income</b>	<b>3</b>	<b>80</b>

## Note 12.1 Finance expenditure

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

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
<b>Interest expense:</b>		
Loans from the Department of Health and Social Care	364	2,475
Finance leases	242	169
Interest on late payment of commercial debt	1	-
<b>Total interest expense</b>	<b>607</b>	<b>2,644</b>
Unwinding of discount on provisions	(10)	(5)
<b>Total finance costs</b>	<b>597</b>	<b>2,639</b>

## Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
Amounts included within interest payable arising from claims made under this legislation	1	-

## Note 13 Other gains / (losses)

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
Losses on disposal of assets	-	(19)
<b>Total other gains / (losses)</b>	<b>-</b>	<b>(19)</b>

## **Note 14 Discontinued operations**

No services were discontinued in either the 2020/21 or 2019/20 financial years.

**Note 15.1 Intangible assets - 2020/21**

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

\* During the year, £194k of assets were reclassified as equipment under the heading of Plant and Machinery (previously recognised as intangibles) due to being incorrectly classified historically.

**Note 15.2 Intangible assets - 2019/20**

	Software licences £000	Intangible assets under construction £000	Total £000
<b>Valuation / gross cost at 1 April 2019</b>	<b>17,769</b>	<b>318</b>	<b>18,087</b>
Additions	928	-	928
Reclassifications	318	(318)	-
Disposals / derecognition	(25)	-	(25)
<b>Valuation / gross cost at 31 March 2020</b>	<b>18,990</b>	<b>-</b>	<b>18,990</b>
<b>Amortisation at 1 April 2019</b>	<b>8,754</b>	<b>-</b>	<b>8,754</b>
Provided during the year	1,334	-	1,334
Disposals / derecognition	(25)	-	(25)
<b>Amortisation at 31 March 2020</b>	<b>10,063</b>	<b>-</b>	<b>10,063</b>
<b>Net book value at 31 March 2020</b>	<b>8,927</b>	<b>-</b>	<b>8,927</b>
<b>Net book value at 1 April 2019</b>	<b>9,015</b>	<b>318</b>	<b>9,333</b>

**Note 16.1 Property, plant and equipment - 2020/21**

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

\* During the year, £194k of assets were reclassified as equipment under the heading of Plant and Machinery (previously recognised as intangibles) due to being incorrectly classified historically.

**Note 16.2 Property, plant and equipment - 2019/20**

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation / gross cost at 1 April 2019</b>	<b>6,450</b>	<b>109,367</b>	-	<b>18,898</b>	<b>216</b>	<b>4,973</b>	<b>382</b>	<b>140,286</b>
Additions	-	1,684	4,556	1,646	1	520	21	8,428
Impairments	-	(108)	-	-	-	-	-	(108)
Disposals / derecognition	-	-	-	(479)	-	-	-	(479)
<b>Valuation/gross cost at 31 March 2020</b>	<b>6,450</b>	<b>110,943</b>	<b>4,556</b>	<b>20,065</b>	<b>217</b>	<b>5,493</b>	<b>403</b>	<b>148,127</b>
<b>Accumulated depreciation at 1 April 2019</b>	-	<b>5,030</b>	-	<b>12,684</b>	<b>201</b>	<b>2,138</b>	<b>54</b>	<b>20,107</b>
Provided during the year	-	4,438	-	1,099	8	703	39	6,287
Impairments	-	(119)	-	-	-	-	-	(119)
Disposals / derecognition	-	-	-	(448)	-	-	-	(448)
<b>Accumulated depreciation at 31 March 2020</b>	-	<b>9,349</b>	-	<b>13,335</b>	<b>209</b>	<b>2,841</b>	<b>93</b>	<b>25,827</b>
<b>Net book value at 31 March 2020</b>	<b>6,450</b>	<b>101,594</b>	<b>4,556</b>	<b>6,730</b>	<b>8</b>	<b>2,652</b>	<b>310</b>	<b>122,300</b>
<b>Net book value at 1 April 2019</b>	<b>6,450</b>	<b>104,337</b>	-	<b>6,214</b>	<b>15</b>	<b>2,835</b>	<b>328</b>	<b>120,179</b>

**Note 16.3 Property, plant and equipment financing - 2020/21**

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Net book value at 31 March 2021</b>								
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
<b>NBV total at 31 March 2021</b>	<b>6,450</b>	<b>108,223</b>	<b>16,708</b>	<b>14,505</b>	<b>6</b>	<b>5,238</b>	<b>261</b>	<b>151,391</b>

**Note 16.4 Property, plant and equipment financing - 2019/20**

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Net book value at 31 March 2020</b>								
Owned - purchased	6,300	98,598	4,556	5,202	8	2,652	310	117,626
Finance leased	150	2,304	-	1,477	-	-	-	3,931
Owned - donated/granted	-	692	-	51	-	-	-	743
<b>NBV total at 31 March 2020</b>	<b>6,450</b>	<b>101,594</b>	<b>4,556</b>	<b>6,730</b>	<b>8</b>	<b>2,652</b>	<b>310</b>	<b>122,300</b>

## Note 17 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. During 2020/21 the Trust received the following donated assets (from the Department of Health and Social Care):

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

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.

In addition to the above, the Trust recognised the pepper-corn lease for the Breathing Space building which it occupies. The property is included on the Trust's balance sheet as it formed part of the revaluation of assets carried out at 31 March 2021. Prior to 1 April 2020, the Trust was charged full market rent for occupying the building. The property was valued at £3,215k.

## Note 18 Revaluations of property, plant and equipment

During 2020/21 and in line with IAS16, the Trust's land and buildings were revalued as at 31 March 2021 by an independent valuer. The previous revaluation was undertaken as at the 31 March 2018. Between valuations management review and asset verification exercises have assessed the need for impairments.

The valuation was carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. Non operational property, including land was valued to market value. Where assets are held for investment purposes, these have been categorised as such.

In order to meet the underlying objectives established by International Financial Reporting Standards and the application of IAS16 changes, those buildings which qualify as specialised operational assets and therefore, fall to be assessed using the depreciated replacement cost approach have been valued on a modern substitute basis i.e. the valuation approach assumed that the existing asset will be replaced by an asset of modern design and size which is suitable for delivering those services currently being provided where appropriate. Therefore, the Trust has continued to assume that the modern equivalent asset does not require a site as extensive as the actual Rotherham Hospital site. The Trust has recognised that an 8 hectare site is sufficient and the modern equivalent development is in a more appropriate location closer to the M1 and M18 motorway interchange. This approach is consistent with the last 2018 valuation methodology.

### **Note 19 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 were 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 20 Investments in associates and joint ventures**

In 2020/21 The Rotherham NHS Foundation Trust has no investments in associates and joint ventures, nor did it have in 2019/20.

**Note 21 Other investments / financial assets**

In 2020/21 The Rotherham NHS Foundation Trust has no other investments or financial assets, nor did it have in 2019/20.

## Note 22 Disclosure of interests in other entities

### The Rotherham Hospital & Community Charity

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.

	<b>31 March</b>	31 March
	<b>2021</b>	2020
	<b>£000</b>	£000
Total incoming resources	<b>303</b>	137
Resources expended	<b>(217)</b>	(183)
(Losses)/Gains on revaluation and disposals	<b>18</b>	(26)
<b>Net movement in funds</b>	<b>104</b>	<b>(72)</b>
Total Assets	<b>632</b>	319
Total Liabilities	<b>(212)</b>	(3)
<b>Total Charitable Funds</b>	<b>420</b>	<b>316</b>
<b>Total funds made up of:</b>		
- Restricted /endowment funds	<b>122</b>	207
- Unrestricted funds	<b>298</b>	109

The 2020/21 Charitable Funds accounts have not yet been subject to independent review. The 2019/20 Charitable Funds accounts were subject to independent examination and were finalised in December 2020.

### Note 23 Inventories

	<b>31 March</b>	<b>31 March</b>
	<b>2021</b>	<b>2020</b>
	<b>£000</b>	<b>£000</b>
Drugs	927	1,034
Consumables	2,939	2,912
Energy	50	46
<b>Total inventories</b>	<b>3,916</b>	<b>3,992</b>

Inventories recognised in expenses for the year were £23,805k (2019/20: £26,817k). Write-down of inventories recognised as expenses for the year were £343k (2019/20: £17k).

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

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.

At year end, the value of this personal protective equipment held by the trust was written down to reflect the current market prices, recognising that this stock was initially purchased at over-inflated prices at the start of the COVID -19 pandemic. Of the total amount of inventory written down at year end, of £343k, £327k related to the donated personal protective equipment from the Department of Health and Social Care.

## Note 24.1 Receivables

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Current</b>		
Contract receivables	4,880	22,977
Allowance for impaired contract receivables / assets	(979)	(498)
Allowance for other impaired receivables	(37)	(19)
Deposits and advances	-	96
Prepayments (non-PFI)	2,476	2,731
PDC dividend receivable	248	168
VAT receivable	1,124	460
Other receivables	1,048	87
<b>Total current receivables</b>	<b><u>8,760</u></b>	<b><u>26,002</u></b>
<b>Non-current</b>		
Other receivables	52	54
<b>Total non-current receivables</b>	<b><u>52</u></b>	<b><u>54</u></b>
<b>Of which receivable from NHS and DHSC group bodies:</b>		
Current	2,845	18,033
Non-current	52	52

## Note 24.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
<b>Allowances as at 1 April</b>	<b>498</b>	<b>19</b>	<b>873</b>	<b>25</b>
New allowances arising	321	21	171	3
Changes in existing allowances	393	-	(393)	-
Reversals of allowances	(233)	(1)	(150)	(4)
Utilisation of allowances (write offs)	-	(2)	(3)	(5)
<b>Allowances as at 31 Mar 2021</b>	<b>979</b>	<b>37</b>	<b>498</b>	<b>19</b>

## Note 24.3 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 25 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 2021, and 31 March 2020.

**Note 26.1 Non-current assets held for sale and assets in disposal groups**

At the 31 March 2021, the Trust did not have any assets that were held for sale, nor did it at 31 March 2020.

**Note 26.2 Liabilities in disposal groups**

At the 31 March 2021, the Trust did not have any liabilities in disposal groups, nor did it at 31 March 2020.

## Note 27.1 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.

	2020/21	2019/20
	£000	£000
<b>At 1 April</b>	<b>1,367</b>	<b>1,461</b>
Net change in year	29,543	(94)
<b>At 31 March</b>	<b>30,910</b>	<b>1,367</b>
<b>Broken down into:</b>		
Cash at commercial banks and in hand	52	160
Cash with the Government Banking Service	30,858	1,207
<b>Total cash and cash equivalents as in SoFP</b>	<b>30,910</b>	<b>1,367</b>
<b>Total cash and cash equivalents as in SoCF</b>	<b>30,910</b>	<b>1,367</b>

## Note 27.2 Third party assets held by the Trust

At 31 March 2021 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 2020.

## Note 28 Trade and other payables

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Current</b>		
Trade payables	9,769	13,815
Capital payables	6,206	1,856
Accruals	19,164	8,394
Social security costs	2,143	2,025
VAT payables	226	73
Other taxes payable	1,757	1,587
Other payables	135	161
<b>Total current trade and other payables</b>	<b><u>39,400</u></b>	<b><u>27,911</u></b>
<b>Of which payables from NHS and DHSC group bodies:</b>		
Current	4,206	4,699
Non-current	-	-

The Trust had no non-current payables at 31 March 2021, nor did it at 31 March 2020.

## Note 29 Other liabilities

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Current</b>		
Deferred income: contract liabilities	815	1,425
<b>Total other current liabilities</b>	<b>815</b>	<b>1,425</b>

The Trust had no non-current liabilities at 31 March 2021, nor did it at 31 March 2020.

## Note 30.1 Borrowings

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Current</b>		
Loans from DHSC	1,335	59,202
Obligations under finance leases	922	253
<b>Total current borrowings</b>	<b>2,257</b>	<b>59,455</b>
<b>Non-current</b>		
Loans from DHSC	14,000	25,250
Obligations under finance leases	14,142	3,765
<b>Total non-current borrowings</b>	<b>28,142</b>	<b>29,015</b>

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. £67,459k of PDC was provided to the Trust to enable the principal repayment of the outstanding balance.

### Note 30.2 Reconciliation of liabilities arising from financing activities - 2020/21

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

### Note 30.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Finance leases £000	Total £000
<b>Carrying value at 1 April 2019</b>	<b>77,963</b>	<b>3,560</b>	<b>81,523</b>
<b>Cash movements:</b>			
Financing cash flows - payments and receipts of principal	6,497	(281)	<b>6,216</b>
Financing cash flows - payments of interest	(2,484)	(169)	<b>(2,653)</b>
<b>Non-cash movements:</b>			
Additions	-	739	<b>739</b>
Application of effective interest rate	2,476	169	<b>2,645</b>
<b>Carrying value at 31 March 2020</b>	<b>84,452</b>	<b>4,018</b>	<b>88,470</b>

### Note 31 Other financial liabilities

At the 31 March 2021, 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 2020.

## Note 32 Finance leases

### Note 32.1 The Rotherham NHS Foundation Trust as a lessor

The Trust does not have any finance lease receivables. This disclosure presents obligations under finance leases where the Trust is the lessee. Finance lease payables appear within Borrowings in the Statement of Financial Position.

### Note 32.2 The Rotherham NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Gross lease liabilities</b>	<b>19,194</b>	<b>8,244</b>
of which liabilities are due:		
- not later than one year;	1,099	421
- later than one year and not later than five years;	3,795	1,684
- later than five years.	14,300	6,139
Finance charges allocated to future periods	(4,130)	(4,226)
<b>Net lease liabilities</b>	<b>15,064</b>	<b>4,018</b>
of which payable:		
- not later than one year;	922	253
- later than one year and not later than five years;	3,198	1,100
- later than five years.	10,944	2,665

No minimum sublease payments are to be received at the reporting date.

No contingent rent was recognised as an expense in the period.

### Note 33.1 Provisions for liabilities and charges analysis

	<b>Pensions: early departure costs £000</b>	<b>Pensions: injury benefits £000</b>	<b>Legal claims £000</b>	<b>Other £000</b>	<b>Total £000</b>
<b>At 1 April 2020</b>	<b>521</b>	<b>488</b>	<b>88</b>	<b>85</b>	<b>1,182</b>
Change in the discount rate	14	16	-	-	30
Arising during the year	28	45	30	-	103
Utilised during the year	(44)	(32)	(20)	-	(96)
Reversed unused	-	-	(20)	(33)	(53)
Unwinding of discount	(5)	(5)	-	-	(10)
<b>At 31 March 2021</b>	<b>514</b>	<b>512</b>	<b>78</b>	<b>52</b>	<b>1,156</b>
<b>Expected timing of cash flows:</b>					
- not later than one year;	44	32	78	-	154
- later than one year and not later than five years;	182	131	-	-	313
- later than five years.	288	349	-	52	689
<b>Total</b>	<b>514</b>	<b>512</b>	<b>78</b>	<b>52</b>	<b>1,156</b>

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 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.

### Note 33.2 Clinical negligence liabilities

At 31 March 2021, £88,846k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Rotherham NHS Foundation Trust (31 March 2020: £69,524k).

### Note 34 Contingent assets and liabilities

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Value of contingent liabilities</b>		
NHS Resolution legal claims	(29)	(26)
<b>Net value of contingent liabilities</b>	<u>(29)</u>	<u>(26)</u>
<b>Net value of contingent assets</b>	<u>-</u>	<u>-</u>

### Note 35 Contractual capital commitments

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
Property, plant and equipment	2,486	1,732
<b>Total</b>	<u>2,486</u>	<u>1,732</u>

### Note 36 Other financial commitments

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

At 31 March 2021, there are no other financial commitments classed as other. This was also the case at 31 March 2020.

### **Note 37 On-SoFP PFI, LIFT or other service concession arrangements**

In December 2019, the Trust entered into an 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, and was awarded to Veolia ES Resource Efficiency (UK) Limited (Veolia).

Whilst work has been on-going to install the equipment, the 20 year contract does not officially commence until all the works have been completed; the current expected start date is July 2021.

The Trust has recognised the value of asset installed at the 31 March 2021 (£10.205million) as an asset under construction, as the Trust is already receiving benefit from the new equipment that has been supplied. A compensating liability has been included on the balance sheet to represent the lease liability that will start upon completion of the project.

## **Note 38 Financial instruments**

### **Note 38.1 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 38.2 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 2021	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	4,964	-	-	4,964
Cash and cash equivalents	30,910	-	-	30,910
<b>Total at 31 March 2021</b>	<b>35,874</b>	<b>-</b>	<b>-</b>	<b>35,874</b>

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	22,514	-	-	22,514
Cash and cash equivalents	1,367	-	-	1,367
<b>Total at 31 March 2020</b>	<b>23,881</b>	<b>-</b>	<b>-</b>	<b>23,881</b>

## Note 38.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	fair value through I&E £000	Total book value £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 receivables excluding non financial assets	35,274	-	35,274
<b>Total at 31 March 2021</b>	<b>65,673</b>	<b>-</b>	<b>65,673</b>

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	84,452	-	84,452
Obligations under finance leases	4,018	-	4,018
Trade and other payables excluding non financial liabilities	24,226	-	24,226
<b>Total at 31 March 2020</b>	<b>112,696</b>	<b>-</b>	<b>112,696</b>

### Note 38.4 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.

	<b>31 March 2021 £000</b>	<b>2020 restated* £000</b>
In one year or less	37,955	85,461
In more than one year but not more than five years	9,821	7,832
In more than five years	24,090	25,242
<b>Total</b>	<b><u>71,866</u></b>	<b><u>118,535</u></b>

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

## Note 39 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
<b>Losses</b>				
Cash losses	-	-	1	-
Bad debts and claims abandoned	28	2	21	8
Stores losses and damage to property	12	15	12	18
<b>Total losses</b>	<b>40</b>	<b>17</b>	<b>34</b>	<b>26</b>
<b>Special payments</b>				
Compensation under court order or legally binding arbitration award	3	10	14	104
Ex-gratia payments	17	7	18	6
<b>Total special payments</b>	<b>20</b>	<b>17</b>	<b>32</b>	<b>110</b>
<b>Total losses and special payments</b>	<b>60</b>	<b>34</b>	<b>66</b>	<b>136</b>
Compensation payments received		-		-

## Note 40 Gifts

During the 2020/21 financial year, the Trust did not receive any gifts, nor did it in 2019/20.

## Note 41 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 had no transactions with organisations with which key employees/directors of the Trust have some form of relationship (during 2019/20, the Trust made £8k payments to organisations with which the Trust had a related party relationship). Only those bodies outside the Department of Health & Social Care parent body, are detailed below and are not considered material.

	<b>31 March 2021</b>	31 March 2020	<b>31 March 2021</b>	31 March 2020
	<b>Receipts from Related Party £000</b>	Receipts from Related Party £000	<b>Payments to Related Party £000</b>	Payments to Related Party £000
Magna Enterprises Ltd	<b>0</b>	0	<b>0</b>	8
<b>Total related party transactions</b>	<b>0</b>	0	<b>0</b>	8

During the 2020/21 financial year, no payments were made to or received from organisations classed as being a related party.

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 42 Transfers by absorption**

There have been no transfers by absorption during the 2020/21 financial year, nor were there any in 2019/20

**Note 43 Prior period adjustments**

There have been no prior-period adjustments made to the opening balances of the 2020/21 financial year, nor were there any in 2019/2020.

Due to the change in NHS income as a result of the coronavirus pandemic response, note 3.1 has figures as published in 2019/20 and re-stated as per reporting requirements in 2020/21 for ease of comparison.

**Note 44 Events after the reporting date**

There are no events after the reporting date at the point at which these accounts were approved by Trust Board on 11 June 2021.

## **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 2021 which comprise the Statement of Financial Position, the Statement of Comprehensive Income, 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 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, 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 2021 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 2020/21; 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 are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

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 2020/21 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 statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the National Audit Office 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](http://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 2021.

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 April 2021, we have not reported any significant weaknesses in arrangements for the year ended 31 March 2021.

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 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 April 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 2020/21; 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 2020/21; 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 of 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 in its use of resources.



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

5<sup>th</sup> Floor  
3 Wellington Place  
Leeds  
LS1 4AP

11 June 2021

# Audit Completion Certificate issued to the Council of Governors of The Rotherham NHS Foundation Trust for the year ended 31 March 2021

In our auditor's report dated 11 June 2021 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 in its use of resources.

This work has now been completed.

No matters have come to our attention since 11 June 2021 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 2021.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have identified the following significant weaknesses in the Trust's arrangements for the year ended 31 March 2021:

Significant weaknesses in arrangements	Recommendation
<p><b>Governance and financial management</b></p> <p>The Trust identified significant weaknesses in its arrangements through its own internal governance processes and these were detailed in its Annual Governance Statement for 2020/21. These included:</p> <ul style="list-style-type: none"> <li>• issues in relation to the inception and approval of the Carbon Energy Fund project;</li> <li>• financial monitoring and reporting issues relating to the 2019/20 financial year end which emerged in early 2020/21 and which also had implications in 2020/21; and</li> <li>• breaches in standing financial instructions in relation to the Greenoaks project.</li> </ul> <p>We have reviewed the weaknesses and the actions taken by the Trust.</p> <p>In our view, these matters represent significant weaknesses in arrangements during 2020/21 in relation to:</p>	<p>We recommend that the Trust continues the steps it has already taken during 2020/21 to improve financial monitoring and reporting, improve compliance with internal controls and strengthen and develop governance and oversight at management and Board level.</p> <p>The Trust should formally review its progress to date, to ensure that the changes are embedded.</p>

Significant weaknesses in arrangements	Recommendation
<ul style="list-style-type: none"> <li>Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services; and</li> <li>Governance: how the Trust ensures that it makes informed decisions and properly manages its risks.</li> </ul>	
<p><b>Care Quality Commission inspections</b></p> <p>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.</p> <p>The Trust has developed an action plan to address each area for improvement.</p> <p>In our view, the matters identified by CQC during 2020/21 represent a significant weakness in arrangements in relation to:</p> <ul style="list-style-type: none"> <li>Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and</li> <li>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.</li> </ul>	<p>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.</p>
<p><b>NHS Improvement license conditions</b></p> <p>The Trust has outstanding license conditions in relation to financial planning breaches arising from enforcement action by Monitor (now NHS Improvement (NHSI)) between 2013 and 2015.</p> <p>The Trust has engaged with NHSI and is working through the actions required by the regulator.</p> <p>In our view, these matters represent a significant weakness in arrangements in relation to:</p> <ul style="list-style-type: none"> <li>Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services</li> </ul>	<p>The Trust should continue to take action in response to the issues raised by regulators in relation to financial planning, to appropriately manage financial risk and demonstrate financial sustainability. We recommend that Trust delivers the action plan that is being developed with NHSI to address the outstanding breaches of license conditions. In particular, the Trust now needs to develop a three-year medium term financial plan linked to the revised Trust Strategy. Arrangements for challenging and scrutinising financial risks and performance, including escalation arrangements, should be revisited to ensure they remain 'fit for purpose' and drive the required improvements.</p>

## 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

5<sup>th</sup> Floor  
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30 July 2021

## Acknowledgements

The Rotherham NHS Foundation Trust would like to thank everyone who provided the information for this report, who gave their consent to be photographed, who gave permission for their comments to be included, and to everyone who assisted in ensuring clarity throughout this publication.





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