The Rotherham NHS Foundation Trust

Annual Report and Accounts 2019/20

Ambitious Caring Together

NHS
The Rotherham
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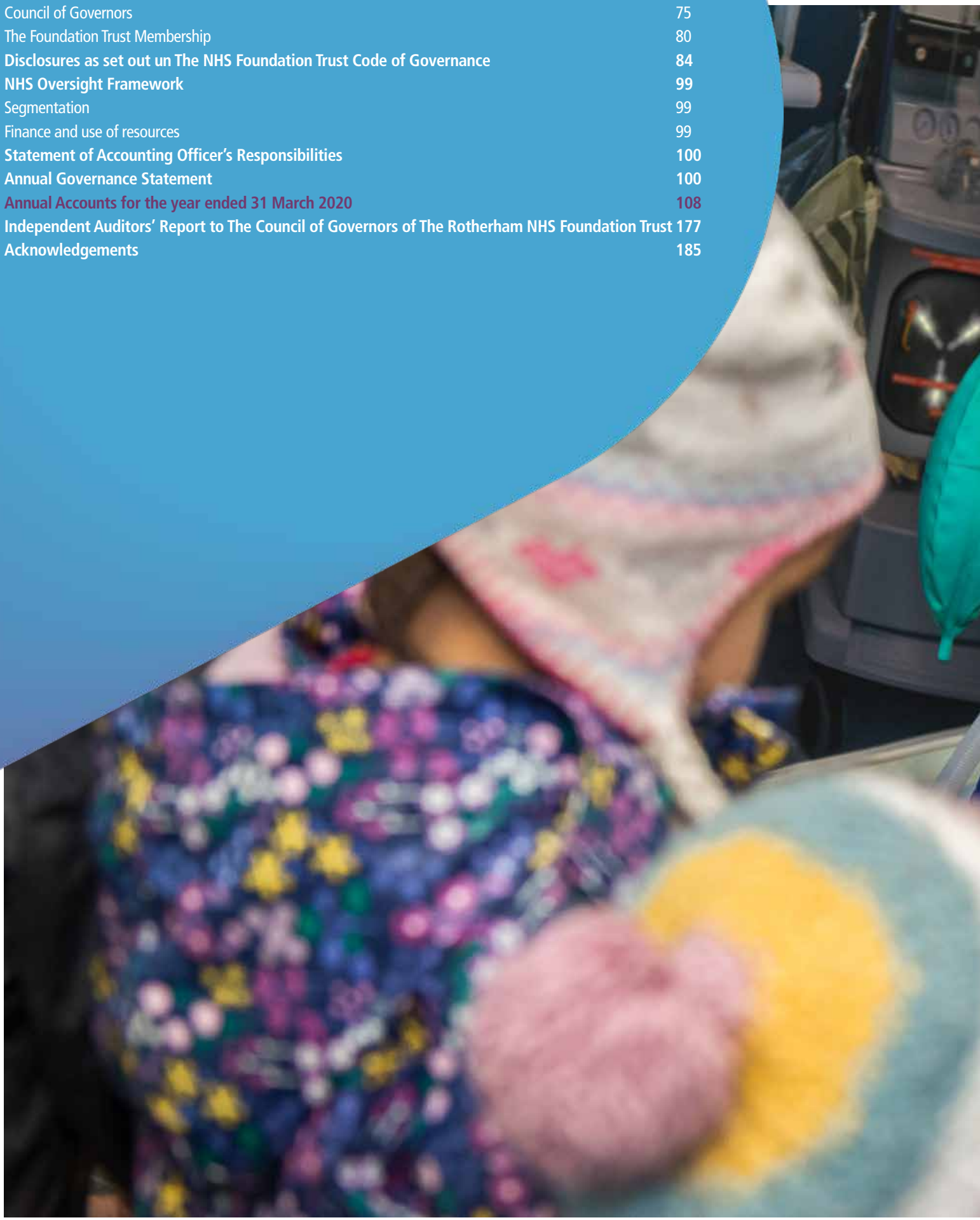
Contents

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Welcome from the Chairman

Welcome to The Rotherham NHS Foundation Trust's Annual Report and Accounts for 2019/20. This document sets out how the Trust performed over the year, including some key achievements, as well as some reflections about the ongoing challenges we face.

As a Trust, quality remains our top priority. Patient safety, clinical effectiveness and patient experience are at the heart of everything we do, as we continue to implement our Quality Improvement Plan under our *'Safe and Sound'* campaign.

In October, we were pleased that the Care Quality Commission (CQC) raised the rating of our Urgent and Emergency Care Centre (UECC) following an unannounced re-inspection. We are also one of 14 Trusts nationally to take part in a field-test pilot of new A&E access standards.

The annual winter pressures in the NHS remain a considerable operational challenge for us, in line with the rest of the NHS. It emphasises the need for all-year planning to ensure consistency and to safeguard quality at all times. We have implemented our Operational Plan but our financial position deteriorated in the last quarter of the financial year and has been a significant concern.

A key area of focus for us is collaboration. As a key partner in the Rotherham Place Plan, we work effectively with colleagues at the Clinical Commissioning Group (CCG), Mental Health Trust and Rotherham Metropolitan Borough Council (MBC) on shared priorities. Work also continues in developing the South Yorkshire and Bassetlaw Integrated Care System (ICS), particularly in response to the NHS Long-Term Plan.

People are our greatest asset and our teams have continued to perform strongly, winning many national awards and accolades along the way. It has been particularly pleasing to see our midwifery team nominated as *'Team of the Year'* in the prestigious Royal College of Midwives annual awards 2020, and one of our midwives has been shortlisted as *'Midwives' Midwife of the Year.'* This resulted in a visit to our maternity services in February by Her Royal Highness, The Princess Royal, who is patron of the Royal College of Midwives.

Meanwhile, our Integrated Discharge Team won the 'Acute Service Redesign Award' in the annual Health Service Journal Awards for their pioneering work in strengthening our approach to discharge management, working in partnership with colleagues at Rotherham MBC.

We also have a new Chief Executive to take us forward, following the departure of Louise Barnett, who served as our Chief Executive from 2013 until February this year. I am delighted that Dr Richard Jenkins has been appointed as our interim Chief Executive, combining it with his existing role as Chief Executive of Barnsley Hospital NHS Foundation Trust. Richard is a highly-experienced NHS leader and a practising clinician who is well known to us.

I am sure he will lead the senior management team effectively on our improvement journey over the next year.

Looking forward, our challenge remains to deliver our Vision: *'To be an outstanding Trust, delivering excellent healthcare at home, in our community and in hospital.'* Quality will remain our priority but we must resolve our financial challenge and ensure we sustainably deliver our financial plan. We are committed to playing our part in ensuring that the South Yorkshire and Bassetlaw Integrated Care System is a success.

The end of this year has been extremely challenging for all of us due to the COVID-19 pandemic and NHS colleagues across the country have been doing a magnificent job and I want to congratulate our Executive Team for their excellent leadership in preparing our Trust and our colleagues to cope with this unprecedented situation. We have valued the excellent joint working with our partners in Rotherham and across the ICS.

Our colleagues at the Trust working in the community and in the hospital have been remarkable in the way they have been caring for our patients and as a Board we value them greatly and are so very proud of them. Thank you for all the donations we have received and for the public expression of support you have shown, your actions are very much appreciated.

Best wishes,

Martin Havenhand
Chairman

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.

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[1] 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.[2] It is projected that Rotherham's population will increase by almost 3% between 2017 and 2027 to reach 270,600. As part of this increase it is believed that people aged over 85 will increase by 30% from 6,000 in 2017 to 7,800 in 2027 and that people aged over 90 will increase by 25% to 2,700 in 2027.[3]

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'.

In terms of the health of the people of Rotherham there are a number of areas in which the picture is worse when compared with the England average:

- The level of cancer diagnoses is higher especially in relation to lung and colorectal cancer
- The number of people aged under 75 who die from cancer is 15% higher
- The dementia diagnosis rate means that Rotherham is rated as 51st highest in England (out of 209 CCGs)
- The determinants of mental health are worse in Rotherham
- Premature deaths due to circulatory disease are worse
- Smoking levels are higher
- Dental decay in 12 year olds is worse and dental decay in those aged 5 is significantly worse
- Life expectancy for both women and men is below the national average

In other indicators the picture in Rotherham is similar to, or better than, the national average:

- Levels of harmful drinking are about average for areas with similar socio-economic characteristics, although binge drinking appears to be more common in the more deprived areas of Rotherham
- The Borough is a low prevalence area for diagnosed HIV
- Reinfection rates for sexually transmitted infections stand at 4.2% for women and 4.7% for men compared to the national rates of 7.1% for women and 9.3% for men
- Avoidable sight loss (e.g. from glaucoma or diabetic retinopathy) is similar to the national average[4]

The Trust has 379 beds and circa 4000 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 five 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

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.

[1] Since April 2019 NHS Improvement and NHS England have been working together as a single organisation.

[2] Source: Rotherham Joint Strategic Needs Assessment (Resident Population) located at: https://archive.rotherham.gov.uk/jsna/info/23/people/48/resident_population last accessed on 05/03/20

[3] Source: Rotherham Joint Strategic Needs Assessment (Resident Population) located at: https://archive.rotherham.gov.uk/jsna/info/23/people/48/resident_population and last accessed on 05/03/20

[4] Source: Rotherham Joint Strategic Needs Assessment (Resident Population) located at: https://archive.rotherham.gov.uk/jsna/info/26/healthy_living and https://archive.rotherham.gov.uk/jsna/info/27/ill_health last accessed on 05/03/20

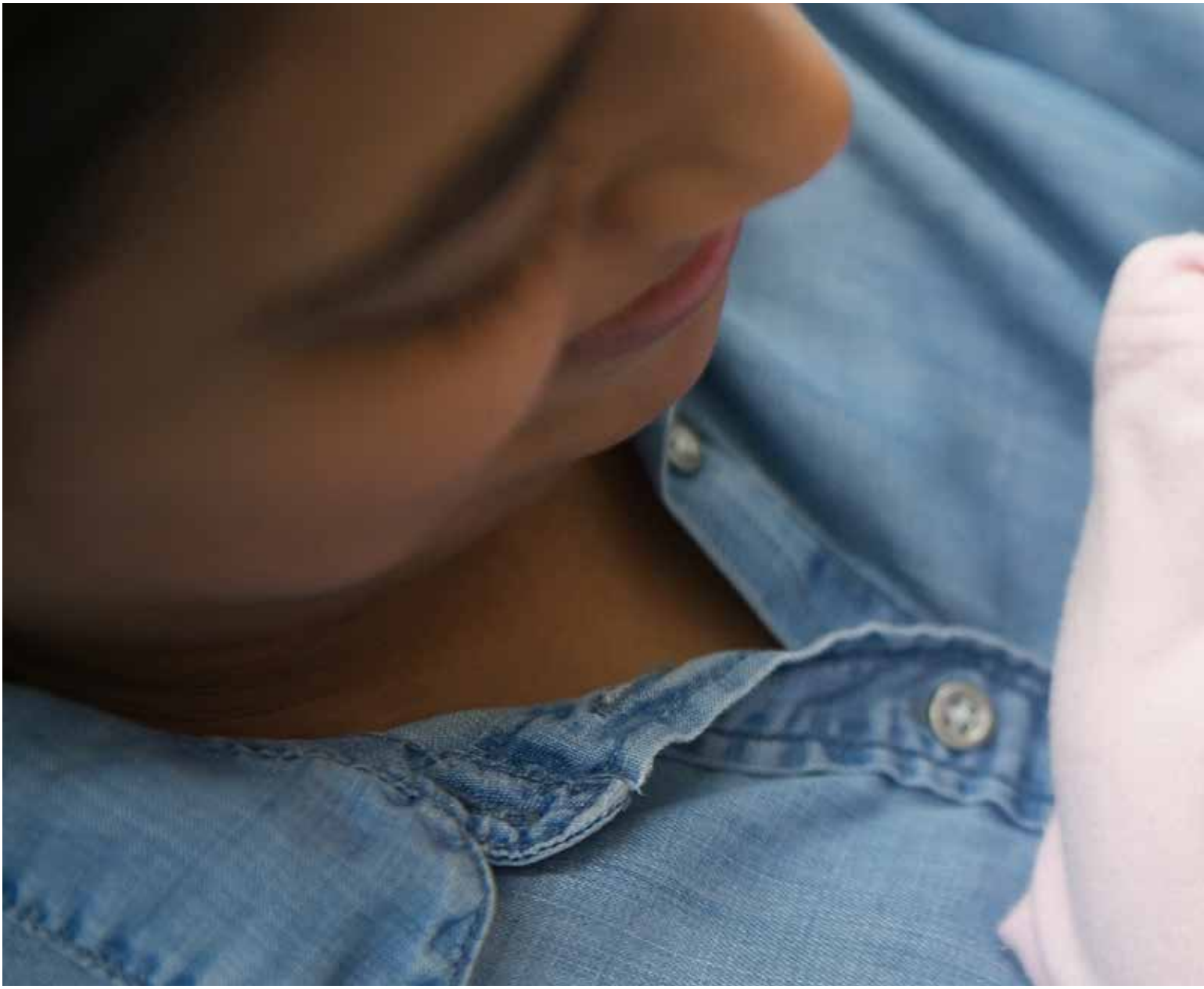
The Trust also provides care in partnership with other providers, including the third sector. This includes, but is not limited to:

- 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 Ear, Nose and Throat (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 (IDT) 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 was successful in being selected to lead 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 for a number of areas, recognising the progress made across health and social care.



National Healthcare Strategies

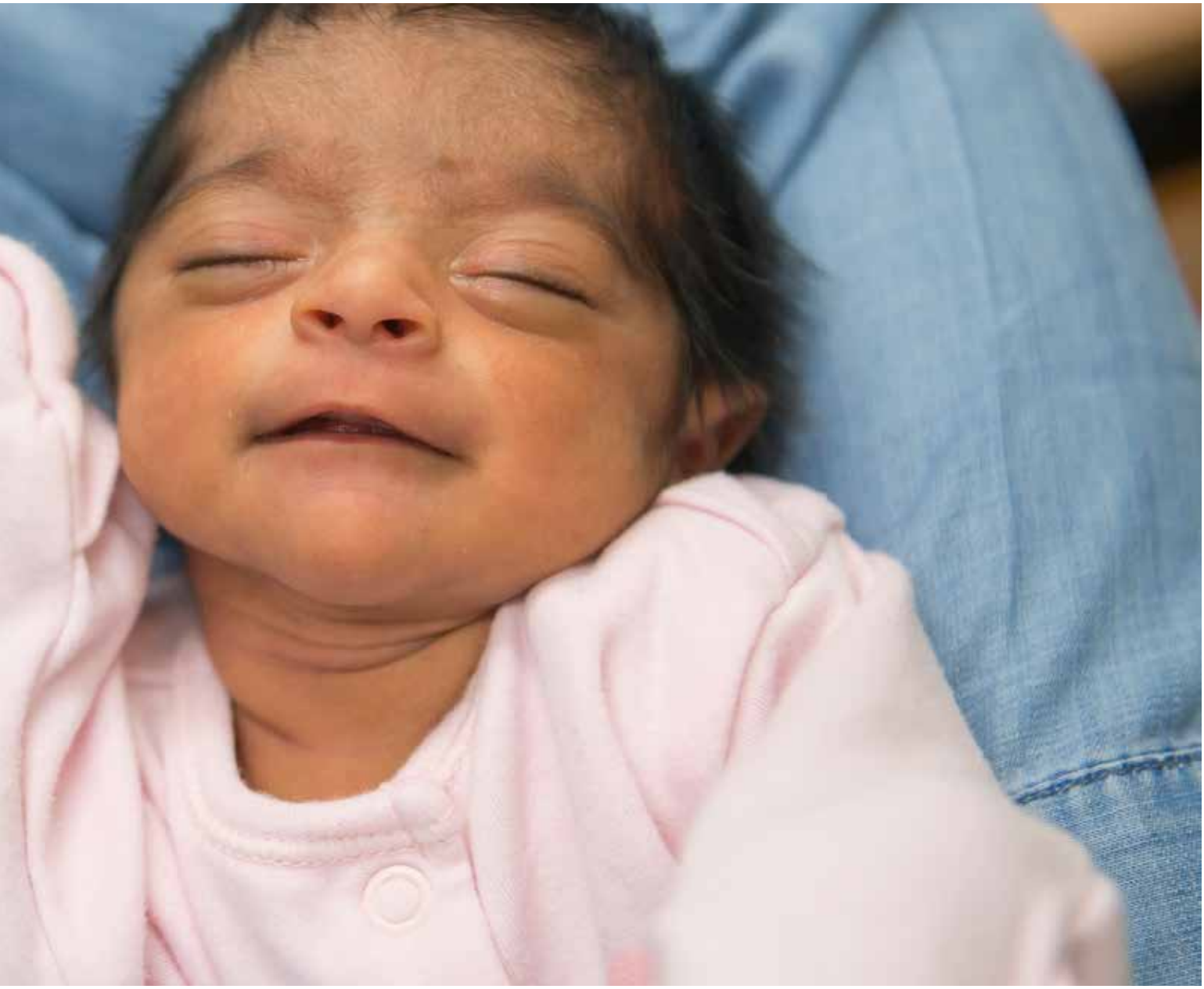
The future ambitions for the NHS have been set out in the NHS Long Term Plan (LTP) which was published in January 2019. It places a focus on improving the quality of care offered to patients through a focus on urgent care pathways, major health conditions and prevention and health inequalities. It also supports key enablers of this ambition through supporting the NHS workforce, making digital mainstream and ensuring effective use of the financial funding settlement.

This overarching national strategy is subsequently distilled through to the SYB ICS. The Trust has been an active contributor to the ICS's Long Term Plan Response, which is a national requirement of ICSs to support the development of the National Implementation Plan. This also guides the Rotherham Place Plan, of which the Trust is a key stakeholder. The Place Plan has been refreshed during 2019 with priorities either updated or reinforced to ensure that it is fully aligned with the ambitions set out in the LTP. Finally, these plans all feed into the Trust's operational objectives and it is critical that our plans dovetail with the vision of the LTP.

COVID-19

The world-wide COVID-19 pandemic led the British government to instruct the NHS to reduce all non-essential elective and urgent activity to free up capacity to treat patients with COVID-19. The Trust did this throughout March 2020 and saw a marked reduction in elective activity. This had a negative knock-on effect on the Trust's delivery of waiting list and cancer targets as well as reduced diagnostic deliverables.

The Trust also experienced a reduction in demand for elective and emergency services as patients and primary care practitioners made a concerted effort to reduce any risks to patients as the national lockdown took effect.



Chief Executive's Statement

The Trust has continued to face a number of challenges during 2019/20, but has also achieved success in other areas.

The six-week-wait diagnostic target, which aims to support patients receiving their diagnostic test within 6 weeks, has traditionally been a standard the Trust has strongly achieved. However, the Trust did not deliver against this performance measure during the year, with smaller specialities, e.g. urology, facing particular challenges. The addition of a dedicated Cancer Improvement Manager mid-year supported the service in being able to decrease the Patient Tracking List from +1,000 patients, to 733 in September 2020, and towards the end of Q3, there were further signs of improvement. Performance against the 31-day cancer treatment target was also strong. However, the onset of the Coronavirus pandemic towards the end of Q4 saw a deterioration, with the Trust achieving only 76.8% against the 85% 6-week wait target for the year. Further work is taking place to improve this position as we move through 2020/21.

Given we have been a field test site for the proposed new A&E standards for 11 of the 12 months of the financial year, 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 particularly focused on; having twenty-seven 12-hour trolley breaches during the year (2018/19: 2) is not satisfactory, and the Trust has taken significant steps to address this position, including a focus on our new assessment pathways to support more timely and effective care for patients.

The new model of care is not yet fully embedded, although improvements have been made, so much so that the CQC recognised progress at their inspection in August 2019 and were able to upgrade our 2018 CQC rating for UECC to 'requires improvement' from 'inadequate'. Clearly there is still some work to be undertaken, and the Trust continues to strive to ensure that the services are rated more positively. The Trust has an improvement plan in place and will continue to further improve the quality and performance of Urgent and Emergency services for patients.

The Trust's Hospital Standardised Mortality Ratio (HSMR) stood at 104 at the start of the year, but had deteriorated to 116.9 by the end of January 2020. The issue has received significant attention during the year from the Board and its committees, with quality improvement work undertaken to understand the reasons for the continuous rise; this has included assessment of coding practices, external reviews, and the appointment of the Trust's first Medical Examiner, and Learning from Deaths Specialist Nurse. Work continues in this area and is being led by the Executive Medical Director.

The Trust's financial challenge remains significant and despite having tackled a number of financial issues in previous years, the Trust did not deliver its financial plan in 2019/20. The financial position deteriorated over the final quarter of the year, and ended the year with a deficit of £4.9M against a break even plan. However, because the South Yorkshire and Bassetlaw Integrated Care System remained in aggregate balance, the Trust qualified for additional Financial Recovery Fund (deficit reduction) monies. As a result, the Trust closed the year with a surplus of £9K.

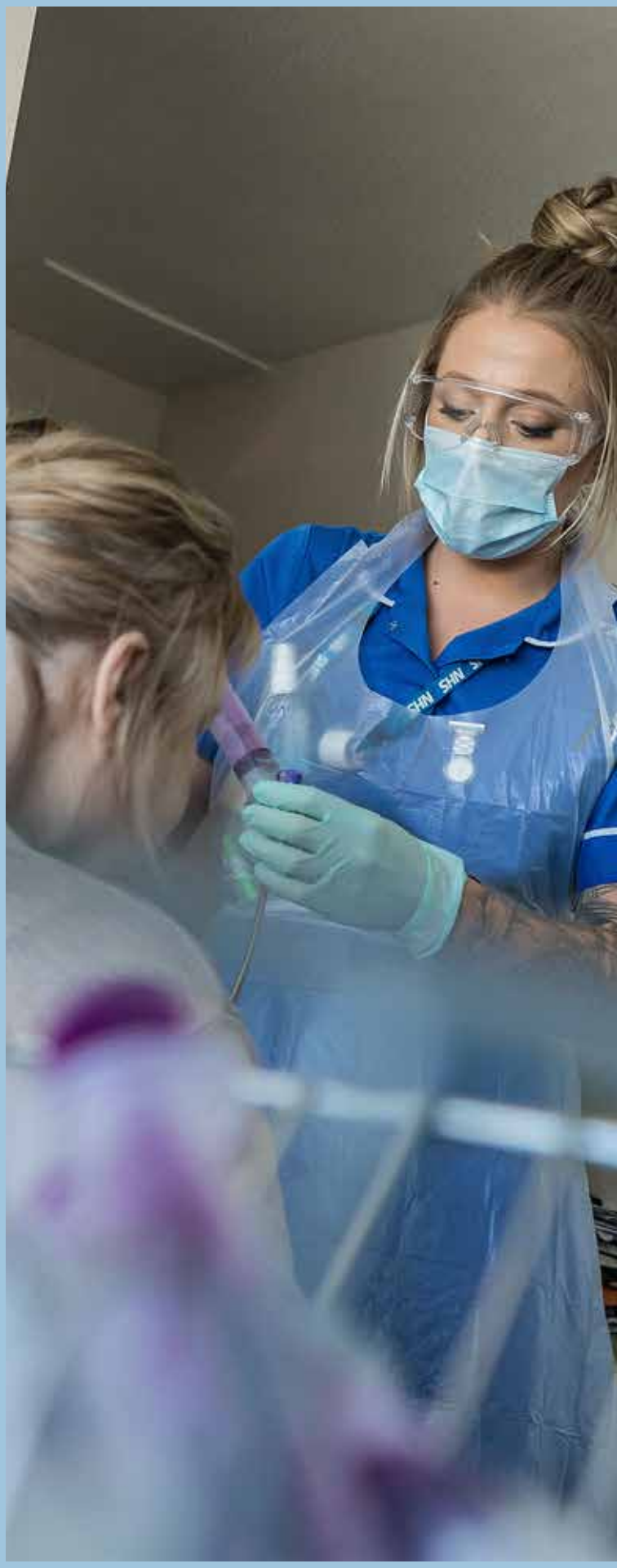
The effective and efficient use of resources remains critical and central to our planning for 2020/21, and the risk to the financial sustainability of the Trust remains; we will need to manage this on a longer term basis, beyond 2020/21.

We have had excellent performance for our Friends & Family Inpatient scores all year, and we have also seen improvements in a number of other areas, including an increase in the percentage of looked after children with assessments reported within 20 days, potential under-reporting of incidents, and non-elective readmissions within 28 days. Improved performance in a number of areas has also been achieved as a result of the ongoing partnership working across the Borough through the Rotherham Integrated Health & Social Care Place Plan, which is bringing partners together across health and social care to improve the health and wellbeing of the population we serve, delivering more joined up integrated services across Rotherham.

We also continue to develop and build upon our Trust 5-year strategy, and have developed a 5-year plan to drive forward delivery of our vision. We continue to implement change across the Trust, we support initiatives across the Rotherham Place and across the South Yorkshire & Bassetlaw Integrated Care System (SYB ICS). This programme of transformation has seen a reconfiguration of our Intermediate Care bed base, the first year of operation of our new Acute Surgical Unit and the full implementation of streaming in our Urgent and Emergency Care Centre. We have equally ambitious plans for 2020/21 which will see us continue our collaboration with partners across health and social care and will include the relocation of our Ophthalmology services to the Rotherham Community Health Centre and implementation of a new model of care for respiratory patients.

Finally, COVID-19. By the time that 'lockdown' had been imposed by the government in late March 2020, the Trust had already been making plans to cope with the expected surge in critically ill patients. 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 inspiring. And whilst the pandemic brought with it a renewed appreciation for the NHS in general, I must say a huge thank you to our incredible colleagues for their ongoing dedication in providing safe and effective care for our patients. Their response has been fantastic, and the astonishing outpouring of support from the public, is well-deserved.

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



The key issues, opportunities and risks that could affect the foundation trust in delivering its objectives and / or its future success and sustainability

Quality of Care

The Trust will continue to strive to deliver the highest quality of compassionate, patient-centred and harm-free care as possible. We will do so by ensuring that appropriate lessons are learnt following the Trust's CQC inspection in September 2018 and August 2019. There is an opportunity to improve quality of care and increase colleague engagement in patient safety by ensuring that our quality governance framework is as robust as possible through the embedding and continued development of the Trust's Safe & Sound Quality Framework. Doing this consistently will ensure the services provided are as clinically effective as possible. There will also be proactive engagement in national initiatives such as the 'Get It Right First Time' (GIRFT) programme and Model Hospital.

The Trust will continue to focus on providing as positive an experience for its patients, relatives and colleagues as possible, by embedding the new patient and public engagement strategy. Furthermore, the Trust will continue to train colleagues in leadership development and quality improvement, launching a Quality Improvement Faculty, which in turn will empower and better enable them to drive further improvements in patient experience and outcomes, and the delivery of high-quality safe care.

The Trust will continue to focus on improving its HSMR[5] / SHMI[6] and the learning from deaths by implementing a Medical Examiners' Office, with monthly reporting on improvements made against the '3Cs' (quality of care; case mix and coding); by ensuring that there are regular, timetabled Structured Judgement Reviews; and by ensuring that any learning is widely disseminated through a regular Safe & Sound Quality Bulletin.

A failure to deliver high-quality patient care could lead to poor patient experience and avoidable harm, and a failure to deliver clinical sustainability; this in turn could eventually lead to financial penalties and regulatory action.

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.

In keeping with much of the NHS, the Trust has a number of vacancies across a range of disciplines particularly medical and nursing roles. This impacts on the ability to deliver high quality care and also impacts on the finances of the Trust. The Trust has high temporary staffing costs, both bank and agency, and a key priority for the coming year is to reduce our spending in this area. We have already committed to working with external partners, such as NHS Professionals, to help deliver more robust, temporary staffing solutions at an affordable cost.

We will also be working with other partners in our local Integrated Care System to increase the supply of staff to fill vacancies on a permanent basis. This includes increasing the number of nursing placements and continuing to develop new roles such as trainee nursing associates and advanced clinical practitioners. We will also develop and expand the use of apprenticeships in the organisation.

Another key workforce risk for the Trust relates to ensuring that we work to improve colleague experience at the Trust. It is clear that we have a committed and loyal workforce, but it is also clear from our staff survey results that there are areas where colleague experience could be better. Over the coming year we will be focusing on ensuring that there are improvements in colleague experience as there is strong evidence linking positive colleague experience to better patient outcomes and we are determined to make improvements in this area.

To support colleagues and improve our people offer, the Trust has listened to colleagues during the year and taken into consideration their feedback in developing a People Strategy. The People Strategy outlines the key priorities for the next three years (2020 – 2023) and centres around four themes:

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 and our own local Pulse surveys.

The Trust's People Strategy has been developed and will be approved by the Board of Directors during quarter one 2020/21.

Finance

The Trust's financial plan for 2019/20 was to deliver a break-even position. There were a number of financial pressures that emerged later in the year which meant that the Trust would not have achieved its plan without the support of additional non-recurrent funding. This funding is classed as Financial Recovery Funds (deficit reduction funding) which is awarded to Trusts who are adverse to their plan, although their wider ICS is in aggregate financial balance.

This value also includes delivering a Cost Improvement Plan of £8.4M against a target of £9.3M (91% delivery).

[5] HSMR: Hospital Standardised Mortality Ratios
[6] SHMI: Summary Hospital-level Mortality Indicator

In addition, the Trust originally agreed an internally-funded capital programme of £5.4M for 2019/20 to support investment in Estates, IT infrastructure and medical equipment. This programme was increased through the receipt of additional national funding for IT, medical equipment and COVID-19 costs to a total capital programme of £8.4M for 2019/20.

Operational Delivery

Emergency Access

The Rotherham NHS Foundation Trust is no longer tracking the national standard of 95% of patients being admitted, transferred or discharged within 4 hours of their arrival at the Urgent and Emergency Care Centre (UECC). The Trust is taking part in a year-long 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. Regrettably, 27 patients waited for longer than 12 hours following a decision to admit into the hospital, compared to 2 such waits in 2018/19. The Trust was challenged in being able to treat and admit these patients within the national access standard, the national picture was one where performance has deteriorated significantly with patients waiting longer across acute hospitals.

In addition, as stated previously, the Urgent and Emergency service was rated as 'Inadequate' by the CQC in last year's inspection. Significant actions have been, and continue to be, taken to ensure improvements are made and sustained to improve the safety and quality of care for our patients with the most recent CQC inspection showing an improvement in rating to 'Requires improvement'.

The organisation's journey of development this year has been to continue to embed effective ward rounds and discharge planning by ward teams with the development and roll out of estimated discharge dates.

Through 2019/20 there will be a continued focus on the importance of improving flow through the medical wards and Acute Medical Unit to support the UECC. The tools used will be strengthened and oversight of the effective use of these tools will assist in this endeavour. 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.

In response to the increased demands placed on the health service over the winter period, the Trust took part in the development of a system-wide Winter Plan. 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 key actions. This resulted in an additional, flexible 24 to 37 beds being opened within the hospital site as well as additional beds being provided by the Clinical Commissioning Group (CCG) within the nursing home sector. The Trust's elective care activity was also reduced during the busiest periods for emergency admissions.

The Trust placed significant focus on the challenges posed by winter and colleagues worked closely with partner organisations. However, as described above, despite winter planning, the failure to sufficiently mitigate acute winter pressures, contributed to the underperformance represented by the long waits within our Urgent and Emergency Care Centre during quarter 4.

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 2019/20 the 18-week Referral to Treatment performance indicator was consistently achieved for the first 8 months, remaining above the 92% national target. During the last quarter the Trust's performance, whilst remaining good nationally, dipped below the 92% to 86.4% in March 2020 due to the cancellation of elective activity to create capacity for COVID-19 patients.

Cancer Waiting Times

Timely management of patients referred onto the cancer pathway is an important focus for the Trust. The organisation has had mixed performance against the cancer standards in previous years and is continuing to drive performance in 2 week waits and breast screening.

Across 2019/20 the organisation met the national standard for patients being treated within 31 days of diagnosis as well as for the 62-day screening target. However, 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. This was due to a number of factors which included a significant increase in referrals into the Trust coupled with workforce challenges in a number of key areas. As would be expected for such a priority group of patients, recovery plans were put in place and enhanced oversight provided to ensure an improvement in performance.

During the year the Trust began monitoring performance against a 28-day cancer diagnosis standard, due for national implementation in April 2020. 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 performance average for 2019/20 indicates that 99.5% of patients waited no longer than six weeks for their diagnostic test. The national standard requires that no more than 1% of patients should wait longer than six weeks and therefore this was a positive achievement for the teams involved in ensuring the timeliness of these tests. Performance should be sustained throughout 2020/21. This is an area of strength in the Trust.

Other Performance Indicators

In terms of the Delayed Transfers of Care indicator, the Trust remained well within the national thresholds and after a difficult winter period finished the year reporting strong performance.

Community services continued to see increased activity across adult and children's services. District Nursing provided close to 6,000 more contacts than the previous year, which 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.

Opportunities for the coming year will be linked to our improvement plans to 'right size' emergency and elective care services providing a platform for developments in elective services improving productivity and patient flow. We plan to improve the waiting times for our patients and will ensure any additional capacity created is part of the local Rotherham commissioning plans. As a Trust we are planning to improve cancer waits for patients and the new, faster cancer diagnostic standard will give the people of Rotherham an opportunity to be seen, diagnosed and treated within an improved time scale.

Looking ahead to 2020/21

As the Trust moves into 2020/21 it must respond to the challenges ahead, including those outlined above. The Trust will need to ensure that it focuses its resources in the right way to respond effectively to these challenges.

The Trust demonstrated good progress in the quality of service provided across its Urgent and Emergency Care Services at the unannounced inspection by the CQC in August 2019. However, the Trust continues to have an overall rating of 'Requires Improvement'. We welcome the feedback from the CQC and other partners as an invaluable source of insight into the services we offer and identification of areas where improvements can be made. Delivering these improvements and improving the quality of care we offer our patients will be a key focus in 2020/21.

Another critical area of focus will be improving the Trust's mortality indicator. The Trust's mortality score is significantly higher than the national average, and this is an area we are determined to address in 2020/21. Ensuring that the Trust fully understands the drivers of this performance and makes rapid and sustained interventions which deliver tangible improvements will be key in 2020/21.

The Trust, as with many other providers, continues to have challenges in delivering a number of the national constitutional standards. As a field test site for the potential new A&E standards, the Trust no longer reports on the 4-hour target. However, the Trust has experienced challenges in effectively delivering its emergency pathways and this has led to adverse impacts on other services in our hospital. Given the increased pressures on site, our elective performance has deteriorated as capacity has been constrained in order to manage our emergency patients and respond to the COVID-19 pandemic. In 2020/21 the Trust will work to deliver more effective patient flow through our organisation and improve our performance against key operational standards, ensuring we deliver a better service to our patients.

Vital to delivering these key improvements will be our colleagues. They are critical to everything that we do. Our recent staff survey results were disappointing, and the Trust is committed to doing more to engage and support our colleagues. In line with our strategy, our strategic theme of 'colleagues' aims to develop engaged and accountable colleagues. Central to this will be the development and implementation of the Trust's People Plan during 2020/21. This will shape our workforce priorities and support the recruitment and retention of a sustainable workforce able to meet current and future demands.

The Executive Directors, led by the Chief Executive of the Trust, are focusing on delivering these mutually supportive improvements. If we can engage our colleagues and leadership teams in delivering more effective emergency pathways, this should have a positive impact on our mortality performance, which will in turn be recognised through an improved CQC rating.

Finally, the Trust continues to be a proactive partner within the South Yorkshire and Bassetlaw Integrated Care System and the Rotherham Integrated Care Partnership. The Trust recognises that many of the challenges we face cannot be solved in isolation and our role as an acute and community provider presents us with a unique opportunity to make tangible changes to the quality of care we offer our population by working with our partner organisations within Rotherham and South Yorkshire.

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.[7]

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 Trust has adequate resources to continue in operational existence for the foreseeable future, subject to additional central funding being provided by the Department of Health and Social Care (DHSC) to help manage working capital and maintain liquidity. For this reason, and as there is no indication from the regulators that the Trust will cease any part of its trading activities, they will continue to adopt the going concern basis in preparing the accounts.

However, the Trust recognises the challenges ahead including the existence of a material uncertainty in relation to the 2020/21 finances of the Trust, the need to take steps regarding its underlying deficit and to continue to work with partners and stakeholders to improve sustainability. The Trust has a strategic commitment to working with partners to achieve this.

On 2 April 2020, the Department of Health and Social Care 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 capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £67.459M are classified as current liabilities within these financial statements. As the repayment of these loans will be 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.

[7] IAS 1 Presentation of Financial Statements (3), p. 38 Government Financial Reporting Manual 2019/20

Performance Analysis

The purpose of the performance analysis is to provide a detailed performance summary of how the organisation measures its performance, a more detailed integrated performance analysis and long-term trend analysis where appropriate.

Development and Performance of the Trust during the Year

It is vital the Trust has an appropriate framework in place to oversee the progress against key milestones and defined outcome measures. It is also important that there is triangulation of performance across quality, workforce, operations and finance, and there are a number of elements in place to provide this.

One such element is the Trust's Integrated Performance Report (IPR). The IPR is provided on a monthly basis to the Board of Directors as well as specific performance reports going to the relevant committees of the Board. It is structured around the requirements of NHS Improvement's Oversight Framework to provide appropriate support in monitoring compliance with key standards and performance indicators.

The IPR and its supporting monthly reports relating to clinical quality, operational performance, workforce and finance, provide the Board of Directors with a holistic view of the Trust's performance, explaining the linkages between each of the different pieces of information. To support the IPR, the Board also uses 'soft' performance measurement feedback such as visits to service areas, patient feedback and other external stakeholder views and reports. The IPR is reviewed annually to reflect the requirements for each new financial year and ensure that any updated or 'local' requirements are reflected appropriately.

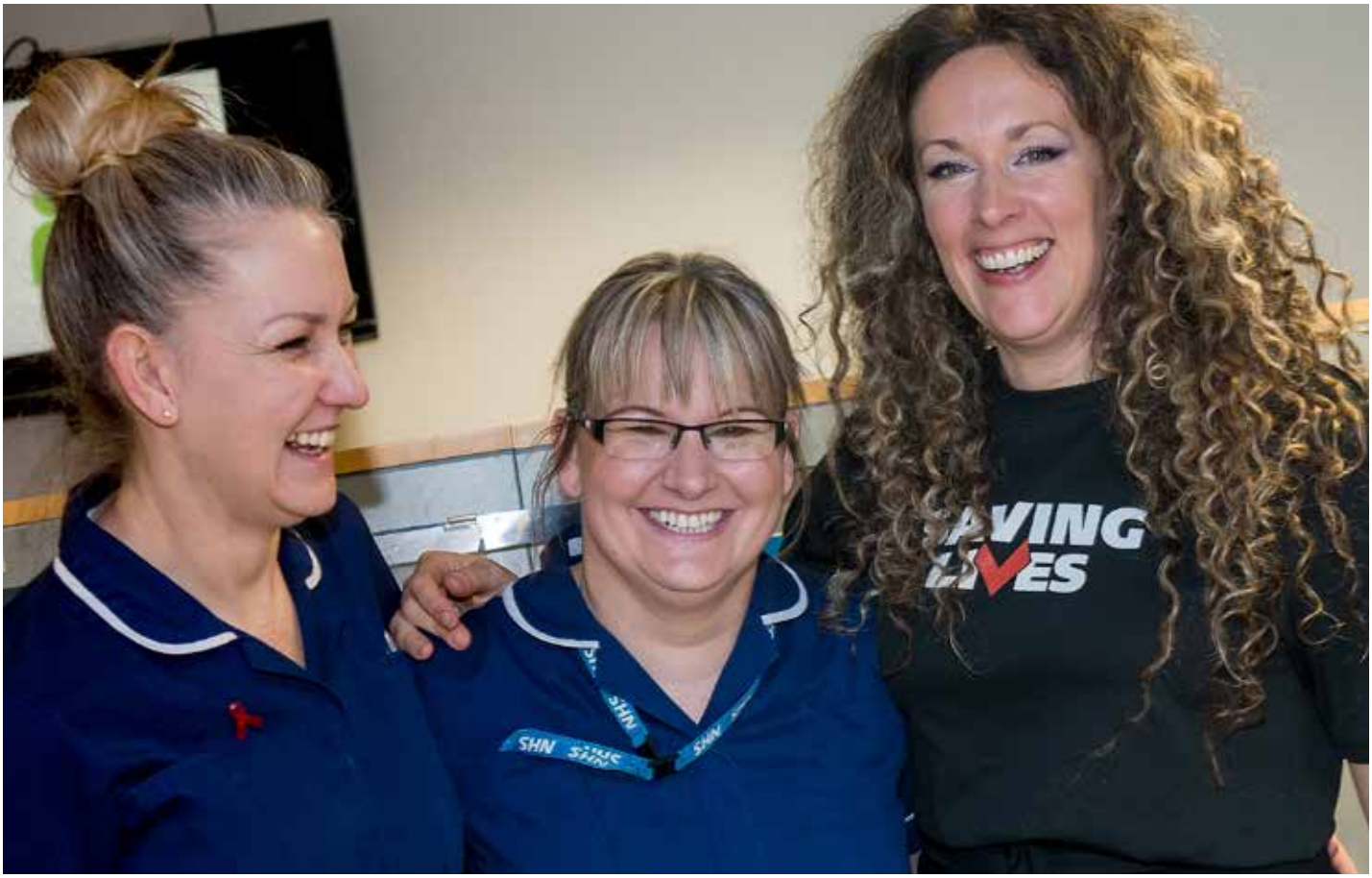
Each Division participates in an Executive Director-led monthly performance review at which the local divisional integrated performance report, structured around the Division's relevant (hard and soft) outcome measures, is reviewed. Clinical teams have timely and relevant information to inform them of progress against their performance objectives, with feedback steps in place to see that data quality issues are addressed.

In addition, the Trust has developed its own data quality kite mark which ensures that the level of assurance for each key quality indicator represented on the IPR is clear, with actions being taken to achieve future compliance and provide assurance across all indicators. The regular review of key performance indicators (KPIs) described above as well as quarterly reviews of the corporate risk register and Board Assurance Framework at Board committees ensures a dynamic and responsive link between KPIs, risk and uncertainty.

Emergency Access

The Rotherham NHS Foundation Trust was a field test site for the new proposed A&E standards for 11 of the 12 months of 2019/20, 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, as they are designed in such a way that it is expected that a number of patients will spend longer in the urgent care department than under the 4-hour standard. This is likely to lead to a more crowded



department, with patients potentially requiring a different type of care to that of a department operating under a 4-hour target. Equally, it has required us to redesign our IT systems to support the delivery of a different set of standards, and 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 11 months of piloting these standards, and to ensure we make the most of being 'ahead of the game'.

Even though we have been testing the new standards, our operational journey of development this year has continued, with a focus on effective ward rounds and discharge planning by ward teams, as well as key patient flow initiatives such as the 'SAFER flow bundle' and 'Red2Green programme'. 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 will be a continued focus on the importance of improving flow through the organisation to support the UECC. 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.

In response to the increased demands placed on the health service over the winter period, the Trust led the development of a system-wide Winter Plan. 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 an additional acute and community capacity being brought on stream from November 2019, with additional beds being provided by the Clinical Commissioning Group (CCG) within the nursing home sector. The Trust's elective care activity was reduced during the busiest periods for emergency admissions in December 2019 and January 2020.

The Trust placed significant focus on the challenges posed by winter and colleagues worked closely with partner organisations in particular to improve the quality and timeliness of transfer of patients from acute settings once they were medically fit to do so.

However, as described above, despite this winter planning, the failure to sufficiently mitigate acute winter pressures contributed to some of the challenges identified above such as the 27 12-hour trolley waits our patients experienced. 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 throughout the year.

18-Week Referral to Treatment Waiting Times

During 2019/20 the 18-week Referral to Treatment performance indicator was achieved for the first 8 months of the year. However, following a period of gradual decline (reflective of that of the whole country), the Trust failed the standard in December 2019 continuing through to March 2020. Despite this, the Trust remained one of the strongest performers in the country against this standard during 2019/20, ranking in the top quartile for every month of the year. Capacity pressures continue to be monitored and actions taken to mitigate risks, to ensure that positive performance returns during 2020/21.

As mentioned above the Trust failed the 18-week target in December 2019 and put in place a plan to recover the position in February / March 2020, however this plan had to be put on hold due to the COVID-19 pandemic.

Cancer Waiting Times

Timely management of patients referred onto a cancer pathway is an important focus for the Trust. Across 2019/20 the organisation met the national standard for patients being treated within 31 days of diagnosis. However, the Trust was not compliant with the 62-day standard of patients being treated following urgent referral from their GP for 3 of the 4 quarters of the year. This was due to a number of factors which included a significant increase in referrals into the Trust coupled with workforce challenges in a number of key areas, and some process issues (which have now been rectified). As would be expected for such a priority group of patients, recovery plans were put in place and enhanced oversight provided to ensure an improvement in performance. Whilst the Trust was reviewing and improving this performance for 2019/20, a return to compliance with the standards is anticipated in 2020/21.

The Trust's plan to return to compliance with the cancer targets during quarter 4 2019/20 was on track with December 2019 performance the best the Trust had seen over the previous nine months and plans in place to deliver sustainable performance during quarter 4. However, once the adjusted activity linked to the COVID-19 pandemic was implemented cancer performance across South Yorkshire was no longer deliverable within the targets.

From 2020/21, the Trust will have an additional Cancer Waiting Times standard to deliver – the Faster Diagnosis Standard, whereby patients are required to have been given a confirmed diagnosis of cancer within 28 days of referral. We have worked hard during the year to redesign relevant processes and ensure we are in a positive place to deliver on this new requirement, but there is still further work to do in one or two more challenged specialties, to ensure all patients receive the same timely and responsive level of care from the Trust.

Diagnostic Waiting Times

The Trust's performance against this standard did deteriorate during March 2020 as a result of the cancellation of all but urgent elective procedures in order to create the capacity required to deal with the COVID-19 pandemic.

However, the Trust's performance average for 2019/20 indicates that 99.5% of patients waited no longer than six weeks for their diagnostic test. The national standard requires that no more than 1% of patients should wait longer than six weeks and therefore this was a positive achievement for the teams involved in ensuring the timeliness of these tests between April 2019 and February 2020.

Other Performance Indicators

In terms of the Delayed Transfers of Care indicator, the Trust remained within the national thresholds for 4 months of the year, seeing a deterioration in performance through winter, to a high percentage rate of 5.63% in February 2020. This reduced considerably in March 2020 to a monthly average of 2.74%, and a positive impact of the COVID-19 pandemic was a system-wide approach to reducing Delayed Transfers of Care which meant that by the first week in April there were no reportable Delayed Transfers of Care within the Trust.

Community services continued to see increased activity across adult and children's services. District Nursing provided close to 6,000 more contacts than the previous year, which 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 continued to respond positively, and in a number of areas have continued to implement new ways of working. Within adult services, this has been through continuing the separation of the planned, routine activity from the urgent response demand. As part of this development, the Care Coordination Centre and Integrated Rapid Response teams have been co-located away from the main acute site to provide a more responsive and integrated approach.

Within children's services, the teams are continuing the work with partners on the implementation of the agreed 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 RMBC on implementing the agreed new approaches in order to deal with the changing demand that is being experienced across the Borough.

Mortality performance continued to be an area of focus during 2019/20. Unfortunately, the Trust saw a gradual deterioration in both its HSMR[8] and SHMI[9] throughout the year. Although this is considered to be due to many factors, making improvements around all of the '3Cs' (quality of care; case mix and coding) was given particular focus. The Medical Director facilitated an extensive independent mortality review of 150 respiratory and heart failure deaths, with the learning widely disseminated across the Trust and to the Board of Directors.

Harm free care performance remained good during the year with the Trust's annual percentage achievement being 93.80% against the target of 95% and achieving over 94% for six months of the year. In relation to Hospital Acquired Infections, there was one case of MRSA and 35 cases of Clostridium difficile recorded during the year against a target of less than 11.

Financial Performance

The Trust achieved its 2019/20 plan of delivering a break-even position and delivered £8.4M (91%) of its Cost Improvement Plan of £9.3M but only following additional non-recurrent Financial Recovery Fund monies at year-end.

[8]Hospital Standardised Mortality Ratio (HSMR). HSMR provides a rolling 12-month picture of mortality data for a time period ending 6 months previously at the time of publishing.
[9]Standardised Hospital Mortality Index (SHMI). SHMI provides a rolling 12-month picture of mortality data for a time period ending 12 months previously in the case of SHMI.

Social, Community and Anti-Bribery Issues

In February 2020, the Trust was awarded Employer of the Year from RNN Group, which owns and operates Rotherham College at their Apprenticeship Awards ceremony. The Trust has around 54 apprentices with RNN Group, which is a grouping of Dearne Valley and Rotherham Colleges that predominantly offers our healthcare courses.

Rotherham's Allied Health Professionals (AHPs) were chosen as 'Northern Flagbearers' for 2019's National AHPs Day back in October 2019. In our Trust we have nine of the fourteen AHP careers represented and it was an opportunity for the various teams here to champion and celebrate the enormous contribution AHPs make to the NHS every single day.

Also in October 2019, four of the Trust's teams were shortlisted in the prestigious HSJ Annual Awards. The awards set out to 'produce a roll call of the best organisations, teams and people in the NHS and the wider health sector.' Our teams were nominated in categories including: Acute or Specialist Service Redesign Initiative; Patient Safety Award; Workforce Initiative of the Year Award; and Connecting Services and Information Award.

The Trust's 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. The Trust is obliged to safeguard NHS funds and resources through compliance with 23 standards for countering fraud, bribery and corruption.

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 which 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.

During the year, counter fraud activity focused on activities to ensure compliance with NHSCFA standards and to address areas of heightened risk including cyber-crime; staff secondary working; bank and agency staff; mandate fraud; declarations of interests and overseas visitors.

The Trust has a Fraud, Bribery and Corruption Policy which is fully supported and endorsed by the Trust. The policy 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 2019/20, 5 referrals of suspected fraud, bribery or corruption were made to the CFS, demonstrating a good awareness and understanding of the Fraud, Bribery and Corruption Policy.

The Rotherham Hospital and Community Charity ('the Charity') aims to raise money to fund resources, equipment and projects which enhance the experience that patients, their families and carers receive from the Trust, in our community and at Rotherham Hospital.

The Charity continued to work with fundraisers, volunteers, local business, schools and organisations to boost funds and raise awareness about the work it does. Corporate support from the Rotherham community included gifts and donations from Rotherham United Football Club and Rotherham United Community Sports Trust, St Bernard's Catholic High School, Asda, Tesco, the Hallam FM Mission Christmas Appeal, the Rotherham Lions Club, Busy Bees Nursery, Co-Op Swinton, Kelford School and the Rawmarsh and District Motorcycle Club.

The Trust's volunteers continued to support the Charity during 2019/20, dedicating their fundraising to the Charity's Dr Ted children's appeal. Their regular fundraising included book, Christmas card and bake sales at Rotherham Hospital.

Trust colleagues were an invaluable support to the Charity once again. Their activities included:

- Fundraisers from the Trust's Antenatal and Newborn Screening Team at Greenoaks 'rocking their odd socks' on 21 March 2019 to mark World Down Syndrome Day. The team invited parents, their families and colleagues to show off their funky footwear to raise awareness about Down Syndrome. They raised £620.
- NHS Big Tea parties were held in the Rooftop Restaurant at Rotherham Hospital and Oakwood Community Unit to celebrate the 71st birthday of the NHS. Colleagues, including the Unison Rotherham Health Branch team, baked cakes and bought raffle tickets. Combined with events in the community, NHS Big Tea parties raised Rotherham's events raised £573.
- A bake sale was hosted by colleagues in Maternity Services, to mark Baby Loss Awareness Week, to raise awareness and support available for families. They raised £704.
- Porter Bob Lumby entertained patients and colleagues alike during his annual Christmas fancy dress walk-round the hospital. He raised £500 for the Special Care Baby Unit's Neonatal Outreach Team.

Successful events also included the Hospital Open Day on 30 November 2019, which included a host of activities, such as a giant Operation game, raffle and arts and crafts, to raise £129 for Dr Ted.

In December 2019, the Charity Christmas Fair and lights switch-on was held in the main entrance of Rotherham Hospital. Youngsters from Busy Bees Nursery and St Bernard's Catholic High School sang carols and players from Rotherham United Football Club switched on the hospital's Christmas tree lights. Santa and Dr Ted also made an appearance helping to raise £1,178.

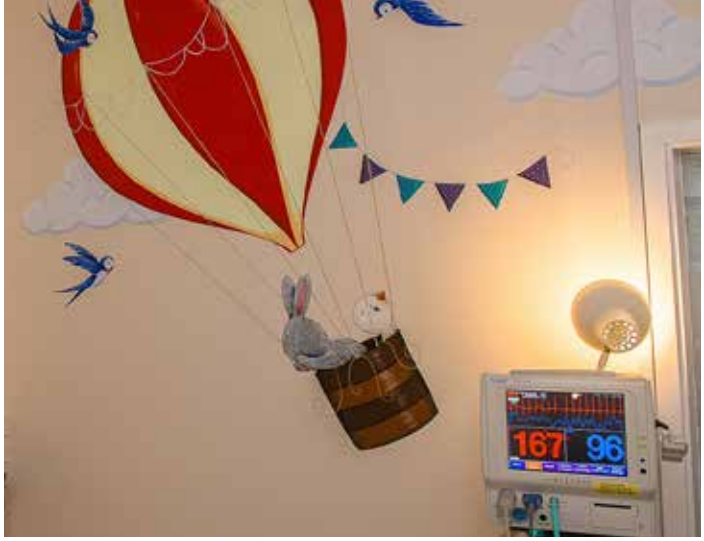
The Charity saw a wealth of support from businesses and organisations in Rotherham in 2019/2020. This included tenants at Parkgate Shopping who supported the annual One Great Day fundraising event, raising £657 for Dr Ted.

Louise Whitworth and Pat Doherty, colleagues at Santander's Rotherham branch, hosted a quiz night and auction in February 2019 at Rotherham Town Cricket Club. The funds raised were matched funded by Santander and totalled £3,225 for the charity's Purple Butterfly Appeal.

Hospitality and Tourism students from the University Centre Rotherham hosted a Ladies' Night at The Wharncliffe Restaurant, raising £335.

Residents at Bakers Field Court ran an Easter raffle, raising £1,001 and more than 70 members of the Rawmarsh and District Motorcycle Club visited the Children's Ward at Rotherham Hospital on Easter Sunday 2019 to deliver a £400 cheque and chocolate treats.

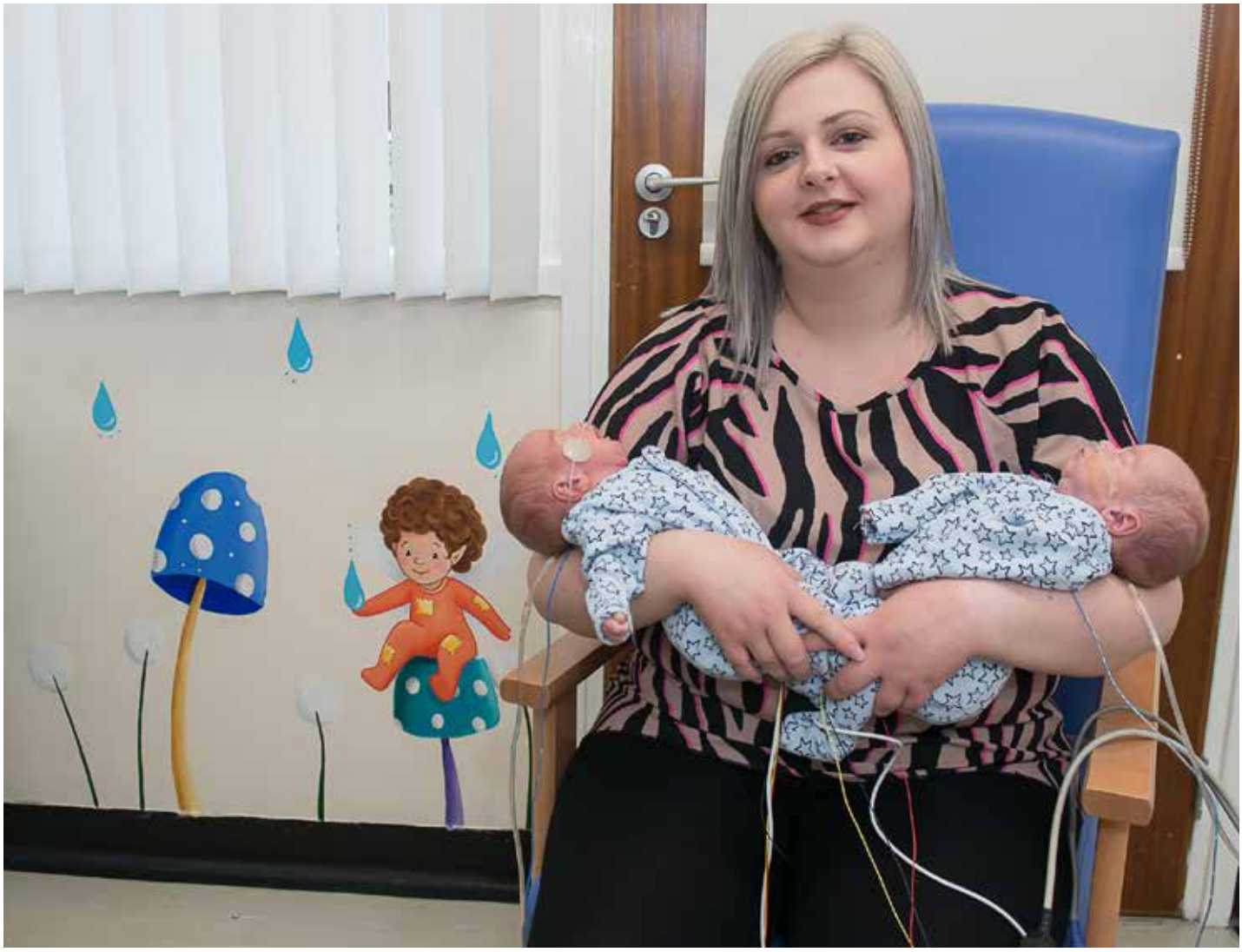
The former Mayor of Rotherham, Cllr Alan Buckley, hosted a Mayor's Ball at the Carlton Park Hotel to raise funds for the Mayor's Charity Appeal. The event raised £9,000 for Dr Ted. The Charity hosted a Halloween Spooktacular event with Unison Rotherham Health and Tesco Maltby, raising £256.



Property solutions provider Fortem launched its annual Trainee Challenge once again with the company's Northern team choosing to undertake a project to help transform the Special Care Baby Unit at Rotherham Hospital. The project involved creating a purpose-built storage facility and a new breastfeeding room. The team also raised an additional £3,500 to fund the added extras to revamp the room.

The Charity funded a host of resources and equipment during 2019/20, including:

- An echocardiography heart scanner and video-linking equipment for Family Health worth £64,321.
- £16,800 funding for Visualite Skylights for the Special Care Baby Unit and the Delivery Suite.
- £2,771 for adjustable height chairs and TVs for the new Bone Health Falls and Fracture Liaison Service.
- £2,053 to fund a supply of activity boxes to aid the recovery of dementia and stroke patients. The boxes contain games and sensory activities to enable patients to socialise and engage with the colleagues caring for them.
- £3,901 to fund the redecoration of the Breast Cancer Holistic Needs Assessment Room in General Surgery. The room provides a private, comforting space for women during their breast cancer journey.
- More than £10,000 to fund artwork by artist Lucy Strutt for the Special Care Baby Unit, UECC and Children's Outpatients.



Human rights and equality reporting

Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap (GPG) reporting data, Public Sector Equality Duty (PSED) data, national staff survey data, data from NHS jobs and census data all provide assurance in this area. The organisation published its first report under the new Workforce Disability Equality Standard (WDES) in August 2019.

During 2019/20, the Trust has seen improvements in WRES metrics alongside improvements in some of the Equality and Diversity theme data in the national staff survey.

During 2019/20, the Trust has been required to report on its gender pay gap as at 31 March 2019. This report showed an increase in the Trust's gender pay gap. Work is being undertaken to analyse the reasons for this increase.

Alongside 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 performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, the GPG, the WDES and the WRES, the Trust is able to deliver on the Public Sector Equality Duty. During the final quarter of 2019/20, the Trust carried out a review of its performance against EDS2, which will be used to inform the setting of revised equality objectives for 2020/21.

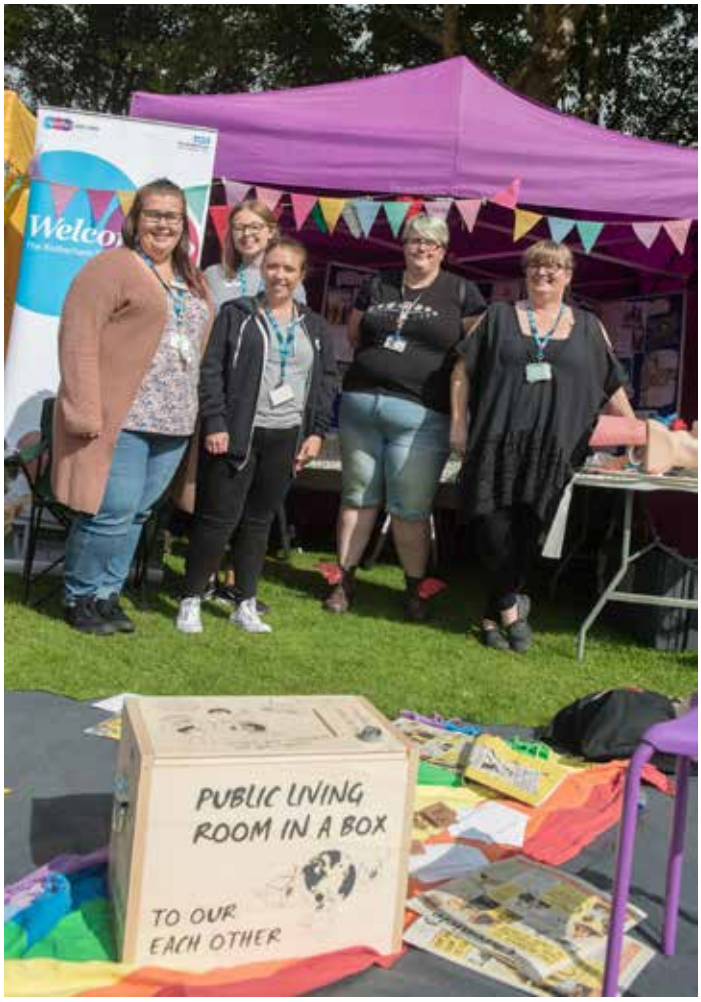
All recruitment campaigns are managed in line with the Trust's policy, this policy has been impact assessed and identified no immediate issues. The Trust is a Level 2 Disability Confident Employer and operates a guaranteed interview scheme for disabled applicants.

Equality and diversity training is mandatory for all colleagues and covers all protected groups. During the last three financial years, the Trust has trained a number of staff to act as Mental Health Champions, who are able to provide support and signposting to colleagues who are experiencing mental ill-health and who work to reduce the stigma around mental illness by encouraging open conversations.

In October 2018, the Trust launched a new Employee Assistance Programme (EAP), which provides confidential support by qualified counsellors 24 hours a day to colleagues.

During the previous financial year (2018/19) the Trust relaunched its Diversity and Inclusion Group, with a refreshed membership and revised Terms of Reference. The Group reports into the Trust's Operational Workforce Group (OWG) and has strong links with the Yorkshire and the Humber Equality and Diversity Leads Network.

During 2019/20, the Trust has supported the development of BAME[10], Disability and LGBT+[11] colleague networks. The Trust has also started to train BAME representatives to sit on interview panels for senior roles and commenced planning for the implementation of NHS Rainbow Badges, which will include the provision of LGBT+ awareness training for staff.



[10]BAME: Black, Asian and minority ethnic
[11]LGBT+: Lesbian, gay, bisexual, transgender/transsexual and 'plus' which represents other sexual identities

Modern Slavery Act

This statement is made pursuant to section 54 of the Modern Slavery Act 2015 and sets out the steps that The Rotherham NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour, including sexual or criminal exploitation. The Trust has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the business or our supply chain.

We operate a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include our policies on: recruitment, equal opportunities, safeguarding, whistleblowing and our Standards of Business Conduct.

The Trust is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

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 and procurement staff attend regular training on changes to procurement legislation.
Additionally, we also:

- Ensure that our suppliers are carefully selected through our robust supplier selection criteria/processes
- Require 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
- Ensure invitation to tender documents contain a clause on human rights issues and clauses giving the Trust the right to terminate a contract for failure to comply with relevant labour laws

When procuring goods and services, we additionally apply NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

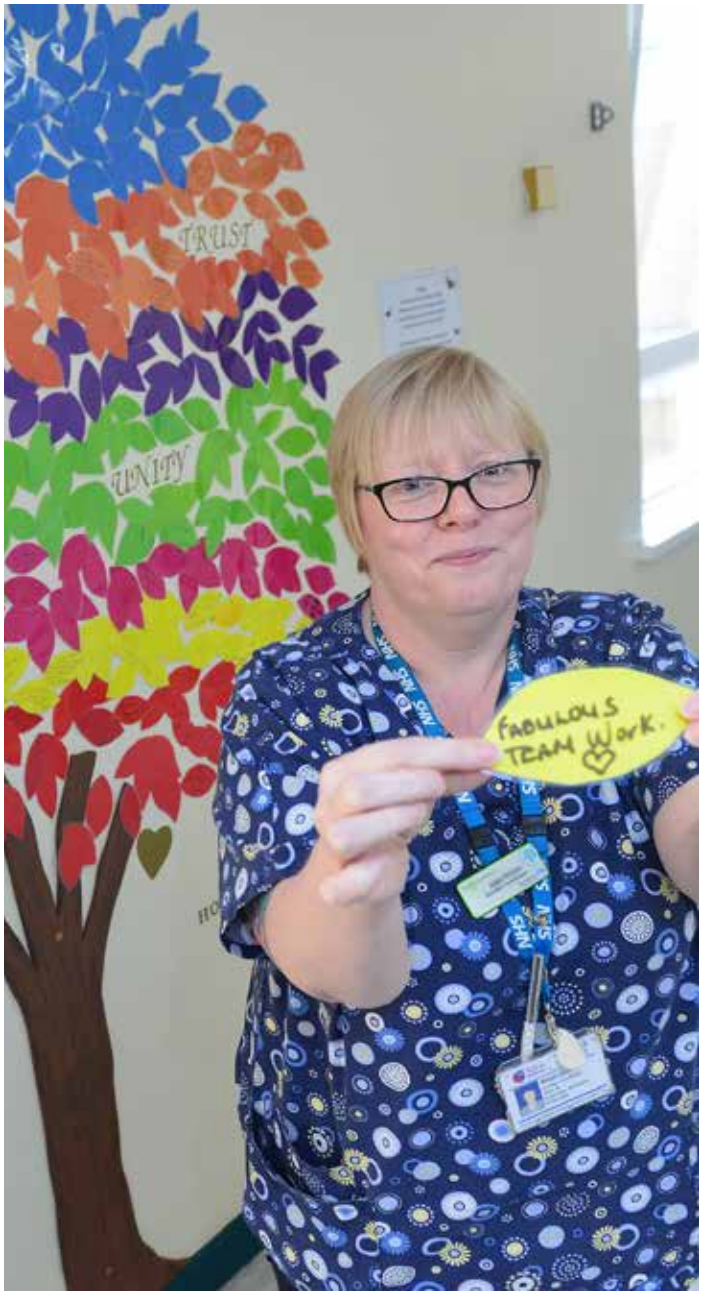
Overseas operations

The Trust does not have any overseas operations.

Any important events since the end of the financial year affecting the Foundation Trust

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 capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers.

Outstanding interim loans totalling £67.459M as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.



Progress against the Sustainable Development Plan

Introduction

As an NHS organisation, and as a spender of public funds, the Trust has an obligation to work in a way that has a positive effect on the communities it serves. Sustainability means spending public money well, using natural resources smartly and efficiently, and building healthy, resilient communities. By making the most of social, environmental and economic assets it is possible to improve health both in the immediate and long term and even in the context of the rising cost of natural resources. Demonstrating that consideration is given to the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

The Rotherham NHS Foundation Trust is committed to demonstrating leadership in sustainability and has produced a Sustainable Development Management Plan (SDMP) in order to set out the route to delivering a sustainable healthcare system that works within the available environmental, financial and social resources, protecting and improving health now and for future generations. The SDMP outlines the Trust's vision and priorities for sustainable development, and ensures that it meets all applicable legislative requirements whilst embedding the principles of sustainable development for the benefit of colleagues, patients and the local community in Rotherham.

The SDMP will embed opportunities to:

- Reduce environmental impact and associated carbon emissions and so benefit from a healthier environment
- Establish local level partnerships and collaboration in order to help the local community flourish and to improve the resilience of services and the built environment in response to severe environmental and climatic changes
- Embed sustainable models of care and support the local community to be well connected, healthy, resilient, independent and manage their lives in a positive way

Policies

In order to embed sustainability within the business it is important to explain where sustainability features within the Trust's process and procedures.

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The Board of Directors approved the Trust's SDMP in 2017 so the plans for a sustainable future are now well known within the organisation and are clearly laid out. One of the ways in which the impact of the organisation on corporate social responsibility is measured is through the use of the Sustainable Development Assessment Tool (SDAT). This is a tool which the Trust continues to work through and update. As an organisation which acknowledges its responsibility towards creating a sustainable future, the running of awareness campaigns promoting the benefits of sustainability to colleagues aids in the achievement of this goal.

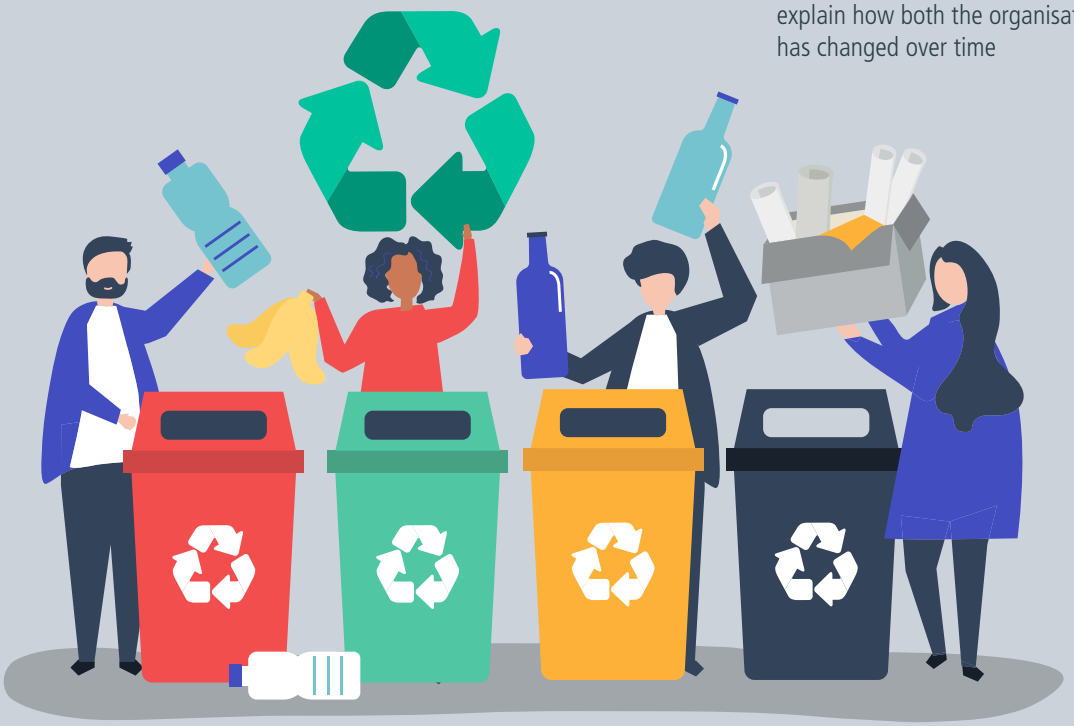
Climate change brings new challenges to the business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The organisation has identified the need for the development of a Board-approved plan for future climate change risks affecting our area. The social and environmental impacts for the Trust have not been assessed.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for the organisation as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. No strategic partnerships are currently established.

Performance

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still ongoing. Therefore, in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time



Resource		2015/16	2016/17	2017/18	2018/19	2019/20
Gas	Use (kWh)	40,577,691	37,312,553	36,277,907	36,483,275	39,825,892
	tCO_2e	8,492	6,853	6,707	6,707	7,325
Oil	Use (kWh)	0	194,400	0	590,000	0
	tCO_2e	0	618	0	1,753	0
Coal	Use (kWh)	0	0	0	0	0
	tCO_2e	0	0	0	0	0
Electricity	Use (kWh)	423,606	708,498	778,945	720,732	657,995
	tCO_2e	212	354	284	221	190
Green Electricity	Use (kWh)	1,037,104	2,306,501	4,412,514	3,486,692	3,183,616
	tCO_2e	378	841	1609	1,071	922
Total Energy CO_2e		**9,024**	**8,570**	**8,561**	**10,336**	**8,437**
Total Energy Spend		**£1,073,928**	**£1,087,629**	**£1,492,854**	**£1,537,401**	**£1,667,330**

Every year our energy provider strives to improve the split of fuel sources used to generate our electricity in order to lessen our impact upon the environment. At present our energy mix is:

- 5.2% coal
- 10.84% gas
- 72.07% nuclear
- 11.73% renewable
- 0.16% other

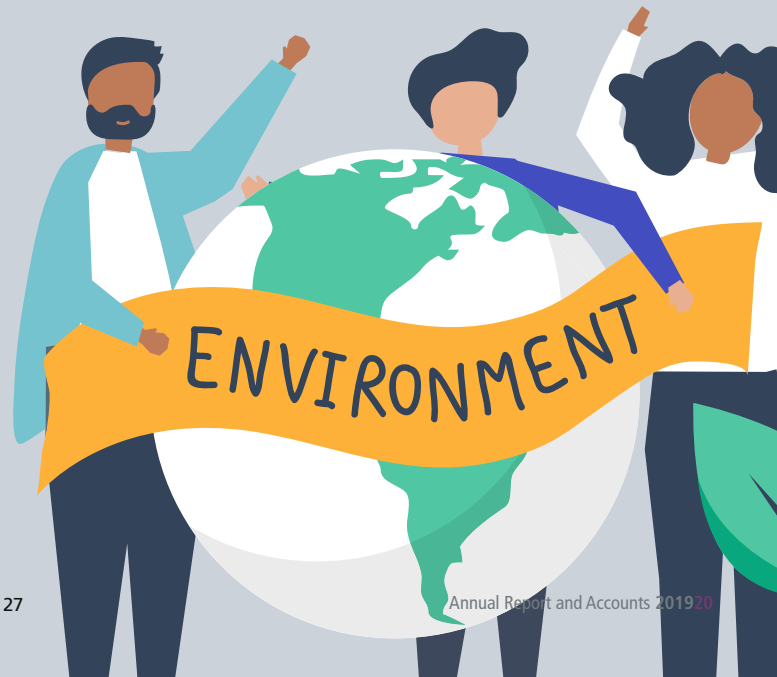
The amount of gas and electricity that is consumed at Rotherham Hospital is totally dependent upon the performance of its Combined Heat and Power plant (CHP). If the CHP achieves its target of a 90% availability then grid electricity will reduce pro-rata and the waste heat will be utilised to supplement the heating and hot water systems, resulting in less gas being bought in from the supplier.

The CHP engine has been affected by ongoing technical issues during the past 12 months resulting in less generation than would be expected. These problems have recently been rectified and it is anticipated that the engine will deliver optimal generation going forward, however, the downtime still had an adverse effect upon the finances of the Trust as it resulted in more electricity being purchased from the supply grid, as well as more gas to provide heating and hot water from the site boilers.

The CHP would normally generate approximately 65% of the hospital base load electricity and supplement the heating and hot water infrastructure via the waste heat that the CHP engine produces.

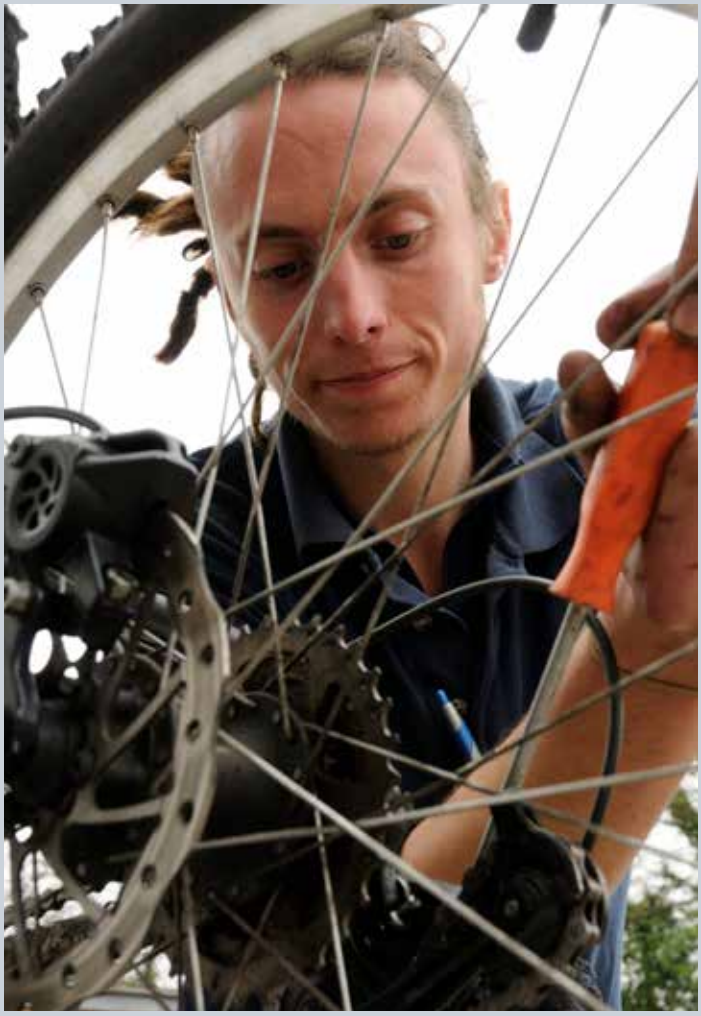
Over the past four years there has been little capital expenditure available to improve the energy performance on site and so the decision has been taken to work with a third party provider to identify and implement energy saving solutions under an Energy Performance Contract (EPC). A partner has been selected and employed to implement this EPC, this contract was signed in December 2019.

The scheme is being thermally driven resulting in the replacement of the CHP, seven Low Temperature Hot Water Boilers, two steam raising boilers and a raft of other measures including a chilled water ring main, the replacement of over 7,000 light fittings with a more energy efficient option (incorporating smart controls and daylight dimming) and improved building heating controls.



All the projects identified will be funded by the energy savings made and these savings will be guaranteed.

The Trust has spent £1,667,330 on energy in 2019, which is £129,929 more than last year, an increase of 7.8%



Travel

The organisation recognises that colleague and visitor travel impact greatly upon the local air quality. This is an area in which the Trust is actively working to reduce vehicle emissions. Air pollution and accidents are a major cause of health issues in the locality, whether that is through respiratory problems or attendance at our UECC. It is the aim of the Trust to reduce the number of cars on site and the amount of colleague travel. Business and lease car mileage information is collected on a monthly basis and the resulting carbon emissions calculated. However, over time it has proved difficult to acquire the necessary data and this has led to a certain amount of information being unavailable (see table below).

Performance

A Green Travel Plan has been developed and the Trust is committed to encouraging active and low carbon travel in order to reduce vehicle carbon emissions, reduce the demand for car parking spaces and promote health and well-being. The organisation has a longstanding relationship with local bus operators, RMBC and South Yorkshire Passenger Transport Executive (SYPTE) to maintain and improve access to Rotherham Hospital by bus. Public transport incentive schemes are popular with colleagues and are aimed at encouraging bus use rather than car use. Cycle to Work schemes and car share initiatives are already in place, whilst other initiatives such as the Dr Bike free cycle maintenance and health check have proved very popular with colleagues.

Resource		2015/16	2016/17	2017/18	2018/19	2019/20
Business travel	miles	894,015	825,198	732,937	631,575	741,519
	tCO_2e	265	246	209	169.45	209
Fleet travel	miles	403,186	423,531	No data available	No data available	No data available
	tCO_2e	104	108			
Patient travel	miles	Data not collected	Data not collected	Data not available	No data available	No data available
	tCO_2e					
Staff travel	miles	263,356	370,552	483,618	449,484	489,962
	tCO_2e	68	95	124	115	132

N.B. It is no longer possible to obtain Fleet travel and Patient Transport data

Waste Disposal Tonnages & Emissions

Waste		2015/16	2016/17	2017/18	2018/19	2019/20
Recycling	(tonnes)	216	187.00	197.00	210.03	181.87
	tCO_2e	4.32	4.07	4.29	4.57	3.88
Other recovery	(tonnes)	573	642.00	700.35	699.83	714.08
	tCO_2e	11.46	14.74	16.08	16.06	15.25
High Temp disposal	(tonnes)	63	61.00	67.68	69.08	67.71
	tCO_2e	4.41	4.27	4.74	4.84	4.74
Landfill	(tonnes)	0.00	0.00	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00	0.00	0.00
Total Waste (tonnes)		852.00	890.00	970.45	978.94	963.66
% Recycled or Re-used		**25%**	**21%**	**20%**	**21.5%**	**19.0%**
Total Waste tCO_2e		**20.19**	**23.08**	**25.11**	**25.47**	**23.87**

N.B. The high temp tCO2e has changed from previous years as the Trust was using the best known available calculation for this, however guidance was provided by the waste disposal company of a revised calculation. This has now been used for the table and backdated to offer a true comparison year on year.

Performance

In line with legislative requirements, none of the waste produced by the Trust is sent to landfill for disposal. Other recovery tonnage has increased by 14.25 tonnes due to improved segregation from 2018/19, and within this calculation, the offensive waste stream has increased by 1.7% (3.75 tonnes) just below the target of 2%.

It was envisaged that due to a change of process within the site, the orange bag waste would increase by 8% on 2018/19 figures, the increase seen was actually 7% and in the main this was due to the increase in patient throughput.

General waste has continued to reduce annually due to increased recycling within the Trust. In 2019/20 the decrease was 0.5% meaning that the key performance indicator of a 1% reduction was therefore not met.

Commentary

Plastic recycling continues to work well and the recycling tonnages have been maintained compared to 2018/19 figures at 1.00 tonne per month produced.

Plastic bottle crushing machines continue to work well within the Trust. To extend this, work is being undertaken to look at the feasibility of a new crusher to be purchased to crush the bottles within the bins in the waste area, allowing for increased recycling.

The Trust continues to review ways of reducing waste and increasing recycling with improved segregation, with trials coming during 2020/21 for the recycling of single use instruments in Theatres.

In line with GDPR[12] regulations, shredding on site commenced in early 2019, to ensure the Trust is fully compliant. This will result in a saving on carbon footprint and reduce down the storage time for confidential waste within the Trust's waste area.

[12] General Data Protection Regulation

Finite resource use – Water

Water		2015/16	2016/17	2017/18	2018/19**	2019/20*
Water	Use (m^3)	97,450	90,224	104,822	101,411	96,186
	tCO_2e	34	31	36	35	33
Sewage	Disposal (m^3)	77,966	92,085	94,340	99,864	100,616
	tCO_2e	55	65	67	71	71

*NB up to end of December 2019, figures extrapolated for full year to March 2020
**NB Actual figures following final accounts

Performance
Due to an increased flushing regime to combat the risk of legionella and achieve compliance there has been a noticeable impact on the amount of water being consumed on site. However, due to increased consumption by tenants the net consumption attributable to the Trust has actually decreased significantly from the previous year.

Modelled Carbon Footprint
The data source for the information provided in the previous sections of this sustainability report is the ERIC (Estates Return Information Collection) return. However, this does not reflect the organisation's entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU). More information is available here: https://www.sduhealth.org.uk/sdat/default.aspx

Modelled trajectory
In line with the NHS commitment to reduce its carbon footprint by 28% by 2020 the Trust is able to report the following progress:

Electricity - reduce electricity consumption by 10% by 2018 against a 2010 baseline **[achieved].**

Gas - reduce gas consumption by 10% by 2018 against a 2010 baseline **[achieved].**

Water - reduce water consumption by 15% against a 2008 baseline by 2020 **[on target].**

Emissions - reduce building energy related greenhouse gas emissions by 10% by 2015 against a 2007 baseline **[achieved];** and by 20% by 2020 against a 2008 baseline **[on target]**.

Adaptation
Events such as heat waves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that the Trust's services continue to meet the needs of the local population during such events a number of policies and protocols have been developed and implemented in partnership with other local agencies.

The Trust, as part of its operational business planning, updates its heat wave plan and winter plan annually to ensure it is able to maintain its operational services during severe weather disruption and projected increases in the demand for health care. This requires the Trust to work closely with partner agencies in ensuring it is able to fulfil its obligations in providing healthcare services. The Trust also carried out business impact assessments for all its services to ensure that they are able to respond to situations as and when they arise.

For a Greener NHS
The NHS in England is the only healthcare system in the world which routinely reports on its greenhouse gas emissions. It contributes 5% of the UK's entire carbon emissions, although NHS emissions have already been cut by almost a fifth in the last decade. On 25 January 2020 Sir Simon Stevens, Chief Executive Officer of the NHS, announced the NHS' plan to reach 'net zero' carbon emissions ahead of 2050, and launched its campaign 'For a Greener NHS'.

Air pollution is linked to killer conditions like heart disease, stroke and lung cancer, contributing to around 36,000 deaths annually. Sir Simon Stevens announced a three-step plan that the NHS will implement during 2020 to tackle this problem.

Firstly, NHS England is establishing an expert panel to chart a practical route map during 2020 to enable the NHS to get to 'net zero', and become the world's first major health service to do so. The expert panel will look at changes the NHS can make in its own activities, in its supply chain, and through wider partnerships thereby also contributing to the government's overall target for the UK.

These changes include the Long Term Plan commitment to better use technology to make up to 30 million outpatient appointments redundant, avoiding thousands of unnecessary trips made by patients to and from hospital. It is estimated that 6.7 billion road miles each year are from patients and their visitors travelling to the NHS.

The panel will also look at changes that can be made in the NHS's medical devices, consumables and pharmaceutical supply, as well as areas the NHS can influence such as the energy sector as the health service moves to using more renewable energy.

Secondly, the NHS will be taking immediate action in 2020 with a proposed new NHS Standard Contract calling on hospitals to reduce carbon emissions from buildings and estates, switch to less polluting anaesthetic gases and improved asthma inhalers, and encourage more active travel for staff.

And finally, the health service will also launch its own grassroots campaign 'For a Greener NHS' to encourage staff and hospitals to cut their impact on people's health and the environment.

The 'For A Greener NHS' campaign will be supported by the UK Health Alliance on Climate Change which includes representative bodies covering over 650,000 NHS staff. The campaign will build on the work already underway to help Trusts and staff to cut emissions, energy use and waste, including phasing out oil and coal boilers and increasing the use of LED lighting and electric vehicles.

Carbon and Energy Fund

In December 2019 the Trust entered into a 20-year Energy Savings Project Agreement (ESPA) that is supported by third party investment in the energy provision infrastructure at the Trust. The project will secure capital investment of c. £10.8M which will be repaid through guaranteed savings from volume reductions in energy consumption. In addition, a service payment will be made over the term of the contract that covers the cost of plant, life cycling costs for 20 years, maintenance and the guarantee of availability, service and savings.

The 20-year contract does not become operational until all the infrastructure has been installed and signed-off by the Trust, which is scheduled to be completed in the final quarter of the financial year 2020/21. During the installation phase of this contract, based on a 14-month period, the Trust will pay the third party an interim service charge of c. £0.1M, which as a minimum, the Trust would expect to be offset by associated energy efficiency savings generated during the same period.

The Trust's appointed legal advisers have produced an independent report on the validity of the non-financial aspects of the ESPA in which they identified that there were five principal contracts that the Trust was required to enter into in relation to the project. At year six of the agreement the Combined Heat and Power plant (CHP) will be replaced and the Trust ensured that any future risks arising from the work were fully understood before it entered into the ESPA.

During the life time of the contract, the Trust will be responsible for the performance and operational management of the contract and will be supported throughout by the Carbon and Energy Fund (CEF) in relation to the measurement and verification of the contractual performance and in providing a technical support role. The CEF is an organisation that has been specifically created to fund, facilitate and project manage complex energy infrastructure upgrades for the NHS and the wider public sector.

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

R. Jenkins

Dr Richard Jenkins
Interim Chief Executive
02 June 2020

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	From 10 February 2020
Nicola Bancroft	Non-Executive Director	From 01 October 2019
Joe Barnes	Non-Executive Director and Senior Independent Director	
George Briggs	Chief Operating Officer	
Heather Craven	Non-Executive Director	
Mark Edgell	Non-Executive Director	
Callum Gardner	Interim Medical Director Medical Director	To 31 October 2019 From 01 November 2019
Lynn Hagger	Non-Executive Director and Vice Chair	
Steven Ned	Joint Director of Workforce	From 01 April 2019
Rumit Shah	Non-Executive Director	From 01 January 2020
Simon Sheppard	Director of Finance	
Mike Smith	Non-Executive Director	From 01 April 2019
Angela Wood	Chief Nurse	
Michael Wright	Interim Deputy Chief Executive	From 10 February 2020
Directors who served during the year, but who had left before year-end		
Louise Barnett	Chief Executive	To 07 February 2020
David Hannah	Non-Executive Director	To 31 January 2020
Chris Holt	Deputy Chief Executive	To 31 May 2019
Barry Mellor	Non-Executive Director	To 30 September 2019
Chris Preston	Interim Deputy Chief Executive Director of Strategy and Transformation[13]	From 07 May 2019 to 09 February 2020 From 10 February 2020 to 08 March 2020

[13] Whilst Chris Preston continued to work for the Trust from 10 February to 08 March 2020, he stepped down as an Executive Director and continued as Director of Strategy & Transformation, a non-voting member of the Board of Directors.

Directors' biographies can be found within the Governance Report beginning on page 64, 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/) or by requesting a copy from the Company Secretary at the address below:

Ms Anna Milanec, 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 2019/20* 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.

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. However, the Trust, in common with all sectors of the economy, has to primarily manage its cash flow according to the requirements of the organisation in order to ensure it has sufficient liquidity, prevent unforeseen bank charges and minimise the extent of interest payable on loan financing.

As can be seen in the table below, during 2019/20 the Trust paid 31.56% (by number) of all of its bills within the 30-day target.

	Number	Value £000's
NON-NHS		
Total Bills Paid in Year	46,345	83,577
Total Bills Paid Within Target	15,141	29,217
Percentage of Bills Paid in Target	32.67%	34.96%
NHS		
Total Bills Paid in Year	2,045	11,425
Total Bills Paid Within Target	133	644
Percentage of Bills Paid in Target	6.50%	5.64%
TOTAL		
Total Bills Paid in Year	48,390	95,002
Total Bills Paid Within Target	15,274	29,861
Percentage of Bills Paid in Target	31.56%	31.43%

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 2019/20 was £318.

The table above shows a deterioration from the position in 2018/19 when the Trust paid 71.75% (by number) of bills within the target. In part this was a planned reduction, and resulted from planned high levels of creditors throughout the first half of the 2019-20 year. The higher levels were required to manage the expected deficit during the first six months of the year. However, the Trust was additionally affected by a deterioration in the income and expenditure position in the last quarter of 2019/20, also putting pressure on cash availability.

In April 2020 the Trust received contract income for both April and May and June's income will be received in May. This new payment in advance process, implemented to support Trusts and suppliers during COVID-19, has enabled us to begin to recover our payment performance. April 2020's performance figures showed that 77% of invoices (by value) were paid within 30 days overall.

Information on Fees and Charges

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

Income disclosures required by section 43(2A) of the NHS Act 2006 (as amended by the Health & Social Care Act 2012)

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 2019/20.

Disclosures relating to NHS Improvement's Well-led framework

During 2019/20, the Board of Directors implemented the recommendations from an external well-led review that was commissioned the previous year. This review identified some areas that needed to be focused on, and an action plan was developed and fully implemented.

The Trust also received an inspection from the Care Quality Commission (CQC) during 2019/20 when a re-inspection of Urgent and Emergency Care services was undertaken. The Trust was pleased to achieve an improved rating following this inspection and a further action plan was developed to take forward the identified recommendations.

In addition, the recommendations from a review of the arrangements for risk management and quality governance that had previously been undertaken during 2018/19 were fully implemented.

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 another particularly busy year, with several service developments which have positively impacted on patient care, such as the refurbishment of the endoscopy decontamination unit and the new Greenoaks unit, along with an extensive service review of community respiratory care.

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 has seen a gradual deterioration in both its HSMR and SHMI throughout the year. Although this is considered to be multi-factorial, particular focus continues to be given to making improvements around all of the '3Cs' (quality of care; case mix and coding). This has included an extensive independent mortality review of 150 respiratory and heart failure deaths, facilitated by the Medical Director, with the learning widely disseminated across the Trust and to the Board of Directors.

The Trust has appointed its first Medical Examiner, who 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. In addition, the Medical Examiner has a key role to play in helping the Medical Director improve the Trust's learning from deaths. The Trust has a monthly Mortality Group which reviews performance and learnings from deaths, and which in turn reports into the Patient Safety Group and the Clinical Governance Committee, the latter of which is chaired by the Trust's Medical Director.

Furthermore, the Trust is in the process of expanding its Medical Examiner service in order to create a Medical Examiners' Office with 7-day a week coverage. Throughout 2020/21 there will be continued focus on improving such learning from deaths by ensuring that all deaths are reviewed within a month of death; by optimising the recognition of patients coming to the end of their life; and by ensuring that all such learning is triangulated with learning from adverse incidents and complaints.

In addition, all deaths involving patients with learning disabilities and all deaths going for a Coroner's investigation and/or inquest, now have a stage-2 detailed mortality review (Structure Judgement Review) and are reviewed at the Trust's Serious Incident Panel, chaired by the Medical Director or Chief Nurse, to ensure any issues and appropriate learning are identified in a timely manner in order to continuously improve the quality of care within the organisation.

As part of the Trust's new Safe & Sound Quality Framework, co-owned by the Chief Nurse and Medical Director, the Trust has recently introduced an enhanced senior leadership structure, which will increase Trust oversight, leadership and clinical engagement across a number of quality domains, including patient experience, clinical effectiveness, patient safety and human factors.

This includes the introduction of three new Associate Medical Director posts: one for Patient Safety (which includes responsibility for leading on quality priorities such as sepsis and the deteriorating patient); one for Clinical Effectiveness (which includes responsibility for leading on audit and compliance with NICE guidance); and one for Human Factors (leading on the roll-out of human factors within the Trust and the introduction of important colleague wellbeing mechanisms, such as Schwartz Rounds).

All of the Trust's Associate Medical Director roles are overseen by the Medical Director, who personally leads on patient experience, and will complement the already established senior nursing roles in these areas.

Following a successful pilot on two wards, the Trust went live with electronic prescribing across all in-patient areas (except intensive care) in September 2019, followed by all out-patient areas between December 2019 and February 2020. This has led to a significant reduction in the number of medication omissions, which is now consistently well below 5% (seen as the national benchmark), thus leading to a positive impact on patient care and treatment.

Furthermore, the Medical Director has introduced mandatory training modules for doctors for insulin and anti-coagulation, (these two medication groups are the key drugs in medication incidents) along with enabling access to the other 47 available modules for all medical colleagues. The Trust is also in the process of introducing new Medicines Management training, led by the Chief Pharmacist under the auspices of the Medical Director and Chief Nurse.

The Trust continues to focus on improving the timeliness and effectiveness of responses to deteriorating patients and rolled out electronic observations across the hospital in April 2019. In addition, the Trust has a monthly Safe & Sound Deteriorating Patient and Sepsis Group, which discusses any matter or issue relating to the deteriorating patient, including the results of sepsis audits and local and national quality improvement initiatives. The Medical Director is also in the process of leading on the refinement of a business case to support the launch of a new and enhanced response team called the Acute Response Team (ART). The ART will function 24 hours a day, 7 days a week, and will replace the current Hospital at Night service which only operates out of hours.

The Trust continues to hold a weekly 'Harm Free' meeting, chaired by the Medical Director and Chief Nurse, at which all key incidents and quality issues are discussed and actions agreed. This meeting helps sustain a focus on the quality of care within the organisation and is complemented by the outputs from the Safe & Sound Quality Directorate. The Trust has trained several colleagues in the investigation of serious incidents (RCA[14] training) throughout 2019/20, and is in the process of rolling this out to more colleagues and ensuring that human factors is incorporated into the learning from such root cause analyses.

As of 31 March 2020, there were 40 Serious Incident reports overdue for completion. A number of actions are being undertaken to address this both to provide outcomes for patients and their families and to ensure that any necessary learning can be acted upon without unnecessary delay. This is being led by the newly appointed Head of Patient Safety and Associate Medical Director for Patient Safety working in conjunction with the Clinical Divisions.

Key learning from incidents will be incorporated into a new monthly Safe & Sound quality bulletin, which will have sections written by our leads for patient safety, clinical effectiveness, human factors, patient experience and the Medical Examiner's Office, as well as by the Medical Director and Chief Nurse.

Good progress continues to be made around the identification and management of sepsis, including the introduction of sepsis screening tools across all adult and paediatric wards, as well as in obstetrics; this has been supported by targeted training and education, including through mandatory training, posters in clinical areas, screen savers on computers, and revised policies and procedures. The introduction of electronic prescribing and medicines administration within the Trust has also enabled us to more easily monitor the time between the prescription and administration of antibiotics; this is important, as timely treatment of sepsis leads to better outcomes, since evidence suggests that sepsis can worsen with delayed treatment. As a result, the Trust will continue to focus on the timely administration of antibiotics and the recognition of sepsis throughout 2020/21.

The Trust had an unannounced CQC inspection in September 2018, following which the Trust was rated as 'Requires Improvement' overall, and 'Inadequate' for the Urgent and Emergency Service, with some key areas highlighted for improvement.

Following intense focus on actions required to drive quality improvement, supported by the Trust's new Safe & Sound Quality Framework, the Trust received a further unannounced CQC inspection to our UECC in August 2019, following which UECC was rated as 'Requires Improvement' overall, and 'Good' for Caring.

Since both the unannounced and announced inspections, the Trust has continued to work closely with the CQC to provide them with assurance of the significant improvements made to date, particularly in the UECC, and enhanced senior support has continued to be provided by the Chief Nurse and Medical Director. In addition, the Trust has proactively sought external support to help identify and drive improvements, with the aim of becoming 'Good' by the time of the next CQC inspection and, ultimately, 'Outstanding'.

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 CQC inspections in September, October 2018 and August 2019 are all monitored at Trust-level by the Quality Assurance Committee (one of the Board Assurance Committees) and by the Clinical Governance Committee (operational level committee).

In addition, each of the Clinical Divisions also monitors the quality of care it provides, achievement of its local and national targets and progress with its actions relating to the CQC inspections at their own Divisional meetings.

Board Assurance Committees seek evidence as to performance and compliance in order that they are able to provide assurance to the Board of Directors that quality objectives are being met. The Clinical Governance Committee is the highest level operational committee responsible for monitoring all aspects of the quality of healthcare the Trust provides.

The Clinical Governance Committee, chaired by the Medical Director and supported by the Chief Nurse, has a key role in overseeing the operational delivery of high quality healthcare through the work of a number of sub-groups including those relating to patient experience, patient safety and clinical effectiveness. During 2019/20 the role and functions of these groups and their interface with the governance arrangements in the Clinical Divisions has been the subject of a further external review and the changes recommended by this review are being implemented.

[14] Root cause analysis (RCA)

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

In 2019/20 the Trust was contractually required to deliver the national Commissioning for Quality and Innovation (CQUIN) indicators. The indicators are identified nationally as areas requiring focused work to be undertaken throughout the year with the aim of delivering improvements in performance by year-end.

The indicators and position for the year to date as at quarter 3 against each scheme are detailed below:

CQUIN Indicator Description	Range of Performance (as per CQUIN guidance)		Year-to-Date 2019/20 Position (as at December 2019)
	Minimum	Maximum	
Anti-Microbial Resistance – lower urinary tract infections in older people	60%	90%	Partially achieved: 74%
Anti-Microbial Resistance– antibiotic prophylaxis in colorectal surgery	60%	90%	Partially achieved: 61%
Staff flu vaccinations[15]	60%	80%	80% target achieved at Q3
Alcohol and Tobacco – Screening	40%	80%	Achieved: 99%
Alcohol and tobacco – Tobacco brief advice	50%	90%	Achieved: 100%
Alcohol and tobacco – Alcohol brief advice	50%	90%	Achieved: 92%
Three high impact actions to prevent falls	25%	80%	Not achieved: 18%
Same Day Emergency Care – Pulmonary embolus	50%	75%	Achieved: 88%
Same Day Emergency Care – tachycardia with atrial fibrillation	50%	75%	Achieved: 78%
Same Day Emergency Care – Community acquired pneumonia	50%	75%	Achieved: 99%

Due to the response to COVID-19 the Trust was not required to submit data on its performance for quarter 4.

The Trust also sustained or improved performance in nationally defined quality indicators in the following areas during 2019/20:

- MRSA
- Compliance against 18 week wait targets
- Best Practice Hip Fracture
- Dementia assessments

In April 2019/20 the Chief Nurse and Medical Director launched 'Safe and Sound' framework to support delivery of the Quality Improvement Strategy and Quality Improvement Plan strategy.

It is a new approach developed to allow key initiatives to be delivered and is based on the principles of patient safety, clinical effectiveness and patient experience. It puts quality at the heart of everything we do and states that each and every one of our colleagues has a part to play in continuously improving the quality of care we provide.

It will help us create a culture where each colleague takes responsibility for improving patient care and making the patient's experience as good as it can be.

There are a number of work streams where colleagues have been encouraged to participate to inform change, continuous improvement and the way we do things in future. These work streams are:

- Deteriorating Patient & Mortality
- Engagement and Inclusion
- Information and Innovation
- Governance, Risk and Safety
- Record keeping and Communication
- Workforce, Training and Competence
- Medicines Management

Work has continued throughout the year to promote and embed the 'Safe and Sound' culture.

[15] Final performance not available due to suspending CQUIN reporting linked to COVID-19

Any new or significantly revised services

The Trust provided a full range of acute and community services during 2019/20. During the year the organisation continued to build upon its transformation work programme aimed at reviewing clinical pathways in a number of areas across both acute and community services.

In 2019/20 we:

- Reconfigured the community bed base capacity to support transfer of medically fit patients from hospital to a more appropriate environment for ongoing care
- Reviewed the Respiratory pathway to provide a more community based delivery model aimed at supporting people to manage their condition at home and avoid urgent attendance and admissions
- Continued the ward reconfiguration and specialty/service co-location programme to provide a more effective flow of patients around the hospital
- Implemented the 'Home First' model to provide intervention, advice and guidance to patients to support condition management in their own home
- Introduced Electronic Prescribing across acute hospital wards

During 2019/20 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.

Following a procurement process led by NHS England, the Urgent Dental Access and Out of Hours service covering the Rotherham, Barnsley and Doncaster populations was awarded to an alternative provider and the Trust ceased to deliver this service as of 01 April 2019.

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 inspection and recommendations.

Improvements in Patient / Carer Information

The Trust's Communications Team works closely with both clinical and non-clinical teams to update information for patients and visitors and every effort is made to ensure that the information on the Trust's website is in plain English, concise and well presented to make access to information as easy as possible.

In line with Trust-wide Informatics and Communications strategies, work is progressing with the Trust's website and the Communications Team is also looking at other media through which to communicate information. This work includes providing more hyperlinks through our website to sites such as NHS Choices and speciality-specific expert and support groups and charities. It also includes improving the range of information available and moving away from predominantly paper-based leaflets that can quickly become out of date and may also not be read and appreciated in this format by all service users.

A significant amount of patient health information is also produced through third-party organisations and, where appropriate, the Trust is seeking to utilise these resources to ensure the accuracy of information and minimise the reproduction and review costs associated with the development of in-house patient health information.

Where patient information needs to be produced locally, the Patient Experience Group has been responsible for the review of this from all areas of the Trust during the past year. A new role of Trust lead for Patient and Public Involvement and Engagement was developed in 2019, with the post holder commencing early in 2020. This role will lead the continued development of effective and creative user engagement and involvement and seek to better understand how our current information materials are used; whether they are effective and valued and how patients, families and carers want to receive this information from the Trust. A Patient Information Group is being re-established to support this activity and to provide a central co-ordination point.

The Trust's Communications and Graphic Design Teams work collaboratively with services to create, design and display their key health messages in an accessible and engaging way. This includes supporting the best use of technologies and social media by services, particularly those working with younger patients who appreciate Trust information and service updates to be provided via social media platforms such as Instagram, YouTube, and Facebook etc.

Information on Complaints Handling

The Trust recognises the importance of managing any concerns or complaints raised by patients or families on a patient's behalf, in a timely and effective manner.

During the year, focus continued on encouraging more face-to-face meetings between patients with concerns and staff, this has resulted in 27% of complaints received during 2019/20 being addressed through a Local Resolution meeting.

In addition, for those patients who would rather receive a written response, work remains ongoing to ensure that they receive that response within the agreed timeframe of 30 working days. This work has resulted in the Trust's overall performance being 69% of complaints answered within the agreed timescale.

We are clear that a focus on quality is as important as a focus on performance and handling complaints in the right way is crucial to embedding a culture of continuous improvement. We also appreciate that any missed target reflects poorly on the Trust and potentially exacerbates a complainant's feelings of upset and frustration, and we are working hard to improve the response rate in this regard.

We must ensure that we are not only providing timely responses but also responding in the right way so that complainants are confident that their issues have been handled professionally and sympathetically. To that end the appointment of an Assistant Chief Nurse for Patient Experience has been established with responsibility for monitoring the patient's experience during the complaints process and ensuring lessons have been learned.

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 outcome 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 of the Rotherham Place described above but working across a larger population base 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 2019/20 we have been engaging with the six Primary Care Networks, 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 to deliver Ear Nose and Throat (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 operating model is funded by Clinical Commissioning Groups with activity detailed in agreed respective contracts and charges are made between the two providers to reflect the costs of actual service provision.

The model was introduced to separate the inpatient and daycase activity for ENT and Oral Maxillofacial services, thereby providing sufficient capacity at each site to manage patients in a timely and efficient manner. The current model also supports consultant on-call arrangements across the two sites.

In addition to these services, we have also worked collaboratively with Doncaster and Barnsley Hospital NHS Foundation Trust during 2019/20 to provide an out-of-hours gastrointestinal bleed rota. This has been developed to support consultant on-call arrangements and ensure patients have timely access to specialists dealing with this condition.

Throughout 2019/20 we have been seeking to agree a joint working arrangement with Barnsley NHS Foundation Trust in Gastroenterology. The intention of this is to improve resilience within the service and increase capacity for patients to access appointments, as well as supporting consultant on-call arrangements. This work is still in progress with no final agreements reached as at year-end.

During 2019/20 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 in relation to neurology, vascular, cardiology and chemotherapy services. These provide significant benefits to patients as clinics are provided at Rotherham Hospital allowing them local access to these services which would otherwise result in patients having to travel to Sheffield. Activity is funded through contract agreements with Sheffield Teaching Hospital, with agreed recharges for provision of services to Rotherham.

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 the delivery of the Trust's 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 for patients 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 GDPR[16])
- 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 mentioned above, during 2019/20 we have worked more closely with Connect Healthcare, a Federation of General Practitioners in Rotherham which has been created to identify how GPs can work more collaboratively to meet the needs of the local population. The model of 'Physio 1st' has proved successful and is well embedded. We continue to review other options for collaborative working, along with the Primary Care Networks to establish other potential areas which will benefit patients.

[16] General Data Protection Regulation

This multi-disciplinary and 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 an improved patient experience.

The overall aim of the Trust is to provide the right service, delivered 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.

Consultation with local groups and organisations

In February 2020, the Quality Priorities showcase for colleagues, patients, public and stakeholders took place. This allowed the Quality Priorities for the Trust to be shared with those present to make suggestions for how the improvements could be made.

The Trust has strong links with the local authority, and representatives from the Trust often attend meetings of the local Health Select Commission in order to provide an overview on arising health care matters.

Public and patient involvement activities

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 Involvement and Engagement, 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. The examples below were undertaken during 2019 with Rotherham Clinical Commissioning Group:

- A proposed new model of care for Breathing Space
- The proposed move of Ophthalmology outpatients

The Trust has engaged in a range of activities with service users and the public during 2019/20. This has included the recognition of a number of days of national focus on key health conditions which take place every year and during 2019/20 included: Parkinson's Disease and dementia, deafness and blindness awareness, mental health, carers' rights, organ donation, stroke awareness, learning disabilities and autism, HIV and AIDs and nutrition and hydration.

As a Foundation Trust, we held an **Annual Members' Meeting** in September 2019 for the public to come and hear about key developments. At the meeting the Trust's Board of Directors presented the Trust's Annual Report and Accounts alongside the operational plan, future plans and priorities. Similarly, our monthly Board meetings and papers were fully open and accessible to the public throughout 2019/20 as in previous years.

The Trust's Communications Team compiles a tabloid publication – **Your Health** – on a quarterly basis, containing feature-style stories, information and graphics on topical health issues. The supplement is published as an insert into the weekly Rotherham Advertiser newspaper, with extra copies distributed at key information points, such as reception areas, at all Trust sites.

The Trust held an **Open Day** on Saturday 30 November 2019 with a wide invitation to the people of Rotherham to come and meet the staff teams, see the Trust 'at work' and hear about NHS careers through games, activities, interactive stands and displays. This was a great success and it is intended to build upon this engagement with similar events next year.

The Trust's **Research Team** participated in a series of events throughout the year to promote the research that takes place within the Trust and to explain to patients how they can get involved.

One of these events was World Chronic Obstructive Pulmonary Disease (COPD) Day in December 2019; this was to promote the work that the Research Team have been undertaking to increase the capacity for clinical research at Breathing Space. The Rotherham NHS Foundation Trust has ensured that patients and members of the public were able to take part in research awareness and activities across the Trust, by increasing the team's presence in outpatient clinics and ward environments during 2019/20. This has proved to be a very productive approach, with our total number of patients recruited into research to date being 772 participants against a network target of 550.

The Trust's **Safe and Sound** patient assurance and wellbeing strategy was launched in April 2019. This is a model which makes a single but all-encompassing commitment to each patient, asking them 'Do you feel Safe and Sound?' This approach is underpinned by offering an easily accessible route for any patient, family member or carer who has concerns, to raise these and escalate them if necessary, aiming to achieve early and full resolution whilst the patient is still receiving care from of our services.

In November 2019 new posters describing this Safe and Sound process, were placed at the bedhead of each Trust inpatient to ensure that they knew how to access this assistance. This includes the commitment to all that if local resolution is not achieved, then the support and input of a senior nurse in the Trust can be requested via a dedicated phone line and a visit to the patient will occur within one hour of the call.

Some examples of the many patient engagement activities undertaken during the year are shown below:

World Aids Day was on 1 December 2019, when the colleagues in the Integrated Sexual Health Service provided information displays and advice on a range of sexual health topics to members of the public and staff via their stand.

The Rotherham Maternity Voices Partnership forum was instituted in response to the national 'Better Births' strategy, to provide a voice for service users to give their views and be involved in service development, patient information and patient education. The group continues to meet bi-monthly and also to engage with a range of maternity initiatives from progressing key health messages through its communication channels, gathering women's feedback on new proposals and their experiences of the service, and since September 2019 has been very supportive of the Maternity and Family Health Showcase work.

The monthly **Maternity and Family Health Showcase** launched on 4 September 2019. This is a regular, open house event bringing together acute and community health colleagues in maternity care and children and young people's services, colleagues in public health, commissioning and third sector groups to offer information, education and support to parents-to-be, new parents and their extended families.

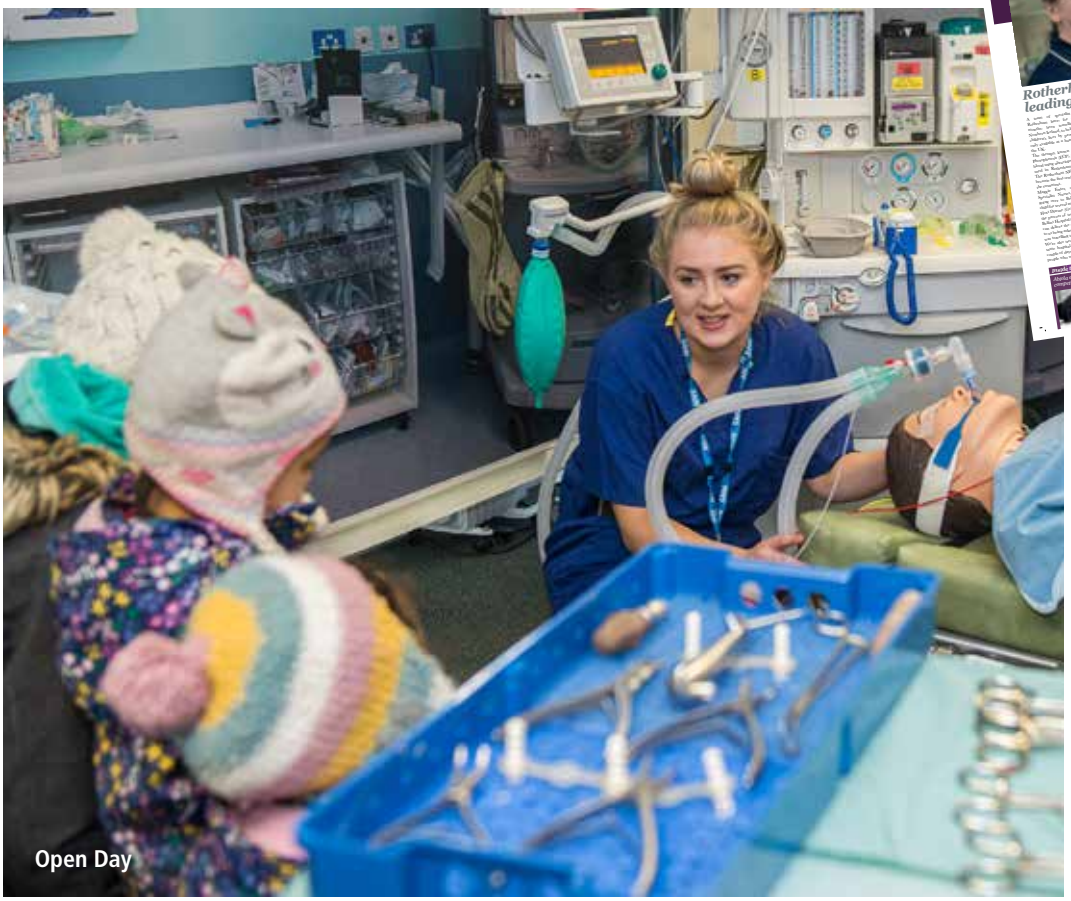
Child Development Service Review. The Trust's work with the local Parent Carer Forum has continued and their views have been captured and progressed within the revised service specification for the Child Development Service.

World Osteoporosis Day. The Bone Health, Falls and Fracture Liaison Service celebrated World Osteoporosis Day in October 2019, in conjunction with the National Osteoporosis Society, with displays and information leaflets for patients, the public and colleagues.

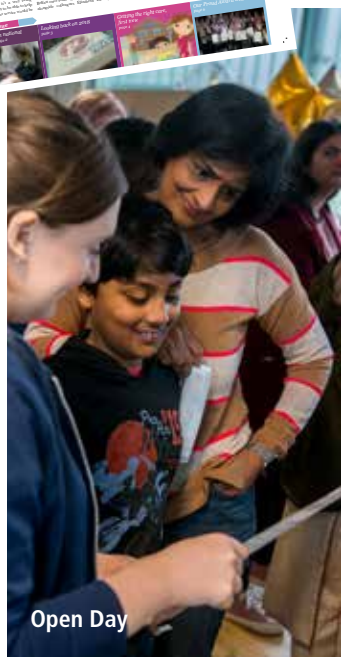
Ophthalmology. The Ophthalmology Service continues to run its bi-annual open days, where past and present patients are invited to discuss the care they receive with nurses, consultants, support colleagues, volunteers and other patient representatives.


World Osteoporosis Day


Maternity and Family Health Showcase



Open Day



Open Day

Open Day

Remuneration Report

Annual Statement on Remuneration from the Chair of the Remuneration Committee (not subject to audit)

I am pleased to present the Remuneration Report for the financial year 2019/20 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, 2019/20

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.

Colleagues subject to Agenda for Change, 2019/20

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.

From 1 April 2018, Agenda for Change pay (increment) points began to be removed from pay bands, removing the bottom overlap point, and increasing top pay points in bands 2 – 8c by 3%.

From 1 April 2019, further restructuring of the pay bands took place; two further points removed from the bottom of band 3, one point removed from the bottom of band 4, two points removed from bottom of band 5, three points removed from the bottom of bands 6 and 7, and one point removed from the bottom of bands 8a – 9.

The top pay point in bands 2 – 8c was increased by 1.7%, with the top pay points in bands 8d and 9 being increased by the monetary value of the increase to band 8c.

Those at the top point of their pay bands on 31 March 2019 received a one-off non-consolidated cash lump sum in their April 2019 pay, amounting to 1.1% of the value of the top payment point in their pay band for colleagues on bands 2 – 8c, and the same monetary value as that given to band 8c, for colleagues on bands 8d and 9.

Further restructuring of the pay bands took place from 1 April 2020 which marked the start of the final year of the three year pay deal.

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 to these staff members 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.

During 2019/20 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 2019/20, the Remuneration Committee did not approve any pay increases during 2019/20 financial year.

As part of a retrospective review relating to the Director of Finance, it was agreed that his salary be increased by £6,900 p.a. backdated to 1 April 2018, bringing his salary up to £128,100 at that point.

Following national guidance recommending that a flat rate uplift of £2,075 p.a., backdated to 1 April 2018 be paid (commensurate with the cash value of the 2018/19 award applied to agenda for change staff at the top of pay bands 8c, 8d and 9), the Committee agreed backdated salary increases for those Executive Directors who were in post on 1 April 2018 and continued in post, i.e. Director of Finance, Chief Operating Officer (ditto), and Chief Executive, be paid.

The second phased review of the Director of Finance's salary was undertaken and it was agreed that this be increased to £135,000 p.a., backdated to 1 April 2019, thus taking the salary up to the benchmarked median for the role.

A £1,354 p.a. cost of living increase was agreed for those substantive Executive Directors in post as at 31 March 2019, with the award being applied to the Medical Director's salary from 1 November 2019, the date at which he became substantive.

The remuneration for Non-Executive directors is determined by the Council of Governors, which did not recommend a pay award to the Non-Executive Directors for 2019/20.

Taking into account guidance published by NHS Improvement relating to Non-Executive Director remuneration, in January 2020 the Council of Governors approved the following:

- Non-Executive Directors: Single uniform rate of £13,000 p.a., with discretion to pay up to £2,000 per annum for up to two individuals in recognition of specific duties. If such duties were to cease, so would the £2,000 increment.

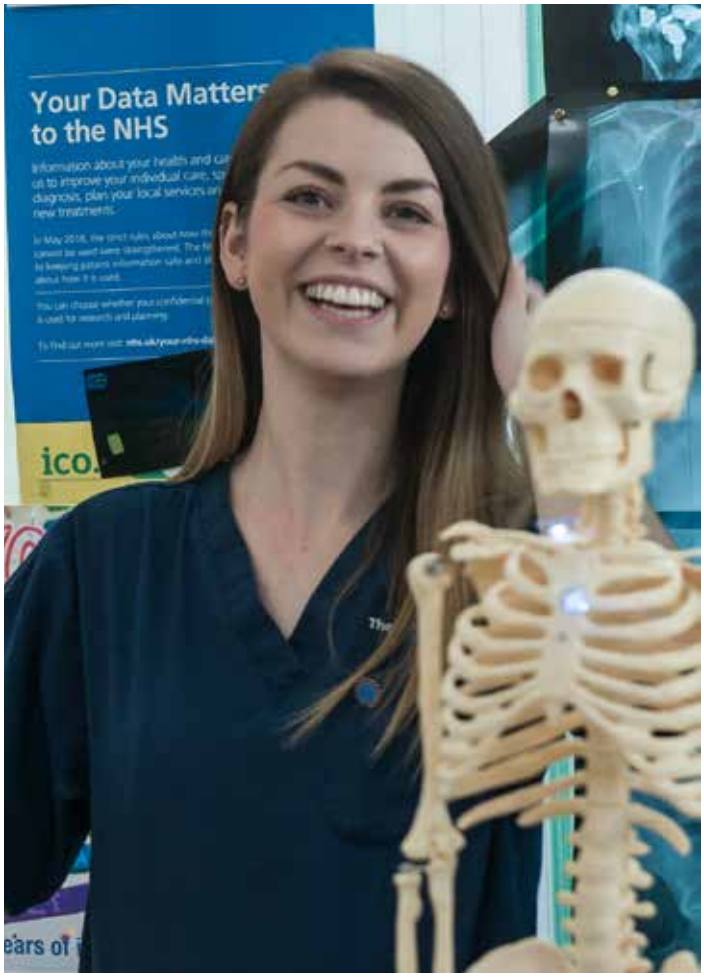
- Chairman: being in the upper quartile of group 2 (the Trust is challenged and the current incumbent is experienced) remuneration of £50,000 p.a. was appropriate.

- General principle that going forward any new Non-Executive Director would be advertised and appointed on the standard rate of £13,000 per annum. Additionally, all existing Non-Executive Directors would, by the end of December 2022, be remunerated at £13,000 per annum.

The Rotherham NHS Foundation Trust has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior managers and we will continue to do this going forward.

Signed:

Joe Barnes
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.

The aims of the updated 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.

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.
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 child care 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.

With the exception of the Chief Executive, the Executive Directors and dental colleagues, 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.

From 1 January 2018, the Treasury increased the threshold for senior pay controls in the NHS to £150,000 and above, against which, 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.

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.

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 2019/20 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, and the need for a transparent policy decided.

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 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 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.

Annual Report on Remuneration

Information not subject to audit

Service Contracts

With the exceptions of Richard Jenkins, Michael Wright, Chris Preston and Callum Gardner (up until 31 October 2019) all Executive Directors who served during the year did so on substantive contracts of employment with no end dates which included a notice period of six months.

With the exceptions listed below, all of the Executive Directors served for the entirety of the financial year 2019/20 (1 April 2019 to 31 March 2020).

Louise Barnett, Chief Executive, employed substantively by the Trust since 01 April 2014, left the Trust on 07 February 2020.
Dr Richard Jenkins became Interim Chief Executive from 10 February 2020.

Dr Callum Gardner served as Interim Medical Director from 03 September 2018 to 31 October 2019. He took up the substantive role as Medical Director on 01 November 2019.

Chris Holt, Deputy Chief Executive, employed by the Trust since 06 October 2014, left the Trust on 31 May 2019, however he stood down from his executive post as Deputy Chief Executive on 06 May 2019.

Chris Preston served as Interim Deputy Chief Executive from 07 May 2019 to 09 February 2020. Michael Wright took up the role of Interim Deputy Chief Executive from 10 February 2020.

Steve Ned took up his post as Joint Director of Workforce on 01 April 2019. (Mr Ned is Director of Workforce at both the Trust and Barnsley NHS Foundation Trust).

Executive Directors who were in post prior to 01 April 2019:

Simon Sheppard, employed by the Trust since 03 November 2014

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

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

None of the Trust's Executive Directors were released by the organisation to serve as a Non-Executive Director elsewhere. However, Mr Ned acts as a joint Director of Workforce at both the Trust and Barnsley Hospital NHS Foundation Trust. Dr Jenkins is Chief Executive at Barnsley Hospital NHS Foundation Trust and was also appointed Interim Chief Executive at the Trust in February 2020.

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 – 31.05.19
01.06.19 – 31.05.21

Barry Mellor
19.09.13 – 18.09.15
19.09.15 – 18.09.19

Joe Barnes
26.09.13 – 25.09.16
26.09.16 – 25.09.19
26.09.19 – 30.09.20

Lynn Hagger (Vice Chair)
01.10.13 – 30.09.16
01.10.16 – 30.09.19
01.10.19 – 30.09.20

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

Dr David Hannah
11.01.18 - 10.01.20
11.01.20 – 31.01.20

Michael Smith
01.04.19 – 31.03.20
01.04.20 – 31.03.22

Nicola Bancroft
01.10.19 - 30.09.22

Dr Rumit 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, Barry Mellor, followed by Joe Barnes (from October 2019), and was composed of four Non-Executive Directors. Its responsibilities are set out in its Terms of Reference, which were updated during the year.

Following this Terms of Reference revision, the Remuneration Committee continues to have delegated responsibility for determining the terms of remuneration for the Chief Executive and the Executive directors and also recommends and takes into account the structure and level of remuneration across the organisation as appropriate. Each member of the committee is considered to be independent and none has a personal financial interest in any of the Committee's decisions.

Other Trust employees attend the meeting as requested by the Chair where appropriate, including the Chief Executive, but none were party to decisions made by the Committee.

No services or advice was received by the Committee from third parties that may have materially assisted with their consideration of any matter.

The committee formally met five times during the financial year; membership and attendance details are shown in the table below.

Meeting date	Barry Mellor (Chair)[17]	Joe Barnes (Vice Chair then Chair)[18]	Heather Craven	Mike Smith	Nicola Bancroft[19]
08 May 2019	√	√	√	√	n/a
17 July 2019	√	√	√	√	n/a
14 Aug 2019	√	√	√	√	n/a
13 Nov 2019	n/a	√	√	X	n/a
02 Dec 2019	n/a	√	√	√	in attendance only
Attendance	3/3	5/5	5/5	4/5	0/0

Membership of the Remuneration Committee was updated on 1 April 2019. Barry Mellor continued to chair the Committee until the end of his term of office; Joe Barnes took over as Chair of the Committee from October 2019; Heather Craven continued as a member and Mike Smith became a member of the Committee. (Nicola Bancroft became a voting member of the Committee from 1 April 2020, and Heather Craven became Vice Chair from the same date)

[17]Barry Mellor left the Remuneration Committee at the end of his term of office as a Non-Executive Director on 30 September 2019.
[18]Joe Barnes became Chair of the Remuneration Committee from October 2019.
[19]Nicola Bancroft joined the Remuneration Committee from February 2020.

Not subject to audit

Disclosures required by the Health & Social Care Act 2012

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	
	2019/20	2018/19	**2019/20**	2018/19
Governors	**25**	26	**3**	2
Directors (including the Chair and Non-Executives)	**20**	18	**9**	9

Expenses shown in £00s	**2019/20**	**2018/19**
	£00	£00
Aggregate sum of expenses paid to Governors	**0**	1
Aggregate sum of expenses paid to Directors	71	106
Total	72*	108*

* figures subject to rounding up

Information subject to audit

The Single Figure Total Table (1) appearing overleaf provides details of each of the components of the remuneration package for Executive Directors, who are subject to the senior managers remuneration policy. A separate table (2) provides details for Non-Executive Directors, whose remuneration is set by the Council of Governors. Set out separately are details of the pension entitlements received by the Executive Directors.

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 Governnance. 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 Table B Pensions, for further details.

Single Total Figure Table	**Period 01/04/19 to 31/03/20**						**Period 01/04/18 to 31/03/19**					
	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)
Mrs L Barnett, Chief Executive (in office to 07/02/2020)	**155 - 160**	**0**	**0**	**0**	**50.0 - 52.5**	**205 - 210**	175 - 180	0	0	0	37.5 - 40.0	215 - 220
Dr R Jenkins, Interim Chief Executive (in office from 10/02/2020)	**15 - 20**	**0**	**0**	**0**	**92.5 - 95.0**	**105 - 110**						
Mr M Wright, Interim Deputy Chief Executive (in office from 10/02/2020)	**20 - 25**	**0**	**0**	**0**	**97.5 - 100.0**	**115 - 120**						
Mr S Ned, Joint Director of Workforce (in office from 01/04/2019)	**75 - 80**	**0**	**0**	**0**	**185 - 187.5**	**265 - 270**						
Mr C Preston, Interim Deputy Chief Executive (in office from 07/05/2019 to 09/02/2020)*	**115 - 120**	**0**	**0**	**0**	**40.0 - 42.5**	**160 - 165**						
Mr S. Sheppard, Director of Finance	**145 - 150**	**0**	**0**	**0**	**102.5 - 105**	**250 - 255**	120 - 125	0	0	0	7.5 - 10.0	125 - 130
Mr C Holt, Deputy Chief Executive (in office to 31/05/2019)	**20 - 25**	**0**	**0**	**0**	**40.0 - 42.5**	**65 - 70**	135 - 140	0	0	0	27.5 - 30.0	165 - 170
Dr C. Gardner, Interim Medical Director (in office to 31/10/2019), Medical Director (in office from 01/11/2019)	**180 - 185**	**0**	**0**	**0**	**60.0 - 62.5**	**240 - 245**	100 - 105	0	0	0	62.5 - 65.0	165 - 170
Mrs A Wood, Chief Nurse	**120 - 125**	**0**	**0**	**0**	**60.0 - 62.5**	**180 - 185**	60 - 65	0	0	0	97.5 - 100.0	155 - 160
Mr G. Briggs, Chief Operating Officer	**125 - 130**	**0**	**0**	**0**	**30.0 - 32.5**	**155 - 160**	125 - 130	0	0	0	285.0 - 287.5	410 - 415

*Whilst Chris Preston continued to work for the Trust from the 10 February to 08 March 2020, he stepped down as an Executive Director and continued as Director of Strategy and Transformation, a non-voting member of the Board of Directors.

Mrs Louise Barnett, Chief Executive, left the Trust on 7 February 2020.

Dr Richard Jenkins became Interim Chief Executive at the Trust from 10 February 2020 as a joint role with Barnsley Hospital NHS Foundation Trust.

Dr Callum Gardner took up the substantive role of Medical Director on 1 November 2019 (interim role from 3 September 2018 to 31 October 2019)

Chris Holt, Deputy Chief Executive, left the Trust on 31 May 2019, however he stood down from his executive post as Deputy Chief Executive on 6 May 2019.

Chris Preston served as Interim Deputy Chief Executive from 7 May 2019 to 9 February 2020.

Michael Wright took up the role of Interim Deputy Chief Executive from 10 February 2020.

Steve Ned took up his post as Joint Director of Workforce on 1 April 2019 (as joint role with Barnsley Hospital NHS Foundation Trust.)

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Single Figure Total 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 Governnance. 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 Table B Pensions, for further details.

Single Total Figure Table	Period 01/04/19 to 31/03/20						Period 01/04/18 to 31/03/19					
	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)	Salary And Fees (bands of £5000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance-Related Bonuses (bands of £5000)	Long-Term Performance-Related Bonuses (bands of £5000)	Pension-Related Benefits (bands of £2500)	Total (bands of £5000)
Mr M Havenhand, Chairman	50 - 55	0	0	0	0	50 - 55	50 - 55	0	0	0	0	50 - 55
Mrs N Bancroft, Non Executive Director (in office from 01/10/2019)	5 - 10	0	0	0	0	5 - 10						
Mr M Edgell, Non-Executive Director	15 - 20	0	0	0	0	15 - 20	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
Mrs L Hagger, Non-Executive Director & Vice Chair	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Mr B Mellor, Non-Executive Director (in office to 30/09/2019)	5 - 10	0	0	0	0	5 - 10	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 Rumit Shah, Non-Executive Director (in office from 01/01/2020)	0 - 5	0	0	0	0	0 - 5						
Mr Mike Smith, Non-Executive Director (in office from 01/04/2019)	15 - 20	0	0	0	0	15 - 20						
Dr D Hannah, Non-Executive Director (in office to 31/01/2020)	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20

The Non-Executive Director remuneration framework, agreed by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration during 2019/20 has been consistent with this framework. No additional payments are made for any additional duties carried out.

The Non-Executive Directors took no pay rise during 2019/20

Non-Executive Directors, including the Trust Chairman, are subject to fixed term appointments.

Pension Entitlements of Executive Directors

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

Name and title	Real increase during the reporting year in pension at pension age (bands of £2,500) £000	Real increase during the reporting year in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at 31 March 2020* (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real increase in Cash Equivalent Transfer Value (for period in post) £000	Employer's contribution to stakeholder pension £000
Mrs L Barnett, Chief Executive (in office to 07/02/2020)	2.5 - 5.0	0.0 - 2.5	45.0 - 50.0	85.0 - 90.0	699	777	30	NA
Dr R Jenkins, Interim Chief Executive (in office from 10/02/2020)	0.0 - 2.5	0.0 - 2.5	75.0 - 80.0	160.0 - 165.0	1,326	1,454	11	NA
Mr M Wright, Interim Deputy Chief Executive (in office from 10/02/2020)	0.0 - 2.5	0.0 - 2.5	25.0 - 30.0	0.0 - 5.0	327	366	1	NA
Mr S Ned, Joint Director of Workforce (in office from 01/04/2019)	7.5 - 10.0	17.5 - 20.0	55.0 - 60.0	140.0 - 145.0	962	1,179	183	NA
Mr C Preston, Interim Deputy Chief Executive (in office from 07/05/2019 to 09/02/2020)*	0.0 - 2.5	0.0 - 2.5	10.0 - 15.0	0.0 - 5.0	145	190	14	NA
Mr S. Sheppard, Director of Finance	5.0 - 7.5	7.5 - 10.0	45.0 - 50.0	105.0 - 110.0	678	799	84	NA
Mr C Holt, Deputy Chief Executive (in office to 31/05/2019)	0.0 - 2.5	0.0 - 2.5	20.0 - 25.0	0.0 - 5.0	214	250	2	NA
Dr C. Gardner, Interim Medical Director (in office to 31/10/2019), Medical Director (in office from 01/11/2019)	2.5 - 5.0	0.0 - 2.5	15.0 - 20.0	0.0 - 5.0	119	171	24	NA
Mrs A Wood, Chief Nurse	2.5 - 5.0	2.5 - 5.0	20.0 - 25.0	35.0 - 40.0	294	367	48	NA
Mr G. Briggs, Chief Operating Officer	0.0 - 2.5	5.0 - 7.5	45.0 - 50.0	140.0 - 145.0	1,014	1,113	57	NA

* 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 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.

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 8 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.

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 2020) on an annualised basis.

The banded mid-point remuneration of the highest paid director in the financial year 2019/20 was £232,500 (2018/19, £177,500). This was 8.5 times (2018/19, 7.13) the median remuneration of the workforce (including directly engaged and agency staff) which was £27,260 (2018/19 £24,915)

	2019/20	2018/19
Mid-Point of £5k Band of Highest Paid Director's Total (Remuneration £000)	**232.5**	177.5
Median Total Remuneration (000s) (includes Direct Engagement and Agency)	**27.3**	24.9
Ratio of Median Remuneration to Midpoint of the Highest Paid Director's Band	**8.52**	7.13

Of the employees in post at 31 March 2020, zero members of the organisation's total workforce (including agency and directly engaged staff) received remuneration in excess of the highest-paid director.

This compares to 30 reported in 2018/19, including directly engaged and agency staff. This reduction in the number of staff receiving remuneration in excess of the highest-paid director is due to a change in the highest paid director, and the highest paid director's salary. It is also due to continued efforts to transfer from agency staff to directly engaged or payrolled staff which means that the highest paid salaries are reducing. In 2019/20 the salaries ranged from £7,626 to £222,726, excluding the highest paid director. (2018/19 £7,235 to £307,747).

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.

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 2019/209, whether or not they were substantively appointed.

Senior Managers with Additional Duties

There were no payments made during 2019/20 to Senior Managers with additional duties.[20]

Payments for Loss of Office

There were no payments made during 2019/20 to Senior Managers for loss of office.

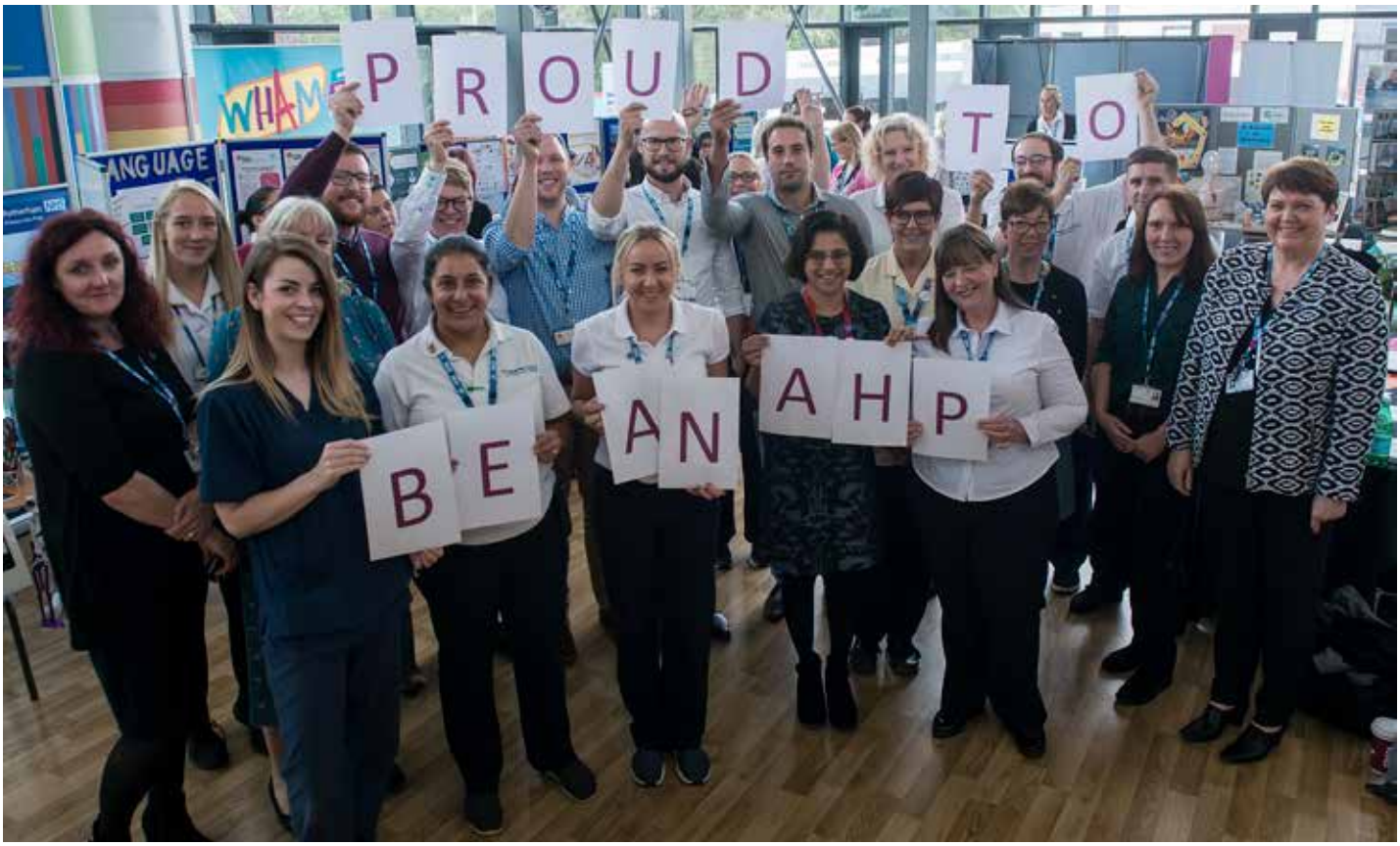
Payments to Past Senior Managers

One payment in lieu of annual leave and in lieu of notice was made during 2019/20 to a past Senior Manager which related to a period in office during 2018/19.

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

R. Jenkins

Dr Richard Jenkins
Interim Chief Executive
02 June 2020



[20] FReM refers to "medical directors and similar staff", and does not include 'deputy CEO' type roles

Staff Report

Analysis of Staff Costs

Staff Costs	2019/20			2018/19		
	Permanent	Other*	Total	Permanent	Other*	Total
	£000	£000	£000	£000	£000	£000
Salaries & wages**	145,031	5,601	150,632	139,880	5,261	145,141
Social security costs	14,651	-	14,651	14,045	-	14,045
Apprenticeship levy	718	-	718	686	-	686
Employer's contributions to NHS pensions***	25,091	-	25,091	16,739	-	16,739
Pension cost - other	83	-	83	46	-	46
Termination benefits	-	-	-	58	-	58
Temporary Staff - External Bank****	-	3,124	3,124	-	-	-
Temporary staff - agency/contract**	-	6,706	6,706	-	9,076	9,076
TOTAL GROSS STAFF COSTS	**185,574**	**15,431**	**201,005**	**171,454**	**14,337**	**185,791**
Of which: Costs capitalised as part of assets	319	205	524	143	89	232

*'Other' staff includes secondments in, and trainee medial staff employed by the local lead unit, but training within The Rotherham NHS FT on rotation.
** The Salaries, Social Security, Apprenticeship levy, Employers contributions and other Pension costs associated with staff employed via a Secondary Contracted Payroll are included in those lines, and not classed as Agency staff as these staff have zero hours permanent contracts direct with the Trust.
*** Employers pension contributions increased by 6.3% in 2019/20.
**** In 2019/20 the Internal Bank arrangements transferred to an External Bank arrangements with NHS Professionals.

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

	2019/20			2018/19		
	Permanent No.	Other* No.	Total No.	Permanent No.	Other* No.	Total No.
Medical and dental	424	86	509	379	103	481
Administration and estates	1,056	11	1,067	1,049	8	1,057
Healthcare assistants and other support staff	858	-	858	845	-	845
Nursing, midwifery and health visiting staff	1,170	48	1,219	1,164	40	1,204
Scientific, therapeutic and technical staff	429	8	437	419	5	424
Social care staff	101	4	105	92	2	94
	4,038	157	4,195	3,947	158	4,105
Of which: Number of employees engaged on Capital projects	7	5	12	3	3	6

*'Other' staff includes secondments in, and trainee medial 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 2020 the breakdown of Trust employed staff by gender was as follows:

	Male	Female	Total
Executive Directors	6	1	7
Non-Executive Directors	5	3	8
Employees	919	3946	4865
Total	930	3950	4880

Analysis of Staff: Ethnicity of Staff

As at end March 2020 the breakdown of Trust employed staff by ethnicity was as follows:

Ethnic Origin	Headcount	% of Workforce
White - British	4198	86.02%
White - Irish	23	0.47%
White - Any other White background	63	1.29%
White English	10	0.20%
White Scottish	3	0.06%
White Welsh	1	0.02%
White Polish	1	0.02%
White ex-USSR	1	0.02%
White Croatian	3	0.06%
White Mixed	2	0.04%
White Other European	19	0.39%
Mixed - White & Black Caribbean	11	0.23%
Mixed - White & Black African	8	0.16%
Mixed - White & Asian	22	0.45%
Mixed - Any other mixed background	9	0.18%
Mixed - Black & White	1	0.02%
Mixed - Chinese & White	2	0.04%
Asian or Asian British - Indian	113	2.32%
Asian or Asian British - Pakistani	99	2.03%
Asian or Asian British - Bangladeshi	7	0.14%
Asian or Asian British - Any other Asian background	36	0.74%
Asian Tamil	1	0.02%
Asian British	1	0.02%
Black or Black British - Caribbean	8	0.16%
Black or Black British - African	54	1.11%
Black or Black British - Any other Black background	6	0.12%
Black Nigerian	2	0.04%
Black British	1	0.02%
Chinese	8	0.16%
Any Other Ethnic Group	38	0.78%
Filipino	1	0.02%
Other Specified	4	0.08%
Not Stated	124	2.54%
Grand Total	**4880**	**100.00%**

Sickness Absence Data

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

Staff policies and actions applied during the financial year

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

Work has continued during 2019/20 to encourage employees to disclose disabilities, as disclosure rates in this area are historically low. These rates have now started to increase. The Trust has engaged with a number of disabled colleagues in carrying out a comprehensive review of its Managing Attendance Policy and improving the support provisions within that policy. The Trust has supported the establishment of a Disability Staff Network.

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

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

Throughout 2019/20, the Trust's Diversity and Inclusion Group has met regularly to review and drive progress against the Trust's Equality, Diversity and Inclusion action plan and has provided regular updates to the Board of Directors 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 colleagues.

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.

Trust managers, with the help from the Occupational Health service provider and Human Resources, regularly make workplace modifications for colleagues which 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. In 2019/20 the Trust launched a Disability Passport Scheme to further support the implementation of 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 payslip messages and attachments. There is also a direct communication facility that is also available to enable colleagues to ask questions of the 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 Team Brief 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 subgroup 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) and Shared Parental Leave.

This year the Trust received external recognition for the changes it has made to its adoption leave policy enabling and making it easier for colleagues to access support at what can be a very difficult and stressful time. The Trust, working in partnership with our trade union colleagues, signed up to the Dying at Work charter, a Trust wide commitment which helps and supports colleagues to remain at work.

The Trust recognises 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 demonstrated when specific events were arranged to support Innovation Week, Values Week and PROUD Week culminating in an awards ceremony for colleagues held on 15 November 2019.

Health & Safety and Occupational Health

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 2019/20. Only organisations able to maintain continued high standards in health and safety achieve the gold award.

The Occupational Health service is located discreetly behind the main Woodside building, offering professional specialist nurse, counselling and proactive occupational health services. As part of the occupational health provision the Trust can access the Employee Assistance Programme (EAP), which provides confidential support by qualified counsellors 24 hours a day to colleagues.

The occupational health service continued to deliver high quality interventions to employees, supporting a healthier, fitter workforce and supporting the Trust's objective to reduce sickness absence.

Countering fraud, bribery and corruption

The Trust's 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 2019/20 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 April 2019 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 which 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 undertaken within the above areas of focus.

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

- Cyber-crime
- Staff secondary working
- Bank and Agency Staff
- Mandate Fraud
- Declarations of interests
- Overseas Visitors

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 2019/20, five 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.

Trade Union Facility Time Disclosures

Communicating and consulting with our employees in partnership with our trade unions and professional bodies is core to our service delivery. 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.

We have had our Trade Union Recognition and Facilities Agreement in place for several years (which is our system for agreeing access to paid time and development for our union colleagues) to enable them to give the best possible support to their members and 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.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 require the Trust to disclose a number of pieces of information relating to the work of Trust employees who are Trade Union representatives. However, during the disclosure period the exact details were not kept due to a changeover in process during the year. Consequently, the Trust has taken the decision to disclose the figures relating to 2017/18 (disclosed in the 2018/19 Annual Report) plus 10% rather than provide an inaccurate figure. This approach has been agreed with the Trust's staff side representatives.

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
25 (equated to 22.05 WTE)	Between 1501 and 5000

Table 2: Percentage of time spent on facility time

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

Percentage of time	Number of employees
0%	
1-50%	25
51%-99%	
100%	

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.

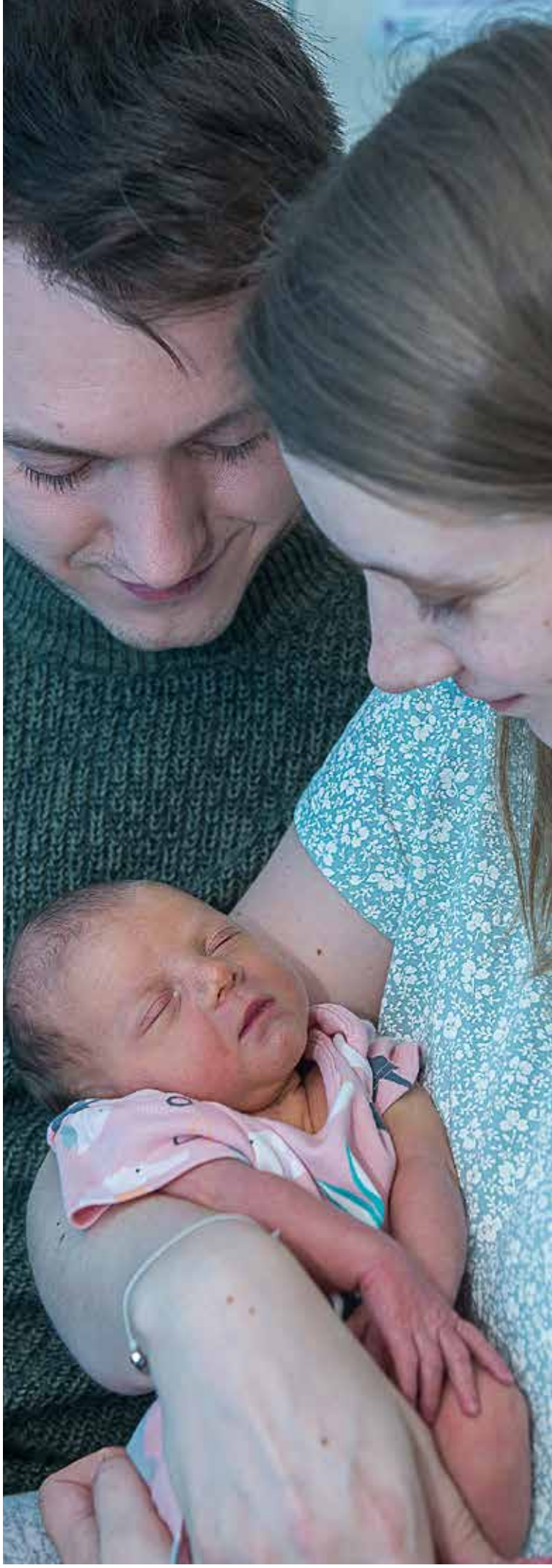
First Column	Figures
Provide the total cost of facility time	£74,000
Provide the total pay bill	£185,574,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.04%

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	0.7%

(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 2019/20 were £208,000, representing a reduction from £827,000 spent during 2018/19 which related to one-off pieces of work which were not repeated. The consultancy work undertaken during 2019/20 was across various functions of the organisation.

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 for exceptional operational reasons.

The standard process during 2019/20 was to seek assurance for all off-payroll workers that they were compliant with IR35 and that all relevant taxes were being paid.

Table 1: For all off-payroll engagements as of 31st March 2020, for more than £245 per day and that last for longer than six months.	
Number of existing engagements as of 31 March 2020	3
Of which;	
Number that have existed for less than one year at time of reporting.	3
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: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months.	
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	3
Of which;	
Number assessed as within the scope of IR35	2
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.	
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.*	10

* There are 7 Board member posts. In year there have been two Chief Executives and three Deputy Chief Executives.

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 table 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 table are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Exit package cost band	Number of compulsory redundancies		Number of other non-compulsory departures agreed		Total number of exit packages by cost band	
	2019/20	2018/19	**2019/20**	2018/19	**2019/20**	2018/19
£50,001 - £100,000	**0**	1	**0**	0	**0**	1
Total number of exit packages by type	**0**	1	**0**	0	**0**	1
Total resource cost £000s	**0**	58	**0**	0	**0**	58

Analysis of non-compulsory departure payments

In 2019/20 there were no non-compulsory departures, and therefore zero payments made (2018/19 £0). This note reflects packages agreed in year, irrespective of the actual date of accrual or payment.

This note excludes payments in lieu of notice (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. In late 2019 our Chief Executive along with senior colleagues held a number of listening sessions with teams across the organisation. These events gave us the opportunity as an organisation to further shape our organisational priorities which were outlined in our overarching Trust 5-year plan.

As a Trust we have taken some really positive steps but we recognise that there is more work to do to achieve our strategic ambition of being in the top 20% of NHS employers for staff engagement.

We recognise that improving colleague engagement is a challenge in the current climate. Therefore, we have sought to embed the approaches we deployed with the acknowledgement that they take time to be felt across the organisation. That said we have seen a steady improvement in our staff survey results both from a completion rate and from our individual improvement journey, albeit our results have not moved us into a more favourable position nationally.

Last year we committed to build an organisation development strategy (OD), revise the engagement and wellbeing strategy and revise and remodel our communication strategy.

The inception of the national Interim People Plan provided us with a framework to incorporate our Trust-wide approach. As a result, we have combined Engagement, OD and wellbeing strategies into a People Strategy. This document clearly sets out where we are as a Trust and our key priorities for the next 3 years and is designed around four themes: Build, Engage, Lead and Learn.

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

We continue 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 the organisation it is.

We have a number of initiatives that recognise and reward our colleagues for the work they do in delivering high quality care. This year we celebrated key achievements and unsung heroes during our Proud Week, recognition of long service awards and recognition of learning events culminating in our prestigious award ceremony. These awards were attended by both colleagues and other stakeholders that we are in partnership with.

We continued to deploy our 'Together We Can' engagement methodology and this has become evident throughout the year as it has been used to inform local improvements in service provision, corporate response to the national 'flu campaign and development of wellbeing initiatives.

The Trust performed well in the annual 'flu campaign. The influenza vaccination was offered to all colleagues and the Trust achieved 80% vaccination rates for frontline workers.

The Trust has continued to develop and drive improvements across the organisation in line with the standards set out in 'Thriving at Work' for example: mental health promotion, complementary therapies, 5 Ways to Wellbeing etc.

National Staff Survey

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

The response rate to the 2019 survey amongst Trust colleagues was 48% (2018: 38%). Scores for each indicator together with that of the survey benchmarking group (combined acute and community trusts) are presented below.

	2019/20		2018/19		2017/18	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.2	9.2	9.2	9.2	9.2	9.2
Health and wellbeing	5.8	6.0	5.8	5.9	5.9	6.0
Immediate managers	6.8	6.9	6.7	6.8	6.6	6.8
Morale	6.0	6.2	5.8	6.2	N/A	N/A
Quality of appraisals	5.2	5.5	4.9	5.4	4.9	5.3
Quality of care	7.2	7.5	7.2	7.4	7.1	7.5
Safe environment – bullying and harassment	8.2	8.2	8.2	8.1	8.3	8.1
Safe environment – violence	9.5	9.5	9.5	9.5	9.5	9.5
Safety culture	6.6	6.8	6.5	6.7	6.3	6.7
Staff engagement	6.7	7.1	6.6	7.0	6.5	7.0
Team Working*	6.5	6.7	N/A	N/A	N/A	N/A

*New category in 2019 survey.

The Trust has shown a slight improvement in 5 out of 10 themes. This year's results show that in comparison with our peers 3 of the 10 are equal to our peer group and 7 are less favourable notably the greatest downturn being staff engagement (0.4 points). The new category this year, team working, was a little below our peer value. The most improved theme (0.2 points) in the 2019 survey was staff morale.

Future priorities and targets

Statement of key priority areas

The Trust has prioritised colleague engagement as a key priority area of focus throughout 2020. This includes divisional actions in relation to local staff results and development of a corporate action plan.

The Trust will revisit the reward and recognition approach, inception and embedding of the new Trust People Plan and continue to work on delivery of the equality, diversity and inclusion agenda. Work is already in progress to examine and support the quality of colleague appraisal and talent management. The Trust will continue in its ambition to provide a supportive psychological wellbeing agenda for colleagues to complement the wellness agenda.

All activities will be aligned to the Operational Plan and 5-year Trust strategy.

Performance against priority areas

The Board of Directors will agree key milestones and delivery targets for the organisation; however, in order to ensure we have adequate capacity within the organisation to succeed given the challenges we will face with COVID-19, it is important to focus on a few core objectives in the short-term. Delivery of the below four objectives will move us forward as an organisation and ensure we make our patients, colleagues and the wider public proud to have the Trust as their local healthcare provider

Monitoring arrangements

Workforce related performance and people objectives will be monitored through the committee 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, colleague friends and family test and other key Trust metrics. These will be managed through a monthly divisional performance meeting and dashboards providing assurance to the 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 assurance to the People Committee.

Future Priorities and how they will be measured

Mortality	Ensure the Trust's mortality rates are being counted and reported correctly
Operational Performance	Comply with national requirements around operational standards
Workforce	Increase the substantive establishment of our staff, including through improving our staff engagement
Financial Stewardship & Governance	Deliver our financial plan based on revised COVID-19 expectations; ensure improved financial stewardship across the organisation

On top of these high-level objectives, there are a small number of key priorities for the Trust over the next 12 months, bearing in mind the impact that COVID-19 may have on our capacity to deliver these.

At a summary level, these priorities are:

Optimising Flow	**Optimise flow through the hospital** by developing resilient emergency pathways, shoring up Same Day Emergency Care provision, increasing early discharge and implementing appropriate streaming and on-site GP OOH services
Outpatient Transformation	**Deliver a step change reduction in the number of face to face appointments**, lowering the overall number and utilising technology solutions where appropriate
Staff Engagement	**Improve staff engagement and morale** by driving a fundamental change in the volume and impact of staff engagement activity in the Trust
Senior Leadership Effectiveness	**Maximise the effectiveness of the senior leadership within the organisation,** empowering staff to work collectively to make informed decisions
Recruitment and Retention	**Increase the proportion of our workforce who are substantively employed by the Trust** and in doing so, reduce the vacancy rate and ensure a minimum 10% in-year reduction in agency cost
Estates Moves	**Complete Ophthalmology move to RCHC and relocate existing Greenoaks services** (ante and post-natal care) and Cystoscopy services to Oakwood Hall
Gastroenterology Service	**Implement joint Gastroenterology service with Barnsley Hospital NHS Foundation Trust**, including a joint GI bleed rota and joint ward cover

It is essential that effective systems and processes are in place to support delivery of the objectives set out within this plan. We will do this via an agreed framework to oversee progress against key milestones and defined outcome measures for each programme of work. Whilst overall responsibility for delivery will sit with the relevant Clinical or Corporate Division, compliance will be monitored and tracked corporately, with monthly reporting to the relevant Board Assurance Committees and the Board of Directors.

The framework will build upon the approach taken within 2019/20 with lead Executive Directors for each objective. Implementation will be overseen by a multi-disciplinary team providing input aligned to their field of expertise. This will include (but is not limited to) Clinical, Managerial, Operational, Financial, Workforce, Information and Digital representation. This inclusive and engaging operating style will be key to providing assurance that any impact of individual schemes has been fully considered at the outset to support a smooth implementation and transition.

Gender Pay Gap

The gender pay gap report shows the difference between the average (mean or median) earnings of men and women. This is expressed as a percentage of men's earnings e.g. women earn 15% less than men. Used to its full potential, gender pay gap reporting is a valuable tool for assessing levels of equality in the workplace, female and male participation, and how effectively talent is being maximised.

Data and statistics provided for this report have been created using the national Electronic Staff Records System Business Intelligence reporting tool, specifically designed to allow NHS Trusts to meet the statutory reporting requirements.

Mean Gender Pay Gap and Median Gender Pay Gap

Gender	Mean Hourly Rate	*Median Hourly Rate
Male	£20.88	£16.09
Female	£15.07	£13.26
Difference	£5.81	£2.82
Pay Gap %	27.83%	17.55%

* This data excludes Long Service Awards

The Trust's Gender Pay Gap as at 31 March 2019 was 17.55%. This is a significant deterioration on the previous year, when it stood at 10.58%. There does not appear to be a single explanation for this change. Whilst the mean hourly rate of pay for women has risen there has been a slight increase in the proportion of men in the highest paid quartile, accompanied by a reduction in the proportion of men in the lowest paid quartile. There has also been a slight increase in the overall percentage of men in the workforce, from 17.1% to 17.4%.

The full gender pay gap report can be accessed here: http://www.therotherhamft.nhs.uk/Equality_and_Diversity/Equality_and_diversity_monitoring_data/

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 Council of Governors' views)
- Ensuring that adequate systems and processes are maintained to deliver the Trust's annual Operational Plan
- Ensuring that its services provide safe, clean, high quality and professional care for patients
- Ensuring robust governance arrangements are in place supported by an effective assurance framework which supports sound systems of internal control including the appointment and dismissal of Board Committees
- Ensuring rigorous performance management which enables the Trust to achieve local and national targets
- Seeking continuous improvement and innovation
- Measuring and monitoring the Trust's effectiveness and efficiency
- Approving proposed expenditure above specified financial limits
- Ensuring that the Trust, at all times, remains compliant with its Licence, as issued by NHS Improvement
- Exercising the powers of the Trust established under statute, as described within the Trust's Constitution

The Board also establishes the values and standards of conduct of the Trust and its colleagues ensuring these are in accordance with NHS values and the 'Nolan Principles' of public life: selflessness, objectivity, integrity, accountability, openness, honesty and leadership. The 'Nolan Principles'[21] set out the ethical standards expected of individuals who hold public office. The Trust has ensured its systems during 2019/20 remained compliant with NHS England's Conflicts of Interest guidance which came into force in June 2017.

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

The day to day management of the organisation is delegated by the Board through the Chief Executive to the Executive Directors. Clear objectives are set and used to ensure that the organisation is managed effectively, efficiently and to the highest standards in accordance with its values. Monthly updates on all aspects of performance are provided to the Board by the Executive Directors.

Composition of the Board of Directors

Full-time Executive Directors and part-time Non-Executive Directors are members of the Board of Directors. Non-Executive Directors are appointed by the Council of Governors and are selected from the Membership of the Trust. Non-Executive Directors are chosen for their 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 relationship 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, during 2019/20 the Board sought to further increase the diversity of its membership, appointing three new Non-Executive Directors and four Executive Directors during the year.

All Executive and Non-Executive Directors received annual performance evaluation and appraisal. For the Chairman the performance appraisal and objective setting is undertaken jointly by the Senior Independent Director and the Lead Governor.
For the Non-Executive Directors performance appraisal is undertaken by the Chairman in conjunction with the Lead Governor. Both appraisal processes are informed by a collective view on each individual Non-Executive Director's performance provided by the Executive Directors.

The Chief Executive's performance appraisal is undertaken by the Chairman and the performance appraisals of the Executive Directors is carried out by the Chief Executive.

During 2019/20 the performance of the Board has been further evaluated internally through Board Development away days, Board seminar sessions and through the on-going, quarterly review of the Board Assurance Framework

In addition, following on from its external well-led review in 2018, the Board continued to work with The Governance Forum to attain 'The Governance Framework' accreditation from The Chartered Governance Institute.

In December 2019 the Trust became the first in England to attain this accreditation.

[21] https://www.gov.uk/government/publications/the-7-principles-of-public-life

Martin Havenhand
Chairman

Dr Richard Jenkins
Interim Chief Executive

Dr Rumit Shah
Non-Executive Director

Lynn Hagger
Non-Executive Director / Vice Chair

Mark Edgell
Non-Executive Director

Heather Craven
Non-Executive Director

Joe Barnes
Non-Executive Director and Senior Independent Director

Nicola Bancroft
Non-Executive Director

Michael Smith
Non-Executive Director

Michael Wright
Interim Deputy Chief Executive

Dr Callum Gardner
Medical Director

Angela Wood
Chief Nurse

Simon Sheppard
Director of Finance

Steven Ned
Director of Workforce

George Briggs
Chief Operating Officer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Following the external well-led review commissioned by the Trust during 2018/19, the Board of Directors implemented the review's recommendations during 2019/20.

The Trust did not receive a Use of Resources assessment from NHS Improvement / England during the year, instead the next such inspection was scheduled for May 2020, although this date was deferred due to COVID-19.

The Board Assurance Framework (BAF), which was highly rated by the Trust's Internal Auditors during 2017/18, was further refined during the year with the support of the Trust's new Internal Auditors, 360 Assurance. The 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.

Meet the Board of Directors

The balance and relevance of the skills, knowledge and expertise that each of the Directors bring to the Trust is demonstrated by the descriptions below of each Director's expertise and experience. Details are provided for those Directors who were in post as at 31 March 2020.

Non-Executive Directors

All Non-Executive Directors on the Board of Directors are considered to be independent. The Trust's policy in relation to Non-Executive Director appointments is that appointments are made for up to a three-year term of office as per the Trust's Constitution with one month's notice on either side. The initial three-year term of office may be renewed once to mean a Non-Executive Director may serve up to 6 consecutive years on the Board of Directors.

A Non-Executive Director may, in exceptional circumstances, serve longer than six years; however, this arrangement is subject to annual review in accordance with *The NHS Foundation Trust Code of Governance*.

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 regulated industries.

He also brings to the Trust extensive experience and knowledge of the South Yorkshire and Bassetlaw community which is invaluable as the Trust continues to develop and enhance local health care services for the future.

The Rotherham NHS Foundation Trust is a key partner in the Rotherham Together Partnership and in March 2019 Martin was appointed Chairman of the Ambition Rotherham Board 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.

During 2019/20 Martin was also chair of the Strategy and Business Planning Committee which ceased at the end of 2019/20.

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.

Nicola is now motivated by the vision, mission and values of the Rotherham NHS Foundation Trust and seeks to provide support for its current and future development.

During 2019/20 Nicola was a member of the Finance & Performance, Audit and Remuneration Committees, becoming Vice-Chair of the Audit Committee in February 2020.

From the beginning of April 2020 Nicola continued as Vice-Chair of the Audit Committee and as a member of the Finance & Performance and Remuneration Committees. She also joined the Charitable Funds Committee as a member.

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. 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. As at end March 2020 Joe had been a Non-Executive member of the Board for six and a half years.

Joe became the Trust's Senior Independent Director in April 2018.

From 01 April 2019 Joe served as Chair of the Audit Committee, Vice-Chair of the Remuneration Committee and a member of the Finance & Performance Committee. In October 2019 Joe took over the Chairmanship of the Remuneration Committee.

From the beginning of April 2020 Joe continued to Chair the Audit Committee and the Remuneration Committee, he also became a member of the newly created People Committee.

Heather Craven

Non-Executive Director

Heather is a Chartered Accountant who trained with KPMG and has spent most of her career working across a wide spectrum of industries at director level including FTSE and AIM listed companies. Since 2006 she has helped a number of organisations, via interim and consultancy roles, to identify operational and financial issues and weaknesses and has delivered solutions to resolve those problems and developed and implemented strategies to deliver growth and profitability.

Heather has been a Non-Executive Director at the Trust since February 2017 and has chaired the Finance and Performance Committee since that date. Heather 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 2019/20 Heather was Chair of the Finance & Performance Committee and a member of the Remuneration and Strategy and Business Planning Committees.

From 01 April 2020 Heather continued as Chair of the Chair of the Finance & Performance Committee, became Vice-Chair of the Remuneration Committee and joined the Charitable Funds Committee as a member.

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 7 years and 10 months.

During 2019/20 Mark chaired the Quality Assurance Committee and was a member of both the Strategy & Business Planning and Nominations Committees.

From April 2020 Mark continued as Chair of the Quality Committee and a member of the Nomination Committee. He also became a member of the Audit 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 but 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 25 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. As at end March 2020 Lynn had served six and a half years as a Non-Executive Director.

During 2019/20 Lynn was Vice-Chair of the Strategy & Business Planning Committee, the Board's Nomination Committee and the Charitable Funds Committee. She was also a member of the Quality Assurance and Audit Committees.

From 01 April 2020 Lynn became Chair of the newly formed People Committee, continued as Vice-Chair of the Nomination Committee, Vice-Chair of the Charitable Funds Committee and as a member of the Quality 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 36 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 a 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.

Rumit was a member of the Quality Assurance and Nominations Committees during 2020.

From 01 April 2020 Rumit became Vice-Chair of the Quality and Finance & Performance Committees and continued as a 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 2019/20 Michael was a member of the Finance & Performance, Quality Assurance and Remuneration Committees. He was also a member of the Charitable Funds Committee, assuming the Chairmanship of this committee in October 2019.

From April 2020 Michael continued as Chair of the Charitable Funds Committee and as a member of the Remuneration Committee. He became Vice-Chair of the new People Committee and joined the Audit Committee as a member.

Executive Directors

Dr Richard Jenkins
Interim Chief Executive Officer

Richard joined the Trust on 10 February 2020 as Interim Chief Executive on a part-time basis. He is also Chief Executive at Barnsley Hospital NHS Foundation Trust and 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

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 a 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 30 plus 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.

Over recent years, George has enjoyed working in a number of permanent and interim roles across the UK which gave him the opportunity to support and learn from a varied number of NHS organisations.

Dr Callum Gardner
Interim Medical Director (from 03 September 2018 to 31 October 2019)
Medical Director (from 01 November 2019)

Dr Gardner initially joined the Trust as Interim Executive Medical Director in September 2018, bringing a wealth of experience to the organisation. His previous role was as Divisional Director for the Emergency & Medicine division at North West Anglia NHS Foundation Trust (NWAFT), 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, 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 permanent Medical Director in November 2019 and continues to hold joint responsibility for quality and clinical governance with the Chief Nurse, under the new Safe & Sound Quality Directorate.

Steve 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.

Simon Sheppard
Director of Finance

Simon Sheppard joined the Trust in November 2014 from the University Hospitals of Leicester NHS Trust where he was Acting Director of Finance and, before that, Deputy Director of Finance and Procurement.

Simon started in the NHS on the Graduate Management Training Scheme and has over 20 years' experience at a senior level in large acute teaching hospitals including the Nottingham University Hospitals NHS Trust.

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 32 years, joined the Trust from Northern Lincolnshire and Goole NHS Foundation Trust where she was the Interim Deputy Chief Nurse, on secondment from her substantive role as Deputy Director of Nursing at NHS England. She has held a number of senior nursing roles throughout her career, both strategic and operational, including significant experience in acute settings. She has a track record of achievement in quality, patient safety and patient experience agendas, and is passionate about patients receiving safe, good quality care.

Non-Executive Director Attendance at Board of Directors' Meetings 2019/20

Board of Directors	Martin Havenhand (Chair)	Nicola Bancroft	Joe Barnes	Heather Craven	Mark Edgell	Lynn Hagger	David Hannah	Barry Mellor	Michael Smith	Rumit Shah
Total attended	13	6	11	13	11	13	8	6	11	2
Total eligible	13	6	13	13	13	13	10	6	13	2

Executive Director Attendance at Board of Directors' Meetings 2019/20

Board of Directors	Louise Barnett	Richard Jenkins	George Briggs	Callum Gardner	Chris Holt	Steve Ned	Simon Sheppard	Angela Wood	Chris Preston	Michael Wright
Total attended	10	1	12	11	1	13	12	12	7	1
Total eligible	12	1	13	13	3	13	13	13	8	1

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/) or by requesting a copy from the Company Secretary at the address below:

Ms Anna Milanec,
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 those of 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/)

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/)

For details regarding the work of the Remuneration Committee during 2019/20 please see the Remuneration Report section of this Annual Report.

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)[22].

The Committee was chaired throughout the year by Joe Barnes, a Non-Executive Director with relevant financial experience. From April 2019 to January 2020 four of the Non-Executive Directors were members of the Audit Committee, all of whom were considered to be independent. From February 2020 three Non-Executive Directors were members of the 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.

The Committee has met on five occasions throughout the financial year and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

[22] Fourth edition, 2018

Audit Committee	Joe Barnes (Chair)	Lynn Hagger	David Hannah	Barry Mellor	Nicola Bancroft
2019					
23 April	Y	Y	Y	Y	
22 May	Y	Y	Y	Y	
11 September	Y	Y	Y	Y	
11 December	Y	Y	Y		
2020					
25 March	Y	Y			Y
Attendance	5/5	5/5	4/4	3/3	1/1

The following areas were the significant issues considered by the Audit Committee during 2019/20:

- Annual Governance Statement 2018/19
- Annual Report and Accounts 2018/19
- Quality Account and Report 2018/19
- Head of Internal Audit Opinion 2018/19
- External Audit ISA 260 review 2018/19
- Internal Audit (TIAA) annual work plan for 2019/20
- Internal Audit (360 Assurance) annual work plan for remainder of 2019/20 as well as draft 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 2019/20
- Trust's Risk Register (scores of 15 and above)
- Annual Review of Standards of Business Conduct
- Annual Report of the Audit Committee 2018/19
- Freedom to Speak up Guardian Annual Update 2018/19
- Changes to Accounting Policies 2019/20

Exceptional items considered were:

- External Audit 2018/19 de-brief
- Operational Plan 2018/19 objectives
- General Data Protection Regulations
- Internal Audit procurement process during 2019/20
- External Audit procurement during 2020
- Cyber security report
- Requirements of International Financial Reporting Standard (IFRS) 8 relating to operating segments
- Counter Fraud Service Engagement Meeting on 24 January 2020
- Governance Diagnostics

Review of:

- Internal Auditor effectiveness
- External Auditor effectiveness

The significant risks identified by the External Auditors (PwC) at the 2019/20 audit planning meeting on 13 March 2020 were:

- Risk of management override of controls
- Risk of fraud in income recognition
- Risk of fraud in expenditure recognition
- Financial sustainability
- Carrying value of property, plant and equipment

During 2019/20 the Audit Committee has continued to critically assess and review the judgements that have been applied in relation to the significant risks identified by the External Auditor as well as the Trust's compliance with the relevant accounting standards.

Internal Auditors

From April until May 2019 the Committee worked with 'TIAA' as its Internal Audit provider to strengthen the Trust's internal control processes. From June 2019 onwards 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 2019/20 'PricewaterhouseCoopers LLP (PwC)' continued as the Trust's External Auditor. This contract began on 1 October 2016 and ended on 30 September 2019 (it was a three-year contract with the option to extend for one year plus one year). The total value of the contract for three years was £187,320 (£62,440 p.a.).

At the February 2019 Audit Committee meeting the Committee supported a recommendation to the Council of Governors at their April 2019 meeting, via the Trust Chairman, that a further contract term be offered to 'PwC'. The Council of Governors approved the extension of PwC's contract for a period of one year from October 2019. The cost of the additional one year of the contract was £83,800.

The annual review of the effectiveness of the External Audit function was undertaken in September 2019 and concluded that the provision of the External Audit service was sufficient in supporting the Committee in fulfilling its role

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 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 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 on 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

Attendance at Nominations Committee (Executive Director appointments) 2019/20

Nominations Committee	Martin Havenhand (Chair)	Mark Edgell	Lynn Hagger (Vice Chair)	David Hannah	Rumit Shah	Louise Barnett	Steve Ned
2019							
08 July	Y	Y	Y	Y		Y	Y
11 October	Y	Y	Y	N		N	N
29 October	Y	Y	Y	Y		N	Y
26 November	Y	Y	Y	Y		Y	N
17 December	Y	Y	Y	Y		Y	Y
24 December	Y	Y	Y	N		N	Y
2020							
04 February	Y	Y	Y		Y	Y	Y
Attendance	7/7	7/7	7/7	4/5	1/1	4/7	5/7

During 2019/20 Martin Havenhand continued as Chair of the Nominations Committee, Lynn Hagger was Vice-Chair and Mark Edgell was a member. David Hannah served as a member until the end of his term of office on 31 January 2020 when Rumit Shah became a member of the Committee.

Executive Director Appointments

The recruitment process undertaken to appoint an Interim Chief Executive during 2019/20 was as follows. Initially the intention was to appoint a substantive replacement Chief Executive and external recruitment consultants were appointed to undertake this task. Subsequently, and following discussions with the Integrated Care System and NHS England / Improvement, it was decided to pursue the appointment of an interim Chief Executive.

Following an interview process held on 14 November 2019, a Governors' Nominations Committee held on 22 November 2019, and a Board Nominations Committee held on 26 November 2019, it was proposed that Dr Richard Jenkins, current Chief Executive at Barnsley NHS Foundation Trust, should be appointed as part-time, Interim Chief Executive of the Trust. Dr Jenkins took up this role on 10 February 2020.

Following the resignation of the Deputy Chief Executive in May 2019, the decision was taken to appoint an Interim Deputy Chief Executive for the duration of the financial year. Chris Preston joined the organisation from The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust on a fixed term contract basis and had also previously worked at the Trust in another senior management role; Chris had over 20 years of senior management and Board-level experience across both health and energy sectors.

The recruitment process undertaken to appoint a second Interim Deputy Chief Executive Officer during 2019/20 was as follows. Following the appointment of the Interim Chief Executive (detailed above), and the resignation of the Interim Deputy Chief Executive, a decision was taken to appoint a second Interim Deputy Chief Executive. An interview for this role took place on 24 December 2019 involving the Chairman and three Non-Executive Directors (supported by Dr Richard Jenkins and Steven Ned, Director of Workforce). Following this process, Mr Michael Wright was appointed as Interim Deputy Chief Executive and took up his role on 10 February 2020.

The recruitment process undertaken to appoint a new Medical Director during 2019/20 was as follows:

- Meeting of the Nominations Committee to discuss the requirements for the post and timelines
- Applications invited by external search agency
- Shortlisting took place, with approval for shortlisted applicants by Nominations Committee members
- A comprehensive selection process took place on 08 July 2019 which resulted in the appointment of Dr Callum Gardner as the new, substantive Medical Director with effect from 01 November 2019

Performance Appraisal Process for Executive Directors

The Chairman undertakes the performance appraisal of the Chief Executive and the Chief Executive undertakes the performance appraisals of the Executive Directors.

Non-Executive Director Appointments

The Governors' 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, reflect 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 composed of at least six Governors (two Public Governors which should include the Lead Governor, two Staff Governors and two Partner Governors).

The Committee makes recommendations as appropriate to the Council of Governors with regard to the outcome of the meetings, with the minutes also routinely provided to all Council members.

The Committee met on three occasions during 2019/20.

At the start of 2019/20 the Council of Governors, based upon the recommendation of the Committee, approved the appointment of Mr Michael Smith as a Non-Executive Director. The skill requirements for this appointment, which included a knowledge of, and background in, mental health issues had been based upon a number of matters raised by the Care Quality Commission during their inspection in 2018.

The fact that Mr Smith was also a Non-Executive Director at Humber Teaching NHS Foundation Trust (which provides a variety of services for people with mental health problems, learning disabilities, addictions and community services) was made known to the Governors throughout the recruitment process.

The Council of Governors also approved the Committee's Terms of Reference and based upon the recommendation of the Committee, agreed that there be no uplift in Non-Executive Directors' and the Chair's remuneration during 2019/20.

Performance Appraisal Process for Non-Executive Directors

The Chair and Non-Executive Directors annual appraisal and objective setting process was undertaken in quarter one of 2019/20.

The performance appraisal for the Chairman is jointly undertaken by the Lead Governor and the Senior Independent Director. The Chairman undertakes the appraisals of the Non-Executive Directors in conjunction with the Lead Governor. All Non-Executive Director performance appraisals are informed by the feedback from fellow Non-Executive Directors, the Executive Directors and members of the Council of Governors.

In June 2019, 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 the terms of office for all the Non-Executive Directors, including the Chairman, whose current term would conclude during 2019/20. The recommendations from the Committee were approved by the Council of Governors at their October 2019 meeting.

In order to align the commencement dates for future appointments, the Committee recommended that the Council of Governors approve the proposal that all future Non-Executive Director appointments would start at the beginning, and conclude at the end of the month.

The Committee considered the 'special arrangements for part time office holders' in relation to the tax treatment of Non-Executive Directors' expenses which would see them being personally responsible for payment of taxes in this area. The Committee recommended a change to the Non-Executive Directors' terms and conditions in relation to liability for payment of the tax, which was subsequently approved by the Council of Governors.

Following agreement at the April 2019 Council of Governors meeting, recruitment was undertaken during quarter two to appoint two new Non-Executive Directors to replace Mr Barry Mellor whose term of office concluded in September 2019 and Dr David Hannah whose term of office concluded in January 2020.

Following an analysis of the current Board of Directors' 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, which interviewed a total of six candidates, supported by the recruitment agency in an advisory capacity. All shortlisted candidates had the opportunity to meet both the Vice-Chair and the Senior Independent Director.

Based upon the recommendation from the Committee, the Council of Governors approved the appointment of Miss Nicola Bancroft for a three-year term of office and Dr Rumit Shah initially for a two-year term to facilitate succession planning.

The third meeting of the Committee in quarter three, considered the reappointment of Mr Smith for a further two-year term, once his initial

one-year term had concluded. The Committee considered that the reasons for his appointment were still relevant and the Trust wished to retain his skills and knowledge.

At that same meeting three guidance documents relating to Non-Executive Directors issued by NHS England / Improvement (NHSE/I) were considered.

One of these documents related to the appraisal process for provider Chairs and introduced a standardised approach to Chair appraisal. The second provided advice to provider trusts as to how to attract, recruit and develop their Chairs. Although not specifically for Foundation Trusts, these documents would be utilised by the Trust as part of the forthcoming appraisal process for the Chairman.

The third document dealt with the remuneration for provider Chairs and Non-Executive Directors and proposed changes designed to close the gap between the remuneration of Non-Executive Directors in NHS trusts and those within Foundation Trusts.

The Committee considered the position for each Non-Executive Director, and recommended the following to the Council of Governors:

- Non-Executive Directors: Single uniform rate of £13,000 p.a., with discretion to pay up to £2,000 per annum for up to two individuals in recognition of specific duties. If such duties were to cease, so would the £2,000 increment.

- Chairman: being in the upper quartile of group 2 (the Trust is challenged and the current incumbent is experienced) remuneration of £50,000 p.a. was appropriate.

- General principle that going forward any new Non-Executive Director would be advertised and appointed on the standard rate of £13,000 per annum. Additionally, all existing Non-Executive Directors would, by the end of December 2022, be remunerated at £13,000 per annum.

The Council of Governors approved the Committee's recommendations at its meeting in January 2020.

Non-statutory Committees of the Board 2019/20

Quality Assurance Committee
Finance & Performance Committee
Strategy & Business Planning Committee

The annual revision of the Terms of Reference of the non-Statutory Board Committees were approved by the Board of Directors in April 2019.

Self-assessments of the effectiveness of each of the non-statutory committees of the Board were undertaken during January 2020 through anonymous surveys sent to committee members and the results were reported to the Committees at their February 2020 meetings.

At its meeting in February 2020 the Board of Directors agreed that as of April 2020 the non-statutory Committees of the Board would continue to include the Quality Committee and Finance & Performance Committee. Recognising the progress made by the Strategy & Business Planning Committee in improving the maturity of the strategic, transformation and business planning infrastructure of the Trust, it was further agreed that the Strategy & Business Planning Committee would cease from 31 March 2020 with the Board of Directors continuing to oversee these matters. Given the importance of workforce matters, both nationally and locally, the Board agreed to the formation of a People Committee from April 2020 to lead on the provision of assurance to the Board in respect of workforce issues.

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 Auditor; 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 constituencies 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 the Electoral Reform Service in accordance with the requirements of the Trust's Constitution.

During 2019/20 the members of the Council of Governors were:

Constituency	Name	Term of Office
Public Governors (elected):		
Wentworth North (Covering the electoral wards of Hoober, Swinton, Wath)	Vacancy x2	01.04.2019 to 31.05.2020
Wentworth South (Covering the electoral wards of Rawmarsh, Silverwood, Valley)	Lt Col Robert McPherson Vacancy x1	01.06.2017 to 31.05.2020 01.04.2019 to 31.05.2020
Wentworth Valley (Covering the electoral wards of Hellaby, Maltby, Wickersley)	Mr Graham Barry Jenkinson Vacancy x1	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 01.04.2019 to 31.05.2020
Rotherham South (Covering the electoral wards of Boston Castle, Rotherham East, Sitwell)	Dr Beverly Bennett Mrs Jo Brookes Mrs Marilyn Gambles Mr A A Zaidi	01.06.2016 to 31.05.2019 01.06.2016 to 31.05.2019 01.06.2019 to 31.05.2022 01.06.2019 to 31.05.2022
Rotherham North (Covering the electoral wards of Keppel, Rotherham West, Wingfield)	Mrs Valerie Lindsay Vacancy Vacancy x2	01.06.2016 to 31.05.2019 01.04.2019 to 31.05.2019 01.06.2019 to 31.05.2020
Rother Valley South (Covering the electoral wards of Anston & Woodsetts, Dinnington, Wales)	Mrs Judy Dalton Mr Gavin Rimmer **(Lead Governor)**	01.06.2017 to 31.05.2020 01.06.2014 to 31.05.2017 Re-elected 01.06.2017 to 31.05.2020
Rother Valley West (Covering the electoral wards of Brinsworth & Catcliffe, Holderness, Rother Vale)	Mrs Hilda Littlewood Mr Dennis Moore	01.06.2017 to 31.05.2020 01.06.2018 to 31.05.2021
Rest of England (Covering those who live outside the borough)	Dr Stephen Hudson Vacancy x1 Vacancy x1	01.06.2018 to 31.05.2021 Resigned 26.06.2019 27.06.2019 to 31.05.2020 01.04.2019 to 31.05.2020
Staff Governors (elected x5):	Mrs Catherine Ripley	01.06.2016 to 31.05.2019
	Mrs Anne Rolfe	Co-opted 15.01.2019 to 31.05.2019
	Vacancy	23.03.2019 to 31.05.2019
	Vacancy	01.04.2019 to 31.05.2019
	Mrs June Lovett	01.06.2018 to 31.05.2021 Left organisation 31.03.2020
	Dr Julian McDonough	01.06.2019 to 31.05.2022
	Mr Christopher Bott	01.06.2019 to 31.05.2022
	Dr Andrew Mellor	01.06.2019 to 31.05.2022 Left organisation 12.02.2020
	Mr Owen Dickinson	01.06.2019 to 31.05.2022

Constituency	Name	Term of Office
Partner Governor Organisations (nominated/appointed):		
Sheffield Hallam University	Dr Christopher Low Dr Joanne Lidster	01.08.2015 to 31.07.2018 Reappointed 01.08.2018 to 31.07.2021 Stood down 10.05.2019 17.05.2019 to 16.05.2022
Sheffield University	Vacancy	05.01.2019 to 31.03.2019
Rotherham Partnership	Vacancy	27.09.2018 to 31.03.2019
Voluntary Action Rotherham	Mrs Jean Flanagan	01.09.2017 to 31.08.2020
Rotherham Metropolitan Borough Council	Cllr Patricia Jarvis	06.02.2017 to 05.02.2020
Barnsley and Rotherham Chamber of Commerce	Vacancy x1 Ms Tricia Smith	01.04.2019 to 19.01.2020 20.01.2020 to 19.01.2023
Rotherham Ethnic Minority Alliance	Mr Shakoor Adalat	12.02.2019 to 11.02.2022

Attendance 2019/20

Council of Governors meeting	Number of meetings held during tenure	Number of meetings attended
Mr Shakoor Adalat	5	2
Dr Beverly Bennett	1	1
Mr Christopher Bott	4	4
Mrs Jo Brookes	1	1
Mr Owen Dickinson	4	4
Mrs Marilyn Gambles	4	3
Mrs Judy Dalton	5	3
Mrs Jean Flanagan	5	3
Dr Stephen Hudson	1	0
Cllr Patricia Jarvis	5	5
Mr Graham Barry Jenkinson	5	5
Dr Joanne Lidster	4	3
Mrs Valerie Lindsay	1	1
Mrs Hilda Littlewood	5	5
Mrs June Lovett	5	4
Dr Christopher Low	1	0
Dr Julian McDonough	4	4
Lt Col Robert McPherson	5	3
Dr Andrew Mellor	4	2
Mr Dennis Moore	5	2
Mr Gavin Rimmer	5	4
Mrs Catherine Ripley	1	1
Mrs Anne Rolfe	1	1
Ms Tricia Smith	0	0
Mr A A Zaidi	4	4

There were four scheduled meetings of the Council of Governors during 2019/20, with an additional extraordinary meeting held in December 2019 to approve the appointment of the Interim Chief Executive. Attendance is detailed left:

Members of the Board of Directors (Executive and Non-Executive Directors) have routinely attended the quarterly scheduled Council of Governors meetings to ensure that they develop an understanding of the view of Governors and Members. Their attendance during 2019/20 was as follows:

Current Non-Executive Directors	Number of meetings attended
Martin Havenhand	5
Nicola Bancroft	2
Joe Barnes	5
Heather Craven	4
Mark Edgell	4
Lynn Hagger	4
Michael Smith	3
Rumit Shah	0
Previous Non-Executive Directors	**Number of meetings attended**
David Hannah	4
Barry Mellor	1
Current Executive Directors	**Number of meetings attended**
Richard Jenkins [23]	0
George Briggs	2
Callum Gardner	3
Steven Ned	1
Simon Sheppard	3
Angela Wood	1
Michael Wright [23]	0
Previous Executive Directors	**Number of meetings attended**
Louise Barnett	2
Chris Holt	0
Chris Preston	2

[23] Richard Jenkins and Michael Wright joined the Trust after the last meeting of the Council of Governors for the financial year 2019/20.

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

Ms Anna Milanec, Director of Corporate Affairs/Company Secretary
General Management Department
Level D
The Rotherham NHS Foundation Trust
Moorgate Road
Rotherham S60 2UD

Members who wish to communicate with the Governors can do so by sending an email to rgh-tr.public.governors@nhs.net . Alternatively, they may write to the Governor at the following address:

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


All Departments
Toilets

The Foundation Trust Membership

As a Foundation Trust, the Trust works closely with its Membership and continues to involve and engage Members in the Trust's strategic direction through sustained, two-way communication plans. During 2019/20 the strategy for involving Members included the following initiatives.

In March 2019, the Trust launched 'Your Health'. This quarterly magazine replaced 'Your Choice', the annual Members' magazine, and is available to patients, Members and the public at various NHS locations, published via the local media and through the Trust's website.

'Your Health' provides news from the hospital and community health services, showcasing services, providing health educational advice, career options within the NHS and outlining future plans for the Trust. It continues to be utilised to promote the role of Governors and announce the forthcoming annual Council of Governor Elections, encouraging Members to stand as Governors and to vote for their Governor.

We continue to hold quarterly Governors' Surgeries, which provide an opportunity for our Members to speak with our Governors, giving their views on services and asking questions of our Governors. The feedback from these sessions is seen by the senior management within the Trust to ensure opportunities for quality improvements in patient care and experience are acted upon.

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.

As at 24 February 2020 there were 15,567 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'

Public Members are able to contact their local Governor by sending an e-mail to: rgh-tr.public.governors@nhs.net indicating the name of the Governor they wish to contact in the subject line of the e-mail.

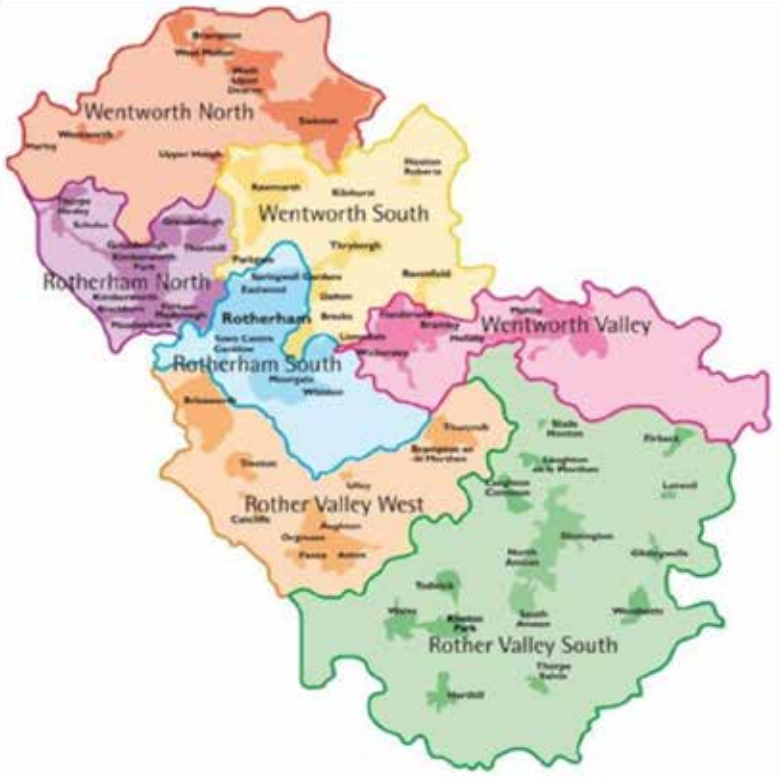
In a similar manner staff Members are able to contact their Governor by sending an e-mail to: rgh-tr.staffgovernors@nhs.net also including the name of the Governor in the subject line of the e-mail.

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

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 a 'Rest of England' constituency), not be a Member of the staff constituency and have made an application for membership to the Trust.

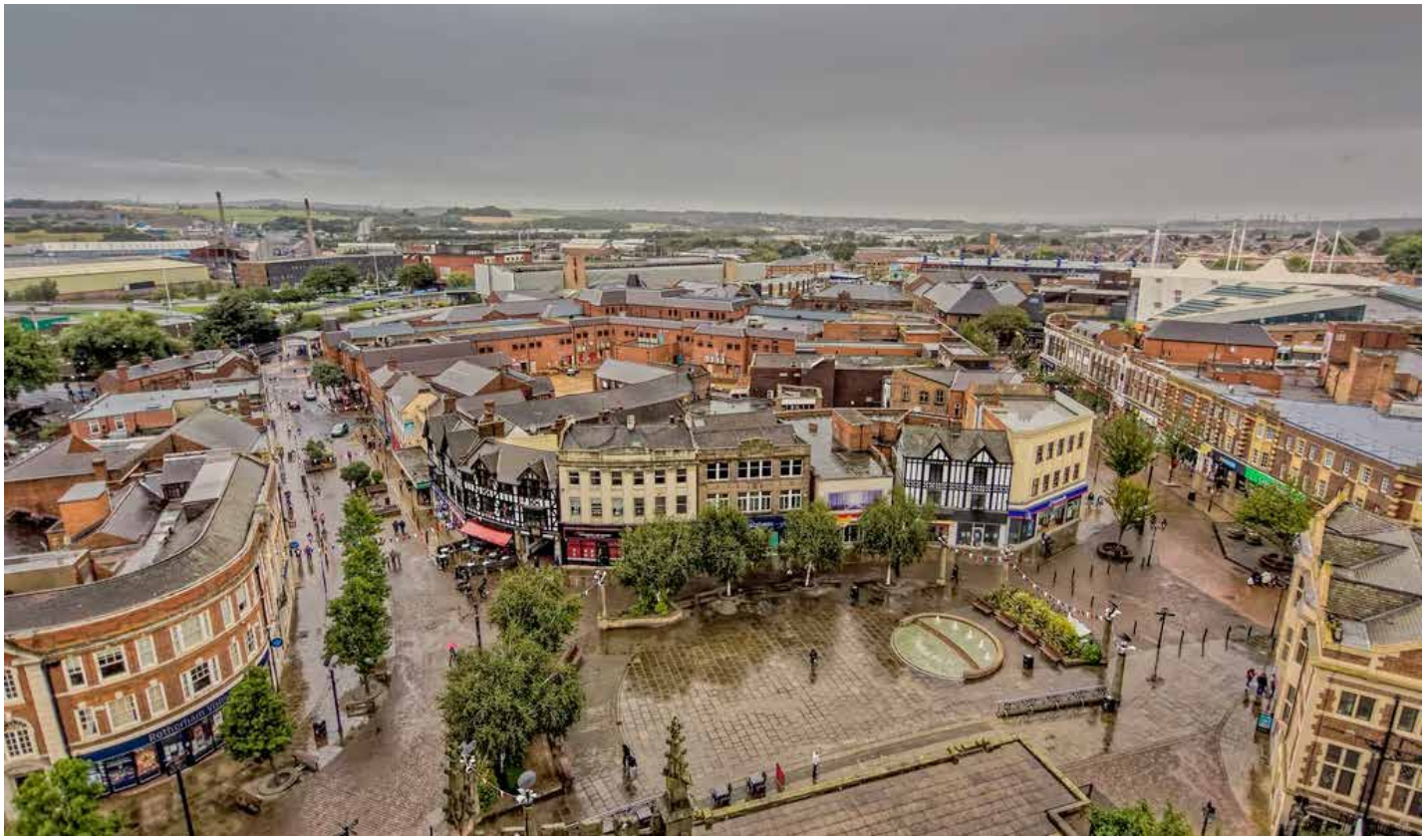
To become a Staff Member, the person must be at least 16 years of age, be employed by the Trust with a permanent contract or have worked at the hospital for at least 12 months and have opted in to Trust Membership[24].

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 (Hoober, Swinton, Wath)
Wentworth Valley (Hellaby, Maltby, Wickersley)
Rother Valley West (Brinsworth & Catcliffe, Holderness, Rother Vale)
Rother Valley South (Anston & Woodsetts, Dinnington, Wales)
Rest of England (covers all areas not within Rotherham Metropolitan Borough Council boundaries)

[24]From April 2018 staff had to opt-in to become a member



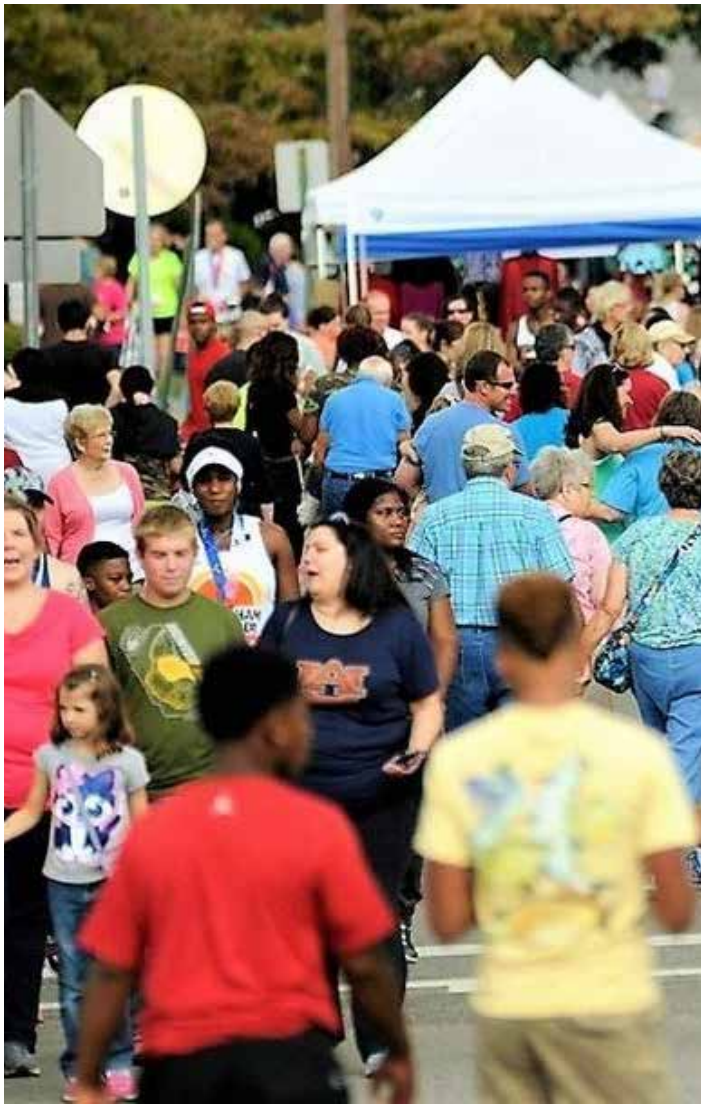
Membership composition as at 24 February 2020

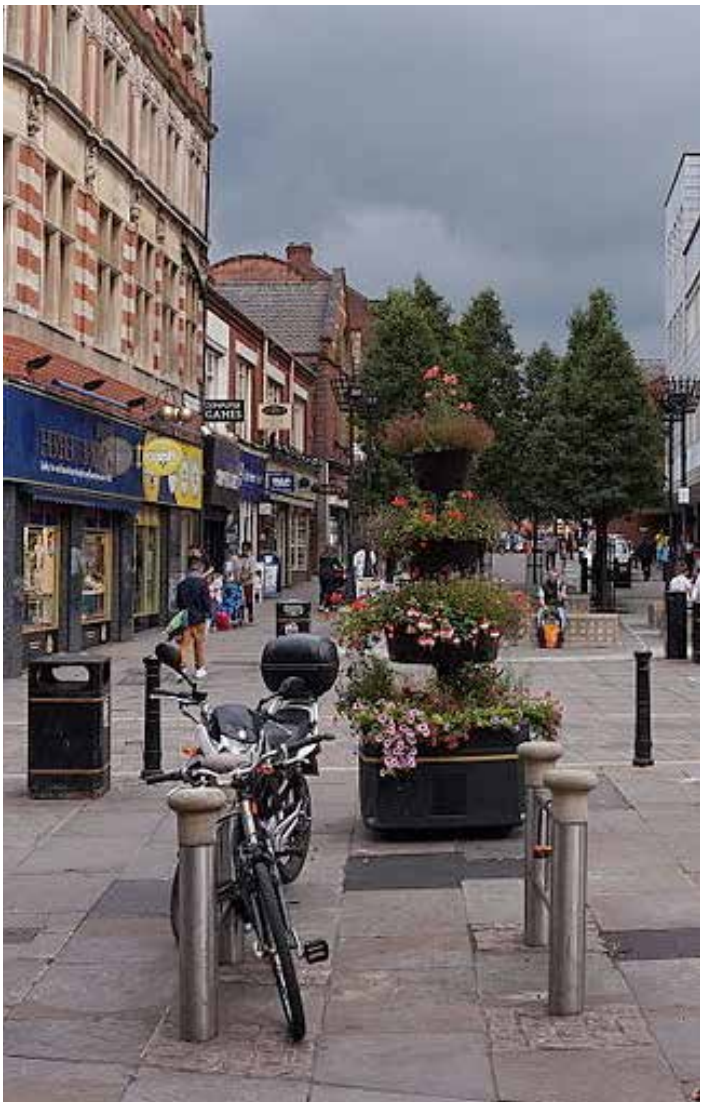
Public	
Rotherham South	1,899
Rotherham North	1,420
Wentworth South	1,574
Wentworth North	1,122
Wentworth Valley	1,604
Rother Valley West	1,236
Rother Valley South	978
Rest of England	1,470
Out of trust area	0
Total number of Public Members	11,303
Staff	
Staff Class	4,264
Total number of Staff Members	4,264
Total Membership:	15,567

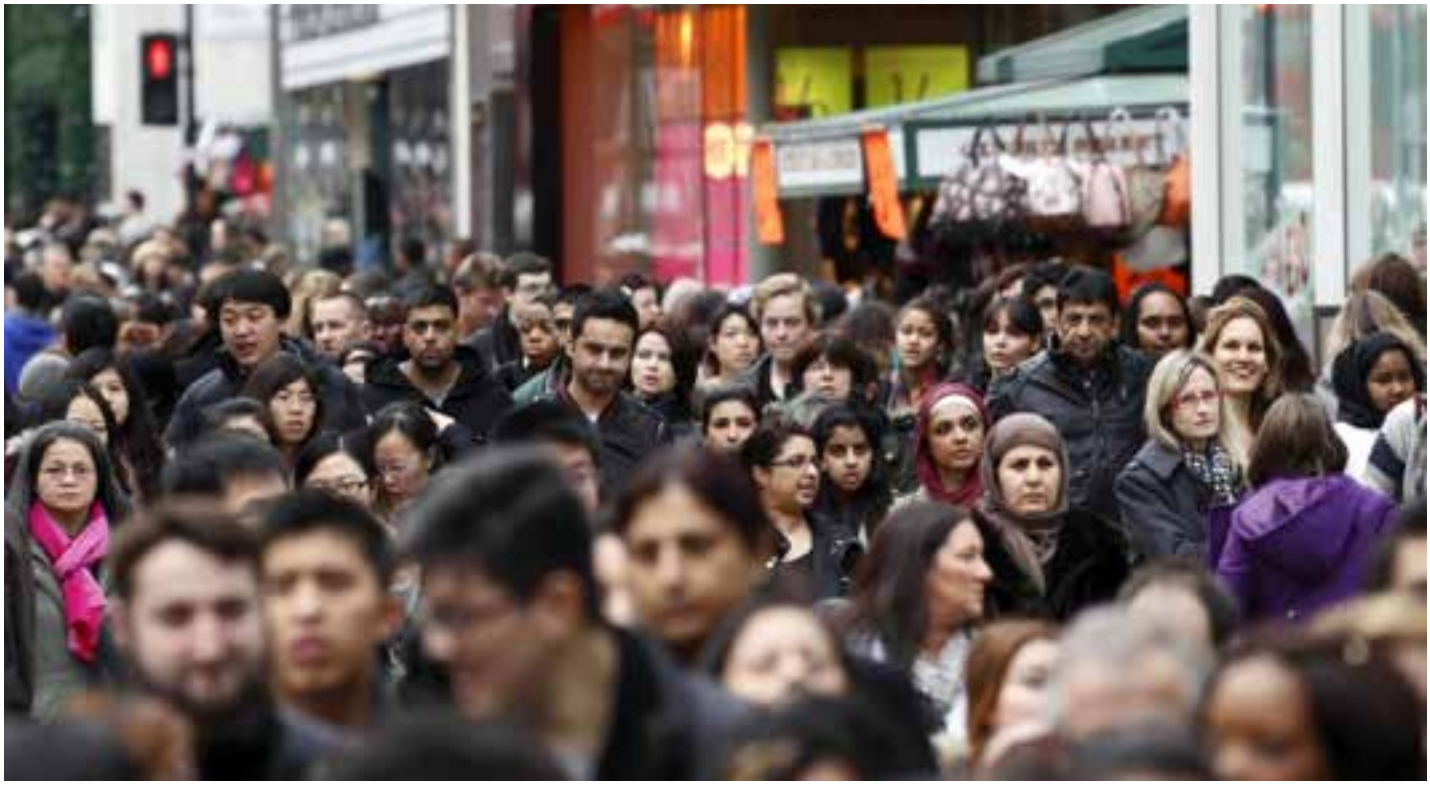
The Trust values the continued support and engagement of its Membership and recognises the importance of a Membership that is representative of all the communities it serves. The Trust strives to ensure that its Membership is as representative of the population as possible.

As at 24 February 2020 the Trust's membership was composed as follows:

Membership Breakdown	Public	Staff	Total
Age			
0-16	0	1	1
17-21	3	30	33
22-29	444	515	959
30-39	1,329	958	2,287
40-49	1,407	1,004	2,411
50-59	1,866	1,270	3,136
60-74	2,786	474	3,260
75+	2,233	9	2,242
Not stated	1,235	3	1,238
Gender			
Unspecified	3	2	5
Male	4,450	673	5,123
Female	6,850	3,589	10,439
Transgender	0	0	0
Ethnicity			
White - English, Welsh, Scottish, Northern Irish, British	3,921	2,802	6,723
White - Irish	16	9	25
White - Gypsy or Irish Traveller	0	0	0
White - Other	13	30	43
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	8	5	13
Asian or Asian British - Indian	34	54	88
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	20	18	38
Black or Black British - African	24	21	45
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	67	28	95
Not stated	7,004	1,236	8,240
Total numbers of Members	11,303	4,264	15,567







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

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board and Council of Governors	A.1.1	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. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors. These arrangements should be kept under review at least annually.	Compliant 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.
2: Disclose	Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration[25] committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. *Part of this requirement is also contained within paragraph 7.25 as part of the directors' report.*	Compliant. Included in the Annual Report as follows: Directors' Report, Remuneration Report and Governance & Organisational Structure section (Board of Directors, Audit Committee, Nominations Committee)
2: Disclose	Council of Governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. 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.	Compliant. Included in Governance & Organisational Structure section (Council of Governors Section) Attendance by individual Governors at Council of Governors' meetings is included in the Annual Report in the Governance & Organisational Structure section (Council of Governors section)
Additional requirement of FT ARM*	Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Compliant. Included in Governance & Organisational Structure section (Council of Governors Section)

*Foundation Trust Annual Reporting Manual

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary. 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: • has been an employee of the NHS foundation trust within the last five years; • 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; • 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; • has close family ties with any of the NHS foundation trust's advisers, directors or senior employees; • holds cross-directorships or has significant links with other directors through involvement in other companies or bodies; • has served on the board of the NHS foundation trust for more than six years from the date of their first appointment; or • is an appointed representative of the NHS foundation trust's university medical or dental school.	Compliant. Statement re: independence of Non-Executive Directors included in Governance & 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 & Organisational Structure (Composition of the Board of Directors section).
2: Disclose	Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. Both statements should also be available on the NHS foundation trust's website.	Compliant. Included in the Governance & Organisational Structure section (Composition of the Board of Directors and Meet the Board of Directors section)
Additional requirement of FT ARM	Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Compliant. Included in the Directors' Report (Meet the Board of Directors section)
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 the 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)

[25] 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.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
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: The Chairman and Assistant Director of Strategy, Planning & Integration attended the Governors Forum on 19 February 2020 to discuss the draft Operational Plan for 2020/21. The Staff Governors then canvased the opinion of their Members at a Governors' Surgery held on 27 February 2020. Their views have been communicated to the Board of Directors and incorporated into the Operational Plan 2020/21.
Additional requirement of FT ARM	Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Compliant. During 2019/20 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.
2: Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted, bearing in mind the desirability for independent assessment, and the reason why the NHS foundation trust adopted a particular method of performance evaluation.	Compliant. Included in Governance & 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. At the end of each Board meeting one of the Executive or Non-Executive Directors feeds back their evaluation of the meeting.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Board	B.6.2	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.	Compliant. Included in Governance & 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) During the previous financial year (2018/19) The Governance Forum / RSM were commissioned by the Trust to undertake an external well-led review. The Governance Forum also continued to facilitate the Board Development Programme during 2019/20. In addition, NHS Improvement undertook their Use of Resources assessment of the Trust in September 2018 and the 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	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. There should be a statement by the external auditor about their reporting responsibilities Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 7.92.	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	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.	Compliant. Included in the Annual Governance Statement section
2: Disclose	Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (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.	Compliant. Included in Governance & Organisational Structure section (Audit Committee section)

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
2: Disclose	Audit Committee / Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable
2: Disclose	Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Compliant. • Included in Governance & Organisational Structure section (Audit Committee section) • Included in Governance & Organisational Structure section (Audit Committee section) • Not applicable: No non-audit services were provided by PwC during 2019/20
2: Disclose	Board / Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Compliant. None of the Trust's Executive Directors were released, for example to serve as a Non-Executive Director elsewhere, during 2019/20
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.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
Additional requirement of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Compliant. Included in FT Membership section of Governance & Organisational Structure section
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: • Board of Directors section • At end of Council of Governors section.
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	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 organisation, consideration of clinical governance matters occurs.	Compliant.
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.

*Government financial reporting manual

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
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 to be the chairperson of the same NHS foundation trust.	Compliant.
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.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
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 procedures of the council of governors should be reviewed regularly as described in provision B.6.5.	Compliant.
6: Comply or explain	Council of Governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. 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.	Compliant.
6: Comply or explain	Council of Governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. 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.	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.
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	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. 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.	Compliant.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Board / Council of Governors	B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence. 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.	Compliant.
6: Comply or explain	Nomination Committee(s)	B.2.3	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). The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate. 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 evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	Compliant.
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 comparable size and complexity, nor the chairpersonship of such an organisation.	Compliant.

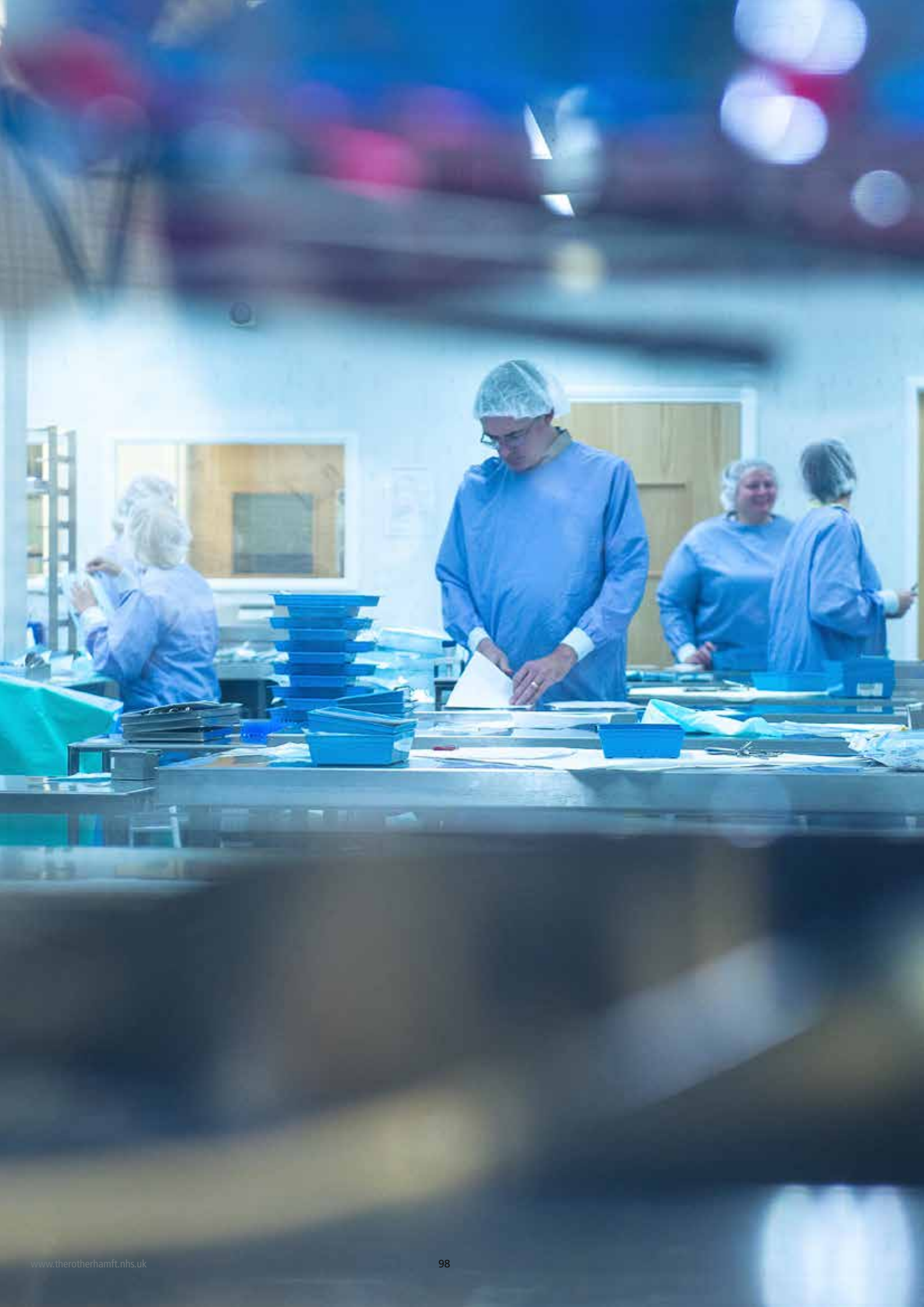
Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Board / Council of Governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. 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.	Compliant.
6: Comply or explain	Board	B.5.2	The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. 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.	Compliant.
6: Comply or explain	Board	B.5.3	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. 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.	Compliant.
6: Comply or explain	Board / Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties. 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.	Compliant.
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.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Chair / Council of Governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors. • communicating with their member constituencies and the public and transmitting their views to the board of directors; and • contributing to the development of forward plans of NHS foundation trusts. 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: *Your statutory duties: A reference guide for NHS foundation trust governors*	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. 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 and determine whether the proposed removal is reasonable or otherwise.	Compliant.
6: Comply or explain	Board / Remuneration Committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Non-compliant The Chairman discussed the Chief Executive's notice period with the Non-Executive Directors and the risks of her not serving the full notice period were assessed and agreed.
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.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
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. 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: • the NHS foundation trust's financial condition; • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	Compliant
6: Comply or explain	Board / Audit Committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors. 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.	Compliant.
6: Comply or explain	Council of Governors / Audit Committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors. 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.	Compliant.
6: Comply or explain	Council of Governors / Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.	Compliant.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Council of Governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	Compliant.
6: Comply or explain	Audit Committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. 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	Compliant.
6: Comply or explain	Remuneration Committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: 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. 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. iii) Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. 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.	Compliant.
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.

Part of schedule A	Relating to	CoG ref	Summary of requirement	Self-assessment
6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. 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.	Compliant.
6: Comply or explain	Remuneration Committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. 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.	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 **clarify in writing** how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g., Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups).	Compliant.
6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole. 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.	Compliant.
6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. 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.	Compliant: Schedule of third parties with whom the Trust has a duty of cooperation is located on Trust website here: http://www.therotherhamft.nhs.uk/key_documents/
6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	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 has been in receipt of mandated support from NHS Improvement.

This segmentation information is the Trust's position as at 31 March 2020.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website[26].

During 2019/20, 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. This evidence has not yet been formally submitted to the regulator by the organisation due to the extensive changes that have taken place across the NHS since the requirements were enforced, in addition to the Trust's financial position.

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.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the NHS Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2019/20 scores				2018/19 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial Sustainability	Capital service capacity	3	4	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	4
Financial Efficiency	I&E margin	2	4	4	4	4	4	4	4
Financial Controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	1	2	2	2	3	3	3	3
Overall Scoring		3	3	3	3	3	3	3	3

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

R. Jenkins

Dr Richard Jenkins
Interim Chief Executive
02 June 2020

[26]Source of latest segmentation information dated 20 April 2020: https://improvement.nhs.uk/resources/single-oversight-framework-segmentation/, last accessed on 21 April 2020

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.

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.*

Signed:

Dr Richard Jenkins
Interim Chief Executive
02 June 2020

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 2020 and up to the date of approval of the annual report and accounts.

The Board of Directors is responsible for ensuring sound risk management systems are in place throughout the organisation, and is supported by a number of committees which oversee the effectiveness of risk management, internal control and assurance arrangements, including the Audit Committee. Ultimately, I have the responsibility, as Chief Executive and Accounting Officer, for the management of risk in the organisation.

To support me, each member of the executive team has an area of responsibility for risk management, in accordance with their portfolios and as reflected in their role descriptions, which supports me in my role as Accounting Officer.

We have also appointed a Senior Independent Director who is available to any colleague or Governor should they have concerns that they feel they are unable to raise via normal communication channels with the Chair, Chief Executive or any of the board members.

The risk and control framework

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risks which may lead to failure of objectives and the organisational strategy. It is based on an on-going process of identifying and prioritising the risks to the achievement of the Trust's strategy, and evaluating the potential for those risks to be realised and the impact that they might have, whilst ensuring as far as possible that they are managed effectively, efficiently and economically.

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

- The Trust Board is responsible for establishing principal strategic and corporate objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that effective systems are in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and the Corporate Risk Register.

- Audit Committee, 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) formally the Quality Assurance Committee (QAC) 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.

- Finance and Performance Committee (FPC) is responsible for scrutinising aspects of financial 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 was established on 1 April 2020 and 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.

The Trust's risk management strategy, approved by the Board, sets out the organisational approach to risk, the Executive and Non-Executive Director responsibilities, and the framework in place for the management of risk throughout the organisation. Risk appetite is determined by the board and is reviewed on a regular basis. The Strategy also includes details of the role of board committees in providing assurance that risks are being managed effectively.

The Board Assurance Framework (BAF) is the mechanism which is used to identify and monitor the Trust's strategic objectives and manage the associated risks that may compromise their achievement. 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 Board as part of its regular monitoring of risk management

The Rotherham NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Registered with Conditions'. The Rotherham NHS Foundation Trust has the following conditions on registration.

In October 2018, the Care Quality Commission 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 Care Quality Commission has not taken enforcement action against the Rotherham NHS Foundation Trust during 2019/20.
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.

The organisation has established quality governance arrangements in place which is underpinned by the Trust's quality framework and the quality improvement strategy.
The Trust monitors compliance of all services. Each service undertakes a self-assessment, which is used to provide assurance that they are assessed against regulatory standards. In addition, this information is reviewed and used to underpin internal reviews of compliance. An action plan is in place and monitored for all must and should dos identified at previous CQC Inspections.

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.

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.

The Trust is committed to delivering excellent care at home, in our community and in hospital. We aim to improve the health and wellbeing of the population we serve, building a healthier future together. To support this, we established quality priorities for 2019/20, which were set out in our previous quality report. Quality targets were linked throughout the divisions and are included in local dashboards which are presented through various committees, monthly performance reviews with the executive directors, and ultimately the Board via the Quality Assurance Committee.

The quality priorities for 2019/20 were:

Patient Safety
- Increase Medication Safety
- Improve the treatment of the deteriorating patient
- Improve mandatory training compliance for medical staff

Patient Experience
- Improve end of life recognition
- Improve patient discharge
- Enhance patient feedback and public engagement

Clinical Effectiveness
- Improving the experience of patients transitioning from children to adult services
- Improve Mortality Reviews
- Improve policy and National Institute for Health and Care Excellence (NICE) guidance compliance

In order for us to operate as a provider of NHS services under licence with the CQC, we must comply with the requirements of NHSI's Quality Governance Framework. NHSI (previously, Monitor) and the CQC have aligned their definition of a 'well-led' organisation which is reflected in the CQC's assessment approach.

During the year, the Trust commissioned an independent well-led review using NHSI's framework. The report identified a number of strengths and good practice, and a few areas for development. These were presented to the board of directors, and an action plan drawn up and followed.

Data Security

Data security risks are managed in line with the Trust's risk management framework, and where appropriate, are recorded on the Trust's risk register.

All Trust colleagues are subject to a code of confidentiality, and access to data held on IT systems is restricted to authorised users. The Trust's IT department maintains up-to-date technical security measures to minimise the threat to Trust network resources from outside threats and inappropriate access.

The Trust has in place standard operating procedures and policies for the reporting of personal data security breaches to the Information Commissioner's Office within the 72 hour deadline. This reporting of incidents is through the Data Security and Protection Incident Reporting tool, which informs NHS Digital, DHSC, the ICO and other regulators.

Network and information system risks which may have a 'significant' impact on the continuity of essential services, are reported to the DHSC, in accordance with the Security of Network and Information Systems Regulations 2018.

Risks and issues involving information security are monitored by the Information Governance Committee (IGC) which escalates issues to the Audit Committee or Board.

Risks to the organisation

The Board's Assurance Framework provides the Trust with a system to identify and monitor risks which may affect achieving the strategic objectives. Each risk is mapped to corresponding controls and assurances, both internal and external.

The highest scoring risks identified via the Board Assurance Framework during 2019/20, are summarised below:

Quality of care:

This relates to the failure to deliver high quality patient care, leading to poor patient experience, avoidable harm and poor clinical outcomes.

Of the Trust's nine quality priorities set at the beginning of the financial year, four were delivered as planned. These were:
- Increase Medication Safety
- Improving the experience of patients transitioning from children to adult services
- Improve Mortality Reviews
- Improve policy and National Institute for Health and Care Excellence (NICE) guidance compliance

Of the remaining five, any required actions to continue implementation or improve performance will be detailed in the quality account (to be published later in the year) and overseen by the Quality Committee.

Our HSMR and SHMI have steadily increased during the year, with both being 117 at year end. This has been a significant area of focus for the Trust with ongoing work, including external reviews and peer reviews, taking place. Further work continues into the new financial year with close focus on ensuring the right care processes are in place and that activity has been counted properly.

The Trust's 62-day cancer position for Quarters 1, 2 and 3 was below the national 85% standard which prompted commencement of a formal cancer improvement programme. At year end, the Trust's performance stood at 69.3%, having deteriorated from an in-month performance in January 2020, prior to the effects of COVID-19, of 81%.

Referral To Treatment (RTT) performance deteriorated in March 2020 due to the cancellation of elective activity to create capacity for COVID-19 patients, and minimise risk to staff and patients. At year end, there were only three specialities meeting the RTT standard with the remaining having experienced a significant decline.

The Trust continued to face challenges in consistently meeting A&E targets, with increases in the percentage of ambulance waits over 60 minutes compared to the previous year (2.73% in 2018/19 compared to 6.23% in 2019/20) and patients having to sometimes wait long periods prior to being taken to the appropriate ward for further care. Much work has been undertaken to improve the situation including recruitment of additional clinicians, consideration of new methods of working, and engaging with external agencies such as ECIST and NHS Improvement academy with signs of improvement evident in the second half of Quarter 4.

Workforce:

We have worked extremely hard to redesign, support and retain our workforce, whilst also recruiting to vacant posts in order to reduce agency spending. Consultant recruitment has been steady during the year resulting in an establishment of 171.27 WTE consultants. Whilst the year out-turn showed a reduction in agency expenditure at £11,216K against a forecast of £11,238K, further controls have been implemented since year end. These include the complete removal of the use of higher cost agencies and the introduction of new weekly internal control meetings led by an executive director.

Financial Sustainability:

In another financially challenging year for the Trust, and following a quarter 4 deterioration, the Trust delivered £4,919K deficit against a planned break even position for 2019/20. However, as a result of the South Yorkshire & Bassetlaw Integrated Care System being in aggregate balance, the Trust received additional non-recurrent Financial Recovery Fund monies to clear the deficit, resulting in a surplus of £9K.

By year end, the Trust's clinical income was adverse to plan with a full year deficit of £239K. Full year outturn of pay costs was adverse to plan by £5,310K with almost 47% of the M12 cost linked to nursing and nursing support staff. Additional expenditure during the year on additional bed capacity (+£1m), delivery of a cost improvement programme resulting in a below plan position of £856K, and an overspend in capital expenditure that transpired in M12, led the Trust to commission an independent review of financial governance during Q1 2020/21 and increase monitoring of financial matters and financial controls.

COVID-19 led to national suspension of usual NHS planning processes for an initial period of the first four months of the new financial year 2020/21. 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.

Future Risks

Potential risks that could affect the Trust achieving its objectives in 2020/21 are similar to those from previous years:

- Standards and quality of care are not achieved;
- Performance against A&E and other access standards;
- The Trust not meeting its financial targets and the financial requirements of the ICS.
- Workforce recruitment, retention and potentially, capacity.

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 reports 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.

All executive directors report to me and the performance of the executive team is held to account through team and individual objectives, which reflect the Board objectives.

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 allocation of a segment 3 sector rating by NHSI in October 2016, reflects the regulatory position.

The Board of Directors, as required under NHS Foundation Trust condition 4(8)(b) assures 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.

Operationally, risk management is delegated through the Risk Management Committee, 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 I chair, include a standing item to consider any new organisational risks scoring 15 and above.

The Risk Management Committee 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.

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

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

Workforce

The Board of Directors and Board Committees (Quality, Finance & Performance and People) receive regular reports detailing the staffing arrangements in place to provide assurance in respect of safety, sustainability and effectiveness. The reports detail areas of risk and mitigation strategies in relation to workforce. Workforce assurance is also provided through the Board Committees in respect of key workforce metrics, e.g. establishment data, sickness absence and turnover. The Board has also approved a 'Workforce Plan' which has a key objective to support and enable Clinical Divisions and Corporate Services to develop robust workforce planning strategies. In accordance with the recommendations of 'Developing Workforce Safeguards' the Trust will use a triangulated approach to maintaining assurance around workforce strategies and safe staffing systems. This approach will include utilising evidence based tools, e.g. establishment reviews, roster information together with professional judgement and patient outcome measures. The Nursing and Medical Directors will provide a statement to the Board detailing the outcome of this evidence based approach.

The Foundation Trust is not fully compliant with the registration requirements of the Care Quality Commission, and its current registration status is 'Registered with Conditions'. In October 2018, the Care Quality Commission served a condition on the Trust registration relating to mitigation of the risks within the Urgent and Emergency Care Centre paediatric area with a focus on medical and nursing staffing levels.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

As an employer 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.

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

The Foundation 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.

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 the monthly finance 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, divisional reviews are presented to the FPC to ensure that a sufficient degree of assurance is obtained.

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 and going concern 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.

The Trust underwent a Use of Resources Assessment, led by NHS Improvement, in September 2018, the outcome of which was rated as 'requires improvement'. Due to the COVID-19 pandemic, the Trust's scheduled review, which was planned for April 2020, was postponed.

Information governance

The Trust has an established process for managing the Information Governance agenda, led by the SIRO, the Medical Director as Caldicott Guardian, and supported by the Data Protection Officer.

The Information Governance Committee is responsible for monitoring and controlling risks relating to data security. The Information Governance Committee escalates breaches and any arising risks to the Audit Committee (formally through the Trust Management Committee). All Information Governance security related incidents were reported via the Data Security and Protection Incident Reporting tool.

One incident was reported during the financial year involving personal data, which was disclosed due to human error. The ICO determined that no further action was required by the Trust and no action was taken against it.

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), was carried out in Q2 2019/20, 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 'inadequate' to 'robust'.

The process supports the Data Protection and Security Toolkit assertion 1.7 and was 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.

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 NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee [and risk/ clinical governance/ quality committee, if appropriate] and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The key considerations of my review of the effectiveness of the system of internal control can be summarised as follows:

- 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 Risk Management Committee has overseen the effectiveness of all the Trust's risk management arrangements including the on-going development of the Trust's risk register.
- A clinical audit programme is in place and is overseen by the Clinical Effectiveness and Research Group, with details appearing in the Trust's Quality Account, to be published later in the year.
- 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 also has a key role 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 BAF.
- Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan for 2019/20 approved by the Audit Committee. This work included identifying and evaluating 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 a higher level of assurance than the previous year.

The Head of Internal Audit Opinion for 2019/20 is produced below: "I am providing an opinion of **moderate assurance** that there is a generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk.

In providing our opinion we consider three areas:
- Board Assurance Framework and strategic risk management
- Internal audit plan out-turn
- Follow up of internal audit actions

Board Assurance Framework (BAF) and strategic risk management: moderate assurance. We raised some high risk actions in our Stage 1 review in November 2019; these were acted upon and progressed in quarter 4.

Internal audit plan outturn: limited assurance. We have issued a number of core reviews with a limited assurance opinion. Risk-based reviews have also led to a range of significant issues being raised.

Follow up of actions: significant assurance. The Trust has implemented 80% of actions in line with original timeframes.

This Opinion should be taken in its entirety for the Annual Governance Statement and any other purpose for which it is repeated."

In addition, I gain assurance from the following third party sources:
- reports from the internal and external auditors and the local counter fraud specialist
- national patient surveys
- service accreditations
- JAG* and GIRFT** inspections
- Royal College / Deanery visits
- Annual NHS Staff Survey
- Outcomes of external Well Led reviews and CQC Inspections

Conclusion

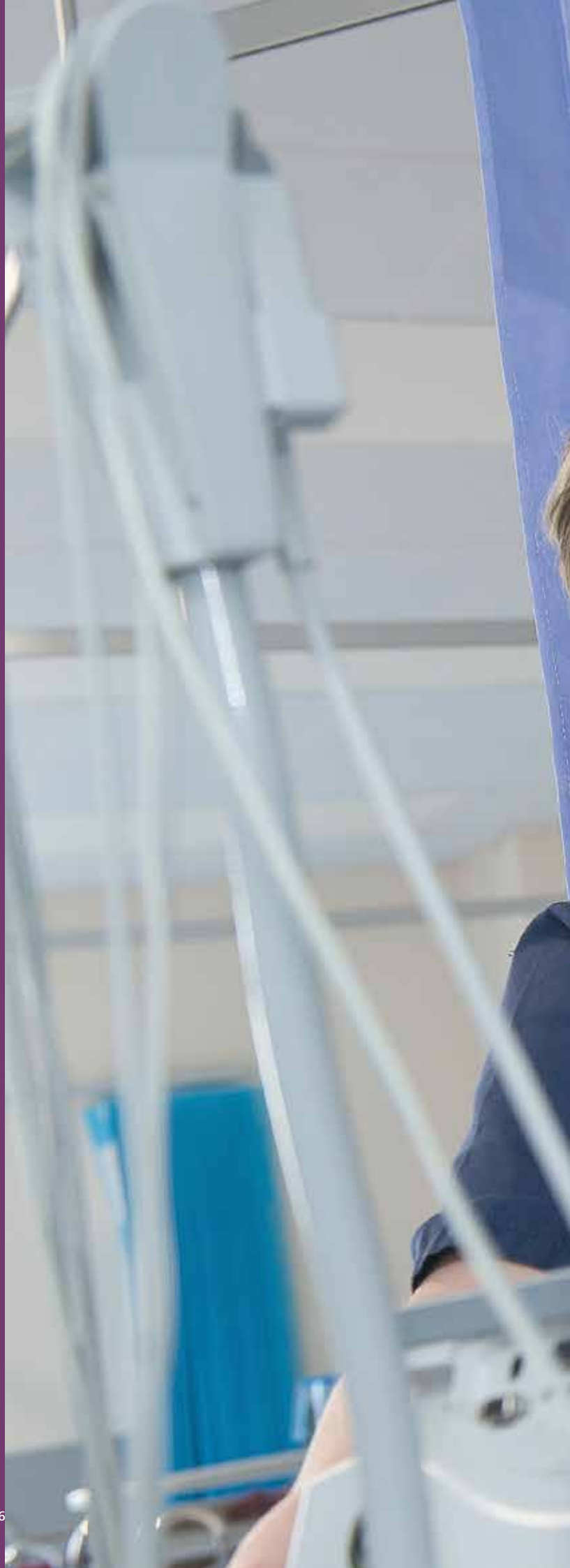
Having joined the Trust only 6 weeks before year end, the task of having to identify whether there are significant internal control issues in the organisation is based on the information that has been made available to me, the result of my own enquiries, engagement with external parties such as those mentioned above, and reliance upon the existing assurance framework and control systems at The Rotherham NHS Foundation Trust.

Acknowledging that there are areas for improvement, for which mitigating actions have been put in place, I confirm that there are no internal control issues that I consider significant.

R. Jenkins

Dr Richard Jenkins
Interim Chief Executive
02 June 2020

*Joint Advisory Group on Gastrointestinal Endoscopy
**Getting It Right First Time



Annual Accounts 2019/20

The Rotherham NHS Foundation Trust

Annual Accounts for the year ended 31 March 2020

Foreword to the accounts

The Rotherham NHS Foundation Trust

These accounts, for the year ended 31 March 2020, 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.

The Accounts of The Rotherham NHS Foundation Trust for the period ending 31 March 2020 follow. The four primary statements: the Statement of Comprehensive Income (SOCI); the Statement of Financial Position (SOFP); the Statement of Changes in Taxpayers' Equity (SOCITE) and the Statement of Cashflows (SCF) are presented first. These are followed by the supporting notes to the accounts.

Note 1 outlines the Foundation Trust's accounting policies. Subsequent notes provide further detail on the four primary statements and are cross referenced accordingly.

The financial statements (Accounts) were approved by the Board on 02 June 2020 and signed on its behalf by:

Signed .....

Name **Dr Richard Jenkins**
Job title **Interim Chief Executive**
Date **02 June 2020**

Statement of Comprehensive Income for year ending 31 March 2020

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	**242,465**	228,870
Other operating income	4	**46,149**	24,669
Total operating income from continuing operations		**288,614**	253,539
Operating expenses	5.1	**(285,195)**	(270,238)
Operating surplus/(deficit) from continuing operations		**3,419**	(16,699)
Finance income	10	**80**	64
Finance expenses	11	**(2,639)**	(2,257)
PDC dividends payable		**(832)**	(1,260)
Net finance costs		**(3,391)**	(3,453)
Gains/(losses) of disposal of non-current assets		**(19)**	(55)
Surplus/(deficit) for the year from continuing operations		**9**	(20,207)
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	12	**-**	225
Surplus/(deficit) for the year		**9**	(19,982)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations and impairments of property, plant and equipment	16	**11**	-
Other reserve movements		**2**	-
Total comprehensive income/(expense) for the period		**22**	(19,982)
Allocation of profits / (losses) for the period:			
Surplus/(deficit) for the year attributable to the Foundation Trust		**9**	(19,982)
Total comprehensive income (expense) for the year attributable to the Foundation Trust.		**22**	(19,982)

Statement of Financial Position as at 31 March 2020

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	13	**8,927**	9,333
Property, plant and equipment	14	**122,300**	120,179
Trade and other receivables	22	**54**	17
Total non-current assets		**131,281**	129,529
Current assets			
Inventories	21	**3,992**	3,577
Trade and other receivables	22	**26,002**	13,888
Cash and cash equivalents	23	**1,367**	1,461
Total current assets		**31,361**	18,926
Current liabilities			
Trade and other payables	24	**(27,911)**	(23,696)
Borrowings	27	**(59,455)**	(5,743)
Provisions	30	**(196)**	(568)
Other liabilities	26	**(1,425)**	(1,353)
Total current liabilities		**(88,987)**	(31,360)
Total assets less current liabilities		**73,655**	117,095
Non-current liabilities			
Borrowings	27	**(29,015)**	(75,780)
Provisions	30	**(986)**	(912)
Total non-current liabilities		**(30,001)**	(76,692)
Total assets employed		**43,654**	40,403
Financed by			
Public dividend capital		**80,038**	76,808
Revaluation reserve		**41,676**	43,136
Income and expenditure reserve		**(78,060)**	(79,541)
Total taxpayers' equity		**43,654**	40,403

The following notes 1 - 36 form part of these accounts.

Signed Richard Jenkins .....

Name **Dr Richard Jenkins**
Position **Interim Chief Executive**
Date **02 June 2020**

Statement of Changes in Taxpayer's Equity for the year ended 31 March 2020

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	76,809	43,136	(79,541)	**40,403**
Surplus/(deficit) for the year			9	**9**
Transfers between reserves		(1,472)	1,472	**-**
Revaluations - PPE		11		**11**
Public dividend capital received	3,229			**3,229**
Other reserve movements	-	1	1	**2**
Taxpayers' and others' equity at 31 March 2020	**80,038**	**41,676**	**(78,060)**	**43,654**

**See additional information on reserves below this table.*

Statement of Changes in Taxpayer's Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	73,403	32,945	(49,368)	56,980
Surplus/(deficit) for the year			(19,982)	(19,982)
Other transfers between reserves		10,191	(10,191)	-
Public dividend capital received	3,406			3,406
Taxpayers' and others' equity at 31 March 2019	76,809	43,136	(79,541)	40,404

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 trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation 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.

At the last trust valuation at 31st March 2018 the trust componentised its asset base. From 1st April 2018 all revaluation reserve balances are recognised at component level.

A review of the indexation movements in asset valuations since the last formal valuation concluded that the Net Book Value of assets held on the Trust's asset register are not materially different from the value they would have held if indexation had been applied. Formal Valuations are conducted every 5 years, with desktop valuations in the interim as required.

The revaluation reserve is reduced each year by an appropriate amount (to the I&E reserve) per the Trust's depreciation policy to 'realise' the gain and reduce the revaluation reserve for each asset to zero by the end of the asset's life.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust, including realised gain transfers from the Revaluation reserve.

Statement of Cash Flows For the Year Ended 31 March 2020

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus/(deficit) (including discontinued operations)		**3,419**	(16,474)
Non-cash income and expense:			
Depreciation and amortisation	5.1	**7,621**	7,115
Impairments and reversals	6	**-**	-
(Increase)/decrease in trade and other receivables		**(11,983)**	(2,355)
(Increase)/decrease in inventories		**(415)**	75
Increase/(decrease) in trade and other payables		**3,065**	1,697
Increase/(decrease) in other liabilities		**72**	129
Increase/(decrease) in provisions		**(293)**	314
Other movements in operating cash flows		**2**	-
Net cash generated from/(used in) operating activities		**1,488**	(9,499)
Cash flows from investing activities			
Interest received		**80**	64
Purchase and sale of financial assets		**-**	-
Purchase of intangible assets		**(806)**	(772)
Sales of intangible assets		**-**	-
Purchase of property, plant, equipment and investment property		**(6,613)**	(6,261)
Sales of property, plant, equipment and investment property		**12**	-
Net cash generated from/(used in) investing activities		**(7,327)**	(6,969)
Cash flows from financing activities			
Public dividend capital received		**3,229**	3,406
Public dividend capital repaid		**-**	-
Movement on loans from the Department of Health		**6,497**	16,908
Movement on other loans		**-**	-
Other capital receipts		**-**	-
Capital element of finance lease rental payments		**(281)**	(126)
Capital element of PFI, LIFT and other service concession payments		**-**	-
Interest on loans		**(2,484)**	(1,948)
Interest element of finance lease		**(169)**	(154)
Interest element of PFI, LIFT and other service concession obligations		**-**	-
PDC dividend (paid)/refunded		**(1,047)**	(1,557)
Cash flows attributable to financing activities of discontinued operations		**-**	-
Cash flows from (used in) other financing activities		**-**	-
Net cash generated from/(used in) financing activities		**5,745**	16,529
Increase/(decrease) in cash and cash equivalents		**(94)**	61
Cash and cash equivalents at 1 April		**1,461**	1,400
Cash and cash equivalents at 31 March	23	**1,367**	1,461

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1.1 Accounting convention

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

1.1.2 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 has delivered a £4,960K deficit against a planned break even position for 2019/20. However, as a result of the South Yorkshire & Bassetlaw Integrated Care System being in aggregate balance, the Trust will receive additional non-recurrent Financial Recovery Fund monies to clear the deficit resulting in a surplus of £9K.

As a consequence, the Trust will achieve its annual control total and secure its Quarter 4 Provider Sustainability Fund/Financial Recovery Fund monies of £5,170K, which is already included within the deficit position referred to above.

Due to recent events concerning COVID-19, the financial planning process for 2020/21 has been suspended nationally and interim financial arrangements put in place, initially covering the period April to July 2020. Included within these financial arrangements are cash agreements with the providers' main commissioners to pay for services provided one month in advance, so that payments to suppliers can be made regularly and promptly. This will negate the need for any further temporary borrowing during this period to support working capital.

At this stage, it is unclear what will happen after this initial four months' period and whether these interim financial arrangements will continue longer than originally advised. However, it is clear that at some point there must be further arrangements put in place to transition back to business as usual, which must include provision for management of working capital and cash so that continuity of supplies can be maintained.

Having considered the material uncertainties and the Trust's financial plans, together with the likelihood of securing additional financial funding to support the financial operations, the directors have determined that it remains appropriate to prepare these accounts on a going concern basis. The accounts do not include any adjustments that would result if the Trust was unable to continue as a going concern.

Note 1.2 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.

1.2.1 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.

1.2.2 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 a professional valuation carried out at 31 March 2018, 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 1.3 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 1.4 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). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3(b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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 and
- the FReM 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 from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

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 1.5 Expenditure on Employee Benefits

1.5.1 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.

1.5.2 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. 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.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS body commits itself to the retirement, regardless of the method of payment.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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%, and the scheme Regulations were amended accordingly. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

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 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

1.7.1 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, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.7.2 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.

1.7.3 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.

1.7.4 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 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 the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.7.5 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'.

1.7.6 Impairments

In accordance with the DH 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.

1.7.7 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 i.e.:
  - 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.

1.7.8 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.

1.7.9 Useful Economic lives of property, plant and equipment

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	3	90
Plant & machinery	5	15
Transport equipment	7	9
Information technology	2	20
Furniture & fittings	10	10

Note 1.8 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 1.9 Intangible assets

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

1.9.2 Measurement

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

1.9.3 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”.

1.9.4 Amortisation

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

1.9.5 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Intangible assets - purchased		
Software	2	20

Note 1.10 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 1.11 Inventories

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

Note 1.12 Cash and cash equivalents

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

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

Note 1.13 Financial assets and financial liabilities

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.

Note 1.13.1 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.

Note 1.13.2 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.

Note 1.13.3 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.

Note 1.13.4 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 Department of Health and Social Care 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.

Note 1.13.5 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.

Note 1.13.6 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.

Note 1.13.7 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 1.14 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, plan 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 PFI assets are recognised as PPE when they come into use. The assets are measured initially at fair value, or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS17. Subsequently, the assets are measured at current value in existing use.
A liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the assets and is subsequently measured as a finance lease liability in accordance with IAS17.
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 meat the annual finance cost and to repay the lease liability over the contract term.
The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

3. ***payment for the replacement of components of the asset during the contract 'lifecycle replacement'*** - Components of the asset replaced by the operator during the contract (lifecycle replacement) are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalise at the time they are provided by the operator and are measured initially at cost.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined 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 PPE in the Trust's SoFP.

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.

Alternative wording applies for PFI assets funded principally by third party usage.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation 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 -0.5% (2018/19 +0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the SoFP date:

A nominal short-term rate of +0.51% (2018/19 +0.76%) for inflation adjusted expected cash flows up to and including 5 years from SoFP date.

A nominal medium-term rate of +0.55% (2018/19 +1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the SoFP date.

A nominal long-term rate of +1.99%(2018/19 +1.99%) for inflation adjusted expected cash flows exceeding 40 years from the SoFP date.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 31 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 31, 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; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 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's 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 requirement 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 (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (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. The PDC dividend calculation is based upon the Trust's group accounts (i.e. including subsidiaries), but excluding consolidated charitable funds.

Note 1.18 Value added tax

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

Note 1.19 Corporation tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of Income and Capital Gains within categories covered by this but the Trust is potentially within the scope of Corporation Tax in respect of activities where income is received from a Non Public Sector source.

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

Note 1.20 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 income and expenditure”) are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.21 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 1.22 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 1.23 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 1.24 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 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.26 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 2019/20. 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 2021 as adapted and interpreted by the FReM.
 IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1st January 2021, 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 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 2021. 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 2021, 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 1.27% 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 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation. In assessing the impact of standard wef 1 April 2020, the Trust expected there to be:

- a reduction in operating lease costs reported in operating expenditure of c. £2.1m
- an increase in depreciation costs reported in operating expenditure of c. £2.5m
- an increase in finance costs reported on SOCI of c. £0.06m
- an increase in Right of Use Assets reported on SOFP in the value of c. £4.0m, with a corresponding long term finance lease payable.

These calculations assumed use of the discount rate of 1.27% for transferring leases. These calculations give an indication of the likely impact, but will now be revised in light of the deferral and therefore will change.

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 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 graphical line charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Likewise only total balance sheet positions and cash flow forecasts are considered for the whole Trust. The Board of Directors as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

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

	Healthcare		**Total**	
	2019/20 £000	2018/19 £000	**2019/20 £000**	2018/19 £000
Income	**288,614**	257,201	**288,614**	257,201
Retained Earnings / (Accumulated Deficit)	**9**	(19,982)	**9**	(19,982)
Segment net assets	**43,654**	40,403	**43,654**	40,403

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2019/20	2018/19
	£000	£000
Acute services		
Elective income	**33,938**	33,703
Non elective income	**61,985**	61,316
First outpatient income	**17,454**	17,057
Follow up outpatient income	**15,777**	14,610
A & E income	**12,911**	11,237
High cost drugs income from commissioners	**10,833**	11,262
Other NHS clinical income	**36,611**	33,480
Community services		
Community services income from CCGs and NHS England	**42,303**	43,695
Community services income from other commissioners	**2,080**	1,852
All services		
Agenda for Change pay award central funding*	**-**	2,656
Additional pensions contribution central funding	**7,646**	-
Other clinical income**	**927**	1,189
Total income from activities	**242,465**	232,057

(See footnotes under 3.2 below)

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2019/20 £000**	2018/19 £000
NHS England*	**28,797**	19,653
CCGs	**201,915**	198,609
Department of Health & Social Care**	**-**	2,656
Other NHS foundation trusts	**251**	-
NHS trusts	**4**	(30)
NHS other	**70**	156
Local authorities	**10,487**	9,585
Non-NHS: overseas patients (chargeable to patient)	**87**	23
NHS Injury Cost Recovery scheme**	**776**	981
Non NHS: other***	**78**	424
Total income from activities	**242,465**	232,057
Of which:		
Related to continuing operations	***242,465***	*228,870*
Related to discontinued operations	**-**	*3,187*

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers 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.*

***Additional Agenda for Change pay award funding of £2.656m was received in 2018/19 separately to contract income to fund the implementation of a new Agenda for Change pay structure for all NHS staff. In 2018/19 the impact of pay changes will be built into NHS tariff prices and this separate disclosure line will not be required.*

****NHS injury scheme income is subject to an allowance for impaired contract receivables. The suggested rate is 21.79% in 2019/20 (21.89% in 2018/19) to reflect expected rates of collection. However, where NHS Providers can make an estimate based on their own local information, this rate can be varied accordingly.*

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

	2019/20	2018/19
	£000	£000
Income recognised this year	**87**	23
Cash payments received in-year	**3**	10
Amounts added to provision for impairment of receivables	**53**	15

There was no Overseas Visitors income written off in year (2018/19 £0).

Note 4 Other operating income

Note 4.1 Other operating income by nature

	2019/20	2018/19
	£000	£000
Research and development	**286**	486
Education and training	**9,483**	8,826
Education and training - notional income from Apprenticeship fund	**451**	251
Charitable and other contributions to expenditure	**5**	5
Non-patient care services to other bodies	**8,049**	9,116
Provider Sustainability Fund / Financial Recovery Fund income*	**21,175**	141
Rental revenue from operating leases	**555**	680
Income in respect of staff costs where accounted on gross basis	**2,051**	1,528
Other income	**4,094**	4,111
Total other operating income	**46,149**	25,144
Of which:		
Related to continuing operations	***46,149***	*24,669*
Related to discontinued operations	**-**	*475*

Further analysis of other Operating Revenue - 'Other income'

Car Parking	**1,327**	1,193
Estates Recharges (external)	**241**	316
IT Recharges (external)	**386**	457
Pharmacy Sales	**245**	331
Clinical Tests	**675**	835
Catering	**-**	2
Staff Accommodation Rentals	**524**	501
Staff Contributions to Employee Benefit Schemes	**443**	405
Property Rentals	**61**	70
Other income not already covered	**192**	1
	4,094	4,111

**An increase in Provider Sustainability Fund and Financial Recovery Fund income was received by the Trust in 2019/20, as part of national central support to move towards a breakeven position.*

Note 4.2 Additional information on revenue from contracts with customers

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,353	1,224
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 4.3 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 4.4 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 2019/20 The Rotherham NHS Foundation Trust had no fees or charges where the scheme individually resulted in income from that service exceeding £1,000k.

Note 4.5 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:

	2019/20	2018/19
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	**241,538**	230,868
Income from services not designated as commissioner requested services	**47,076**	26,333
Total	**288,614**	257,201

Note 4.6 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. The Trust has disposed of equipment assets with a loss on disposal of £19,000. This disposal will not impact the Trust's ability to continue to meet its obligations to provide commissioner requested services, and was part of an annual equipment replacement programme.

Note 5.1 Operating expenses

	2019/20	2018/19
Purchase of Healthcare	**£000**	£000
Purchase of healthcare from non NHS bodies	**1,088**	-
Staff Costs		
Employee expenses - staff and executive directors	**200,161**	185,242
Research and development - staff costs	**320**	259
Remuneration of non-executive directors	**182**	180
Redundancy	**-**	58
Premises and Establishment		
Premises	**10,442**	11,723
Premises (Business rates)	**1,218**	1,181
Establishment	**1,773**	1,922
Rentals under operating leases	**2,511**	3,782
Transport (business travel only)	**667**	812
Transport - other (including patient travel)	**2,045**	904
Depreciation on property, plant and equipment	**6,287**	5,931
Amortisation on intangible assets	**1,334**	1,184
Supplies		
Supplies and services - clinical	**25,418**	26,715
Supplies and services - general	**4,148**	4,168
Drug costs	**16,839**	17,296
Inventories written down	**17**	15
Other Costs		
Clinical negligence	**7,041**	7,548
Consultancy costs	**208**	821
Research and development	**8**	56
Increase/(decrease) in credit loss allowance: contract receivables/assets	**(372)**	280
Increase/(decrease) in credit loss allowance: all other receivables	**(1)**	5
Change in provisions discount rate(s)	**39**	12
Audit fees payable to the external auditor		
audit services - statutory audit	**84**	89
other auditor remuneration (external auditor only - quality account)	**5**	10
Legal fees	**104**	101
Internal audit costs	**91**	88
Training, courses and conferences	**406**	404
Education & Training - notional expenditure from Apprenticeship Levy Fund	**451**	251
Insurance	**217**	218
Other services, eg external payroll	**1,624**	1,121
Losses, ex gratia & special payments	**119**	141
Other	**721**	1,158
Total	**285,195**	273,675
Of which:		
Related to continuing operations	***285,195***	*270,238*
Related to discontinued operations	**-**	*3,437*

Note 5.2 Other auditor remuneration

The Council of Governors appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust for the 3 year period commencing 1 October 2016, with the option to extend for a further two years commencing 1 April 2019. The contract has been extended per this option for 2019/20. The audit fee for the statutory audit is included in note 5.1.

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	**5**	10
Total	**5**	10

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1000k (2018/19: £1000k).

Note 6 Impairment of assets

In 2018/19 and 2019/20 the Rotherham NHS Foundation Trust reviewed its property assets against the relevant in year indexation to assess that the valuation undertaken as at 31st March 2018 still represents a fair view of the value of the assets. This exercise demonstrated that, had indexation been applied to opening values, the closing values at 31st March 2020 would not be materially different from those recorded in the Trust's books. Therefore, no revaluation adjustments are recognised in year. (2018/19 £0).

Note 7 Employee benefits

	2019/20	2018/19
	£000	£000
Salaries and wages	**150,632**	145,141
Social security costs	**14,651**	14,045
Apprentice Levy	**718**	686
Employer's contributions to NHS pensions	**17,445**	16,739
Employer's contributions to NHS pensions (Paid by NHSE on providers behalf (6.3%))	**7,646**	-
Pension cost - other	**83**	46
Termination benefits	**-**	58
Temporary staff - external bank	**3,124**	-
Temporary staff - agency/contract	**6,706**	9,076
Total gross staff costs	**201,005**	185,791
Recoveries in respect of seconded staff netted off expenditure	**-**	-
Total staff costs	**201,005**	185,791
Of which		
Costs capitalised as part of assets	*524*	*232*
Operating expenditure analysed as:		
Employee expenses - staff and executive directors	**200,161**	185,242
Research and Development	**320**	259
Redundancy	**-**	58
Total staff costs excluding capitalised costs.	**200,481**	185,559

Note 7.1 Retirements due to ill-health

During 2019/20 there were no early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £0k (£132k in 2018/19).

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

Note 7.2 Directors' remuneration and other benefits

The requirements under section 412 of the Companies Act 2006 to disclose 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 set out here.

In 2019/20 no advances or credits 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 8 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. Pension costs for defined contribution schemes are disclosed in Note 7.

Note 9 Operating leases

Note 9.1 The Rotherham NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor. The Trust has a lease agreement with Rotherham, Doncaster & South Humber NHS FT for use at Woodlands which expires in 2108. Future lease receipts due at 31st March therefore capture this future commitment among others.

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	**555**	680
Total	**555**	680

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	**481**	482
- later than one year and not later than five years;	**1,671**	1,672
- later than five years.	**6,140**	6,364
Total	**8,292**	8,518

Note 9.2 The Trust as a lessee

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

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	**2,511**	3,782
Total	**2,511**	3,782

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**2,071**	3,651
- later than one year and not later than five years;	**6,474**	1,116
- later than five years.	**123**	135
Total	**8,668**	4,902

Note 10 Finance income

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

	2019/20 £000	2018/19 £000
Interest on bank accounts	**79**	63
Interest on loans and receivables	**1**	1
Total	**80**	64

Note 11 Finance Expense

Note 11.1 Loans and interest

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

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health	**2,475**	2,100
Finance leases	**169**	154
Total interest expense	**2,644**	2,254
Unwinding of discount on provisions	**(5)**	3
Total	**2,639**	2,257

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2019/20 £000	2018/19 £000
Amounts included within interest payable arising from claims made under this legislation	**-**	-

Note 12 Discontinued Operations

No services were discontinued in 2019/20.

The Rotherham Equipment and Wheelchair Service was transferred to a new provider on 1st February 2019. The Dental Access Service was similarly transferred to a new provider with effect from 1st April 2019 and both are therefore classified as discontinued operations at 31st March 2019. This note discloses the total income and expenditure attributable to these services in 2018/19.

	2019/20 £000	2018/19 £000
Operating income of discontinued operations	**-**	3,662
Operating expenses of discontinued operations	**-**	(3,437)
Total	**-**	**225**

Note 13 Intangible Assets

Note 13.1 Intangible assets - 2019/20

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/Gross cost at 1 April 2019 - brought forward	**17,769**	**318**	**18,087**
Additions	**928**	-	**928**
Reclassifications	318	(318)	**-**
Disposals / derecognition	**(25)**	**-**	**(25)**
Gross cost at 31 March 2020	**18,990**	**-**	**18,990**
Amortisation at 1 April 2019 - brought forward	8,754	-	8,754
Provided during the year	1,334	-	1,334
Disposals / derecognition	(25)	-	(25)
Amortisation at 31 March 2020	**10,063**	**-**	**10,063**
Net book value at 31 March 2020	**8,927**	**-**	**8,927**
Net book value at 1 April 2019	**9,015**	**318**	**9,333**

Note 13.2 Intangible assets - 2018/19

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2018 - as previously stated	20,160	318	20,478
Additions	772	-	772
Disposals / derecognition	(3,163)	-	(3,163)
Valuation/gross cost at 31 March 2019	17,769	318	18,087
Amortisation at 1 April 2018 - as previously stated	10,732	-	10,732
Provided during the year	1,184	-	1,184
Disposals / derecognition	(3,162)	-	(3,162)
Amortisation at 31 March 2019	8,754	-	8,754
Net book value at 31 March 2019	9,015	318	9,333
Net book value at 1 April 2018	9,428	318	9,746

Note 14.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**6,450**	**109,367**	**-**	**18,898**	**216**	**4,973**	**382**	**140,286**
Additions	-	1,684	4,556	1,646	1	520	21	**8,428**
Revaluations	-	(108)	-	-	-	-	-	**(108)**
Disposals / derecognition	-	-	-	(479)	-	-	-	**(479)**
Valuation/gross cost at 31 March 2020	**6,450**	**110,943**	**4,556**	**20,065**	**217**	**5,493**	**403**	**148,127**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**5,030**	**-**	**12,684**	**201**	**2,138**	**54**	**20,107**
Provided during the year	-	4,438	-	1,099	8	703	39	**6,287**
Revaluations	-	(119)	-	-	-	-	-	**(119)**
Disposals/ derecognition	-	-	-	(448)	-	-	-	**(448)**
Accumulated depreciation at 31 March 2020	**-**	**9,349**	**-**	**13,335**	**209**	**2,841**	**93**	**25,827**
Net book value at 31 March 2020	**6,450**	**101,594**	**4,556**	**6,730**	**8**	**2,652**	**310**	**122,300**
Net book value at 1 April 2019	**6,450**	**104,337**	**-**	**6,214**	**15**	**2,835**	**328**	**120,179**

Contractual capital commitments not otherwise disclosed in the Accounts are disclosed in Note 32.

Note 14.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - as previously stated	6,450	105,476	-	25,905	216	5,028	180	143,255
Additions	-	3,891	-	1,627	-	1,720	202	7,440
Disposals / derecognition	-	-	-	(8,634)	-	(1,775)	-	(10,409)
Valuation/gross cost at 31 March 2019	6,450	109,367	-	18,898	216	4,973	382	140,286
Accumulated depreciation at 1 April 2018 - as previously stated	-	750	-	20,169	187	3,388	36	24,530
Provided during the year	-	4,280	-	1,094	14	525	18	5,931
Disposals / derecognition	-	-	-	(8,579)	-	(1,775)	-	(10,354)
Accumulated depreciation at 31 March 2019	-	5,030	-	12,684	201	2,138	54	20,107
Net book value at 31 March 2019	6,450	104,337	-	6,214	15	2,835	328	120,179
Net book value at 1 April 2018	6,450	104,726	-	5,736	29	1,640	144	118,725

Contractual capital commitments not otherwise disclosed in the Accounts are disclosed in Note 32.

Note 14.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned	6,300	98,598	4,556	5,202	8	2,652	310	**117,626**
Finance leased	150	2,304	-	1,477	-	-	-	**3,931**
Donated	-	692	-	51	-	-	-	**743**
NBV total at 31 March 2020	**6,450**	**101,594**	**4,556**	**6,730**	**8**	**2,652**	**310**	**122,300**

Note 14.4 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned	6,300	101,208	-	5,232	15	2,835	328	115,918
Finance leased	150	2,408	-	919	-	-	-	3,477
Donated	-	721	-	63	-	-	-	784
NBV total at 31 March 2019	6,450	104,337	-	6,214	15	2,835	328	120,179

Note 15 Donations of property, plant and equipment

The Rotherham NHS Foundation Trust has received no new donations of property, plant and equipment in the financial year.

Note 16 Revaluations and impairments of property, plant and equipment

During 2017/18 and in line with IAS16, the Trust's land and buildings were revalued as at 31st March 2018 by an independent valuer. Between valuations, management review and asset verification exercises are undertaken to assess the need for impairments.

The last 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.

In order to meet the underlying objectives established by International Financial Reporting Standards and the application of IAS 16 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, we have continued to assume that the modern equivalent asset does not require a site as extensive as the actual Rotherham Hospital site. We have 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.

We applied the published market indices in use in March 2020 to ascertain if the total value of assets on our Statement of Financial Position materially reflected changes in the market since the last valuation. We concluded that there was materially no difference, and therefore no valuation changes were made at 31st March 2020.

In making these judgements, the Trust is aware that the Royal Institute of Chartered Surveyors (RICS) has issued a valuation practice notive which gives guidance to valuers where a valuer declares a material uncertainty attached to a valuation in light of the impact of COVID-19 on markets. As explained above, the Trust has not obtained a valuation report for 2019/20 but is should be noted that there may now be greater uncertainty in markets on which the valuation obtained in March 2018 and reflected in these financial statements is based. Given the judgements explained above in preparing these 2019/20 financial statements, the Trust has not deviated from its existing accounting policy by obtaining an additional valuation to which a material uncertainty might be attached.

The valuation of Rotherham Hospital site, on a modern equivalent asset approach, involves the valuer basing their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

It is possible that the COVID-19 pandemic may affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient evidence to affect the assumptions used in the last valuation.

Note 17 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 the former staff residencies.

Note 18 Investments in associates and joint ventures

In 2019/20 The Rotherham NHS Foundation Trust have no investments in associates and joint ventures.

Note 19 Other investments / financial assets (non-current)

In 2019/20 The Rotherham NHS Foundation Trust has no other investments or financial assets.

Note 20 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.

	31 March 2020 £000	31 March 2019 £000
Total incoming resources	**137**	164
Resources expended	**(183)**	(140)
(Losses)/Gains on revaluation and disposals	**(26)**	2
Net movement in funds	**(72)**	26
Total Assets	**319**	394
Total Liabilities	**(3)**	(6)
Total Charitable Funds	**316**	388
Total funds made up of:		
- Restricted /endowment funds	**258**	222
- Unrestricted funds	**58**	166

The 2019/20 Charitable Funds accounts have not yet been subject to independent review. The 2018/19 Charitable Funds accounts were audited and finalised in Dec 19.

Note 21 Inventories

	Drugs £000	**Consumables £000**	**Energy £000**	**Total £000**
Carrying value at 1 April 2019	**861**	**2,667**	**49**	**3,577**
Additions	15,683	11,543	23	**27,249**
Consumed	(15,493)	(11,298)	(26)	**(26,817)**
Write-downs	(17)	-	-	**(17)**
Carrying value at 31 March 2020	**1,034**	**2,912**	**46**	**3,992**
Carrying value at 1 April 2018	822	2,720	110	3,652
Additions	14,353	12,153	42	26,548
Consumed	(14,299)	(12,206)	(103)	(26,608)
Write-downs	(15)	-	-	(15)
Carrying value at 31 March 2019	861	2,667	49	3,577

Note 22.1 Trade and other receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables due from NHS bodies (invoiced)	**3,440**	2,862
Contract receivables due from related WGA parties (invoiced)	**1,372**	414
Contract receivables due from non-WGA bodies (invoiced)	**2,144**	2,253
Contract receivables (IFRS15) not yet invoiced	**16,021**	5,441
Allowance for impaired contract receivables / assets	**(498)**	(873)
Allowance for impaired other receivables	**(19)**	(25)
Deposits and Advances	**96**	48
Prepayments (non-PFI)	**2,731**	2,851
PDC dividend receivable	**168**	-
VAT receivable	**460**	403
Other receivables	**87**	514
Total current trade and other receivables	**26,002**	13,888
Non-current		
Other receivables	**54**	17
Total non-current trade and other receivables	**54**	17

Note 22.2 Allowances for credit losses (doubtful debts)

2019/20	*Contract Receivables* £000	*All other receivables* £000	Total £000
Allowances for credit losses at 1 April - brought forward (before IFRS 9 and IFRS 15 implementation)	873	25	**898**
New allowances arising	171	3	**174**
Changes in calculation of existing allowances	(393)	-	**(393)**
Reversals of allowances (where receivable is collected in-year)	(150)	(4)	**(154)**
Utilisation of allowances (where receivable is written off)	(3)	(5)	**(8)**
At 31 March 2020	498	19	**517**
Loss/(gain) recognised in expenditure	(372)	(1)	**(373)**
2018/19			
Allowances for credit losses at 1 April - brought forward (before IFRS 9 and IFRS 15 implementation)		613	613
Impact of IFRS9 and IFRS15 implementation	593	(593)	-
New allowances arising	530	13	543
Changes in calculation of existing allowances	(16)	2	(14)
Reversals of allowances (where receivable is collected in-year)	(234)	(10)	(244)
At 31 March 2019	873	25	898
Loss/(gain) recognised in expenditure	280	5	285

The level of allowance for credit losses (doubtful debts) is based upon analysis of the type of debtors, the age of the debt and any specific intelligence relevant to individual debtors.

Note 23 Cash and cash equivalents

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.

	2019/20	2018/19
	£000	£000
At 1 April	**1,461**	1,400
Net change in year	**(94)**	61
At 31 March	**1,367**	1,461
Breakdown of cash and cash equivalents		
Cash at commercial banks and in hand	**160**	136
Cash with the Government Banking Service	**1,207**	1,325
Total cash and cash equivalents as in SoCF	**1,367**	1,461

The Trust's cash balances are largely held in the Government Banking Service Royal Bank of Scotland account and also a HSBC account, both of which are considered low risk institutions.

Note 23.1 Third party assets held by the Trust

At 31st March the Trust held less than £1k cash or cash equivalents which relate to monies held on behalf of patients or other parties.

Note 24 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
NHS Trade payables	**1,734**	2,963
Amounts due to other related parties	**1,108**	(16)
Other trade payables	**10,973**	7,309
Receipts in advance*	**-**	939
Capital payables	**1,856**	659
Social security costs	**2,025**	1,975
VAT payable	**73**	92
Other taxes payable	**1,587**	1,533
Other payables	**161**	-
Accruals	**8,394**	8,195
PDC dividend payable	**-**	47
Total current trade and other payables	**27,911**	**23,696**

The Trust held no non-current trade and other payables at the period end.

** Where income has been received in advance of service provision, the negative receivable is reclassified as a payable at the 31st March. In 2018/19 these related to activity with CCGs and NHSE.*

Note 25 Other financial liabilities

The Trust holds no other financial liabilities.

Note 26 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income	**1,425**	1,353
Total other current liabilities	**1,425**	1,353

The Trust held no non-current other liabilities at the period end.

Note 27 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from the Department of Health*	**59,202**	5,595
Obligations under finance leases	**253**	148
Total current borrowings	**59,455**	5,743
Non-current		
Loans from the Department of Health*	**25,250**	72,368
Obligations under finance leases	**3,765**	3,412
Total non-current borrowings	**29,015**	75,780

* 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 20/2021 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £31.806m as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 28 Finance Leases

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.
In year rentals associated with a long term lease for Park Rehabilitation Centre and six equipment leases are categorised as finance lease obligations. The assets are held on the Trust's balance sheet (SOFP).

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	**8,244**	7,897
of which liabilities are due:		
- not later than one year;	**421**	305
- later than one year and not later than five years;	**1,684**	1,221
- later than five years.	**6,139**	6,371
Finance charges allocated to future periods	**(4,226)**	(4,337)
Net lease liabilities	**4,018**	3,560
of which payable:		
- not later than one year;	**253**	148
- later than one year and not later than five years;	**1,100**	651
- later than five years.	**2,665**	2,761

No minimum sublease payments are to be received at the reporting date.
No contingent rent was recognised as an expense in the period.

Note 29 Reconciliation of liabilities from financing activities

	Loans from DHSC £000	**Finance Leases £000**	**Total £000**
Carrying value at 1 April 2019	77,963	3,560	**81,523**
Cash movements:			
Financing cash flows - payments and receipts of principal	6,497	(281)	**6,216**
Financing cash flows - payments of interest	(2,484)	(169)	**(2,653)**
Non-cash movements:			
Additions	-	739	**739**
Interest charge arising in year (application of effective interest rate)	2,476	169	**2,645**
Carrying value at 31 March 2020	**84,452**	**4,018**	**88,470**

Note 30 Provisions and Contingent Liabilities

Note 30.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Pensions - injury benefits*	Legal claims	Clinician pension tax reimbursement	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**530**	**457**	**109**	**-**	**384**	**1,480**
Change in discount rate	20	19	-	-	-	**39**
Arising during the year	49	46	70	52	33	**250**
Utilised during the year	(45)	(32)	(75)	-	(277)	**(429)**
Reversed unused	(30)	-	(16)	-	(107)	**(153)**
Unwinding of discount	(3)	(2)	-	-	-	**(5)**
At 31 March 2020	**521**	**488**	**88**	**52**	**33**	**1,182**
Expected timing of cash flows:						
- not later than one year;	44	31	88	-	33	**196**
- later than one year and not later than five years;	176	128	-	-	-	**304**
- later than five years.	301	329	-	52	-	**682**
Total	**521**	**488**	**88**	**52**	**33**	**1,182**

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.

No provision has been made for additional holiday pay that may be payable as a result of the Flowers case, on the basis that such a liability is unlikely to arise.

Note 30.2 Clinical negligence liabilities

At 31 March 2020, £69,524k is included in the provisions of NHS Resolution in respect of clinical negligence liabilities of The Rotherham NHS Foundation Trust (31 March 2019: £68,042k).

Note 31 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	**(26)**	(40)
Net value of contingent liabilities	**(26)**	(40)

The Trust held no contingent assets at the period end.

Note 32 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	**1,732**	803
Intangible assets	**-**	14
Total	**1,732**	817

Capital commitments as at 31 March 2020 include Measured Term Contract order commitments, new leases for medical equipment (£917k) and small capital schemes where costs are committed under contract, but which are not included elsewhere in the accounts.

Note 33 Financial instruments

Note 33.1 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 33.2 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 2020	*Held at Amortised Cost* **£000**	*Held at fair value through I&E* **£000**	*Held at fair value through OCI* **£000**	*Total* **£000**
Trade and other receivables excluding non financial assets	22,514			**22,514**
Cash and cash equivalents at bank and in hand	1,367			**1,367**
Total at 31 March 2020	**23,881**	**-**	**-**	**23,881**

Assets as per SoFP as at 31 March 2019	*Held at Amortised Cost* **£000**	*Held at fair value through I&E* **£000**	*Held at fair value through OCI* **£000**	*Total* **£000**
Trade and other receivables	10,603			10,603
Cash and cash equivalents at bank	1,461			1,461
Total at 31 March 2019	12,064	-	-	12,064

Note 33.3 Financial liabilities

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

Carrying values of financial liabilities as at 31 March 2020 under IFRS 9	**Held at amortised cost £000**	**Held at fair value through the I&E £000**	**Total £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**
Total at 31 March 2020	**112,696**	**-**	**112,696**

Liabilities as per SoFP as at 31 March 2019	Held at amortised cost £000	Liabilities at fair value through the I&E £000	Total £000
Loans from the Department of Health and Social Care	77,963		77,963
Obligations under finance leases	3,560		3,560
Trade and other payables excluding non	19,110		19,110
Total at 31 March 2019	100,633	-	100,633

Note 33.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	**83,681**	24,853
In more than one year but not more than two years	**11,512**	26,989
In more than two years but not more than five years	**4,588**	34,530
In more than five years	**12,915**	14,261
Total	**112,696**	100,633

Note 34 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	**Total value of cases £000**	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	**1**	**-**	1	2
Bad debts and claims abandoned	**21**	**8**	57	7
Stores losses and damage to property	**12**	**18**	13	66
Total losses	**34**	**26**	71	75
Special payments				
Compensation payments	**14**	**104**	15	58
Ex-gratia payments	**18**	**6**	17	7
Total special payments	**32**	**110**	32	65
Total losses and special payments	**66**	**136**	103	140

There were no compensation payments received in recovery of losses above.

Note 35 Events after the reporting period

See note 27 regarding conversion of loans to Public Capital Dividend.

There have been no other significant events after the reporting period date.

Note 36 Related parties

Note 36.1 Register of Interests

The Rotherham NHS Foundation Trust is 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 has had transactions with a number of organisations with which key employees/directors of the Trust have some form of relationship. Only those bodies, outside the Department of Health & Social Care parent body, are detailed below and are not considered material. See Note 37.2 in respect of the Department of Health & Social Care.

	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	Receipts from Related Party £000	Receipts from Related Party £000	**Payments to Related Party £000**	Payments to Related Party £000
Magna Enterprises Ltd	0	0	**8**	10
Total related party transactions	**0**	0	**8**	10

There was £nil owed, or due at the 31st March in respect of these transactions.

The relationships are:

- A non-executive member of the Board is also a Director/Trustee with Magna Enterprises Ltd.

Note 36.2 Other Related Parties

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

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

Report on the audit of the financial statements

Opinion

In our opinion, The Rotherham NHS Foundation Trust's (the "Trust") financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2020 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

We have audited the financial statements, included within the Annual Report and Accounts 2019/20 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2020; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Taxpayer's Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosures made in note 1 to the financial statements concerning the Trust's ability to continue as a going concern.

The Trust continues to face financial challenges and is currently operating under interim financial arrangements. At this stage, it is unclear what will happen after this initial period of support and whether these interim financial arrangements will continue longer than originally advised as explained in note 1.1.2 to the financial statements.

These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Explanation of material uncertainty

In the year, the Trust delivered a £4.9m deficit against a planned break-even position for 2019/20. However, as a result of the South Yorkshire & Bassetlaw Integrated Care System being in aggregate balance, the Trust will receive additional non-recurrent Financial Recovery Fund monies to clear the deficit resulting in a surplus of £9k. As a consequence, the Trust will achieve its annual control total and secured its Quarter 4 Provider Sustainability Fund/Financial Recovery Fund monies of £5.2m which is already included within the deficit position referred to above.

Due to recent events concerning COVID-19, the financial planning process for 2020/21 has been suspended nationally and interim financial arrangements put in place, initially covering the period from April to July 2020. At this stage it is unclear what will happen after this initial period.

What audit work we performed

In considering the appropriateness of the going concern basis used in the preparation of the financial statements we obtained the 2020/21 financial plan and cash flow forecasts, and:

• compared the assumptions within the Trust's financial plan against assumptions provided by Monitor/ NHSI and our experience in the health sector;

• understood the Trust's response to the Covid-19 pandemic and the interim guidance and measures in place from NHS England and NHS Improvements

• assessed the reasonableness of the plan assumptions and carried out a sensitivity analysis over this plan; and

• considered the reliance that the Trust has on external support to deliver its 2020/21 plan.

Our audit approach

Context

Our audit for the year ended 31 March 2020 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and key audit matters was largely unchanged apart from 1 key audit matter that was new this year in respect of the Trust's response to Covid-19.

Our audit also involved forming a conclusion on the arrangements for securing economy, efficiency and effectiveness in the use of resources (the "3 Es"), in accordance with the Code of Audit Practice.

Overview

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- Overall materiality: £5,750,000 (2019: £4,577,400) which represents 2 % of total operating income from continuing operations
- This was our fourth year audit of the Trust; in considering our approach we considered the Trust's financial performance and clinical performance to identify the areas of greatest risk for the audit process.
- Risk of fraud in revenue and expenditure recognition and management override of controls
- Financial sustainability and going concern
- Valuation of Property, Plant and Equipment
- Covid-19
- Consideration of Accruals and Provisions

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and the conclusion on the arrangements for securing economy, efficiency, and effectiveness in the use of resources, and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified by our audit.

Key audit matter	***How our audit addressed the key audit matter***
Risk of fraud in revenue and expenditure recognition and management override of control *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of revenue and expenditure and notes 3 to 5 for further information.*	*Revenue* For income and expenditure transactions close to the year-end we tested, on a sample basis, that the transaction and the associated income and expenditure had been posted to the correct financial year end by tracing them to invoices or other documentary evidence. Our testing did not identify any balances which had been recorded in the incorrect period.

We focused on this area because there is a heightened risk due to:

- The Trust being under increasing financial pressure: In the year the Trust delivered a £4.9m deficit against a planned break-even position for 2019/20. However, as a result of the South Yorkshire & Bassetlaw integrated Care System being in aggregate balance, the Trust received additional non-recurrent Financial Recovery Fund monies to clear the deficit resulting in a surplus of £9k.
- As a consequence, the Trust met its annual control total and secured its Quarter 4 Provider Sustainability Fund/Financial Recovery Fund monies of £5.2m which is already included within the deficit position referred to above.
- Given the continued financial support required by the Trust, there remains an increased incentive to misreport the Trusts position.

Given these incentives, we considered the key areas of focus to be:

- Recognition of revenue and expenditure;
- Manipulation through journal postings; and
- Items of income or expenditure whose value is dependent upon estimates.

For a sample of income contracts from NHS England and Clinical Commissioning Groups ("CCG"), we obtained and agreed the income received during the year to a signed contract with no exceptions noted.

For a sample of income recognised in relation to over performance against contract (i.e. the 'the true up' income) we agreed to year end settlements with no exceptions noted.

Expenditure

For invoices received/balances paid for a period after the year-end we tested, on a sample basis, that the transactions and the associated expense had been posted to the correct financial year by tracing them to other documentary evidence or invoices. Our testing did not identify any items incorrectly recorded.

We tested a sample of operating expenses from order through to invoice to ensure that this had been correctly accounted for. No differences were identified that required amendment within the financial statements.

Intra- NHS balances

We obtained the Trust's mismatch reports received from NHS Improvement ("NHSI"), which identified balances (debtor, creditor, income or expenditure balances) that were different with the counterparty.

We checked that management had investigated all differences over £300k (based on the National Audit Office's reporting criteria).

We read correspondence with the counterparties, which was consistent with these results. We then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements. Our testing identified a number of errors with the Trust's treatment of balances, and those errors identified which were individually over £300k were amended for in the financial statements. The balances that remained unadjusted do not have a material impact to the year-end financial statements of the Trust.

Manipulation through journal postings

We selected a sample of manual and automated journal transactions that had been recognised in both income and expenditure, focusing in particular on those with unusual account combinations.

We traced these journal entries to supporting documentation (for example, invoices, good received notes and cash receipts and payments) to check that the transaction was valid and had been correctly accounted for within the financial statements.

Our testing identified no issues that required further reporting.

Management estimates

We evaluated and tested management's accounting estimates, focusing on; accruals, provisions, accrued and deferred income; and Property, Plant and Equipment Valuation (see specific areas of focus below).

We evaluated and challenged the key accounting estimates on which management's estimates were based and the basis of their calculation on a sample basis by comparing the assumptions used by management in the calculation of their

	estimate with independent assumptions and investigating any differences. Our testing identified no matters that required amendment within the financial statements of the Trust.
COVID-19 During the course of the audit, both management and the engagement team considered the impact that the ongoing COVID-19 pandemic has had on the activities, suppliers and wider economy of the Trust and its financial statements. In response to the current crisis, NHS England (NHSE) and NHS Improvement (NHSI) have introduced interim guidance and measures that were outlined in their joint letter dated 17th March 2020. However, at this stage, it is unclear what will happen after this initial period of support and whether these interim financial arrangements will continue longer than originally advised. Discussions are ongoing nationally around proposals for returning to normal levels of elective activity and levels of future funding. As a result of this, we determined that the impact of COVID-19 should be a key audit matter.	We performed the following procedures to address the impact that COVID-19 has on the financial statements: • Evaluated the processes and models used by management in its assessment of Covid-19 • Evaluated whether the assumptions are realistic and achievable and consistent with the guidance and measures outlined in the letter from NHS England and NHS Improvement • We have considered the appropriateness of the disclosures made by management and the board of the potential impact of Covid-19. We concluded that management's assessment of the impact of COVID-19 on the financial statements is reasonable.
Valuation of Property, Plant and Equipment See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to Property, Plant and Equipment and note 14 for further information. We focused on this area because Property, Plant and Equipment ('PPE') represents the largest balance in the Trust's Statement of Financial Position. All PPE assets are measured initially at cost. Land and Buildings are subsequently measured at fair value, through full valuations every 5 years and interim valuations after three years, with interim impairment assessments being carried out by management to assess if there is an indication of impairment.	We evaluated and challenged the assumptions and methodology in management's review of the fixed asset register. We have also challenged the useful economic lives of the fixed assets. We also checked and found that the valuation of Land and Buildings had been accurately reflected in the financial statements and that the gains and impairments have been appropriately reflected within the Statement of Comprehensive Income and Reserves. We physically verified a sample of assets across land, buildings and other categories to check existence and, in doing so, assessed whether there was any indication of physical obsolescence which would indicate potential impairment. We found no issues from this testing.
Consideration of accruals and provisions Management have reconsidered the financial position of the Trust at 31 March 2020 in relation to the recoverability of accrued income, and other judgemental areas including provisions. The reconsideration cast doubt on the recoverability of a number of balances with CCG's and other bodies, included within accrued income and other line items. We have discussed and challenged the judgements made, and agree with management that it is appropriate to include an item, below our level of materiality, within the summary of unadjusted misstatements.	We evaluated management's assessment of accrued income and challenged their assumptions and judgements. We selected a sample of invoices at year end and agreed to subsequent invoice and receipt of payment. We selected a sample of accrued income transactions and assessed the period the income was earned and agreed to third party confirmation. We found that no material adjustment is required as a result of this reconsideration.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Trust, the accounting processes and controls, and the environment in which the Trust operates.

In establishing our overall audit approach, we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£5,750,000 (2019: £4,577,400)
How we determined it	2% of total operating income from continuing operations
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £287,500 (2019: £228,870) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance 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 an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2019/20 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2020 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 32 the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' 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 auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

We are required under 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 and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of The Rotherham NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

The scope of our work in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The scope of our work is determined by the requirements outlined in Auditor Guidance Note 3 'Auditors' Work on Value for Money Arrangements' ("AGN 03") issued by the National Audit Office in November 2017. We tailored the scope of our work to address the evaluation criterion specified in AGN 03, that in all material respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

Adverse opinion

As a result of the matters noted below, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2020.

Basis for adverse opinion

Under AGN 03 we are required to report those matters that, in the auditors' professional judgement, were of most significance in forming the conclusion on whether the Trust had in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources and include the most significant assessed risks of failing to put in place proper arrangements that were identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our work on arrangements to secure value for money as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified relating to this work.

Licence Conditions

On 23 April 2013 and subsequently amended in June 2013, September 2013 and June 2015, Monitor issued enforcement action against the Trust.

This related to breaches surrounding financial planning, governance and the Electronic Patient Records System. Compliance certificates, in relation to Electronic Patient Records and governance breaches, were subsequently issued by Monitor in July 2014 and January 2015 respectively.

As at 31 March 2020 the Trust still remains subject to enforcement action in relation to financial planning breaches.

The above issue is evidence of a weakness in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

We reviewed the latest Monitor findings on the NHS website confirming what the breaches relate to and the status of each.

Financial performance and financial specific measures

In the year the Trust delivered a £4.9m deficit against a planned break-even position for 2019/20. However, as a result of the South Yorkshire & Bassetlaw integrated Care System being in aggregate balance, the Trust received additional non-recurrent Financial Recovery Fund monies to clear the deficit resulting in a surplus of £9k. As a consequence, the Trust met its annual control total and secured its Quarter 4 Provider Sustainability Fund/Financial Recovery Fund monies of £5.2m which is already included within the deficit position referred to above.

The deficit against plan noted above, is evidence of a weakness in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Refer to the material uncertainty in relation to going concern paragraph for the details of the audit work performed in relation to this key audit matter.

CQC inspection results

During 2018/19, the Board of Directors commissioned an external "Well-led" review undertaken and completed in-year. This review identified some areas that needed to be focussed on.

The Trust received an inspection from the Care Quality Commission (CQC) during 2018/19. Within that the overall assessment was 'requires improvements' and the CQC assessment in respect of "Well-led" remained at 'requires improvement'. A current CQC inspection is awaiting, although all CQC inspections are currently paused due to COVID-19 until at least August 2020.

We have confirmed CQC inspections are currently paused due to COVID-19 and agreed that the latest CQC report showed that the CQC assessment in respect of "Well-led" remains at 'requires improvement'.

Other matters on which we report by exception

We are required to report to you if:

- the statement given by the directors on page 33, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model, and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report on page 71, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from these responsibilities.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

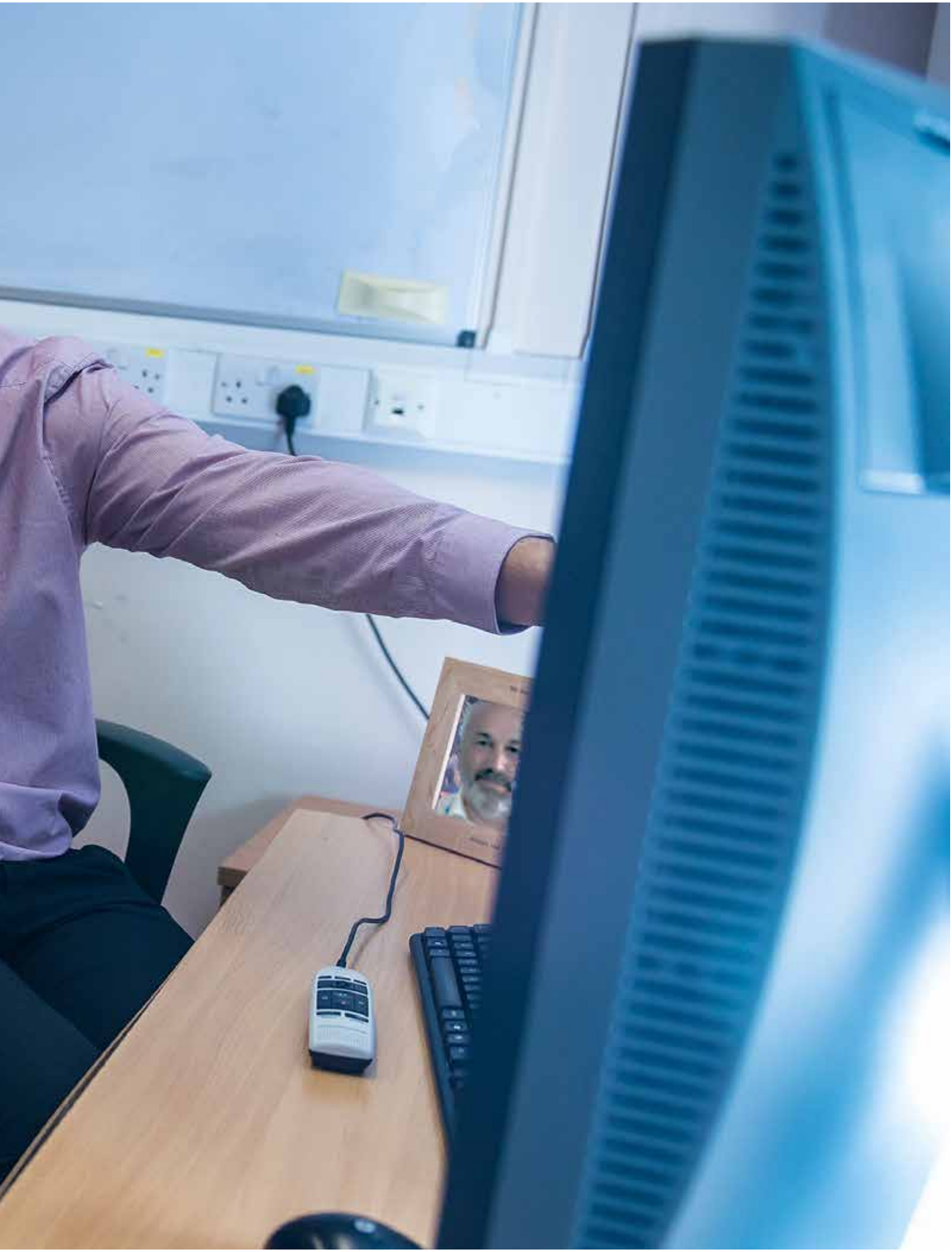
John Minards (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Leeds
2 June 2020

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.


NHS


NHS




ROTHERHAM
STOP SMOKING
AND WITHIN...
ASDA