NHS
Sheffield Health and Social Care
NHS Foundation Trust

Annual Report and Accounts

2020/21

Proud to care in Sheffield

Sheffield Health and Social Care NHS Foundation Trust

Annual Report and Accounts 2020/21

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

Contents

Section 1.0 Welcome from the Chair

It is my great pleasure to welcome you to our Annual Report and Accounts for 2020/21.

I joined Sheffield Health and Social Care NHS Foundation Trust as Chair in August 2020 and it was a challenging time for the organisation. We were at the height of the COVID-19 pandemic and the organisation was seeking to make some key improvements following the publication of our CQC rating in April 2020.

My priority has been listening to the people we serve to understand what is working well for them and identifying where we need to improve. I have heard how COVID-19 has been impacting on them as well as our staff and our wider communities.

The past 12 months has been exceptional for all of us in the NHS as we responded to managing the COVID -19 pandemic and ensuring that we kept our service users and staff safe during these most challenging of times. We met those challenges head on and I am particularly proud of the way our staff tirelessly worked to deliver the best possible care for our service users, their families and carers.

There are some very exciting opportunities that are facing the Trust and I am fortunate to be working with talented and experienced colleagues on the Board, some of whom joined the team just this year. There is still much work to be done but together with our compassionate and committed staff, I am confident that we will progress towards our goal of getting 'back to good' and providing excellent care for our communities.

I want to thank every member of Team SHSC for their contribution over the past 12 months – those in clinical and non-clinical roles who have all pulled together to care for our service users in Sheffield. Your efforts have been phenomenal. Thank you.

This report will give you an overview of what we do, how we have performed and the challenges we face going forward, as well as a detailed analysis of our activities and accounts if you would like to look at things in a bit more detail.

Most of this information can also be found on our website at www.shsc.nhs.uk

I hope you enjoy this Annual Report and Accounts and I look forward to your continued support in 2021/22.

Thank you,

Mike Potts
Chair

Section 2.0 Performance Report

2.1 Performance Overview

This section is to help you understand a bit more about our organisation, our purpose, our objectives, how we've performed against those objectives over the last year and the challenges we face.

Jan Ditheridge, Chief Executive

Chief Executive's review of the year

I am pleased to present my first annual report for Sheffield Health and Care NHS Foundation Trust.

The last year has been a challenge for everyone in society, and our organisation has been no different in feeling the full impact of COVID-19 and all its implications.

We have continued to ensure service users and our staff are at the heart of all our plans and activities. All while trying to make sense of this new world we were all experiencing, keep everyone safe and provide services, in the context of so many things changing.

COVID-19 has not been our only challenge this year. We received our Care Quality Commission (CQC) rating and report at about the same time as the country went into its first lockdown. It was a very difficult report to receive, telling us that areas of our services and the way we organised ourselves had significant shortfalls. This led to a rating of 'inadequate' from the CQC and the Trust being placed in special measures by our regulators.

Our staff also knew things were not right and told us in our staff survey that generally they weren't having a good experience and things hadn't improved over a number of years.

We expect that the CQC will be back with us shortly and although it is a busy time, it is also a time for reflection on the work we have done over the last year to keep people safe through COVID-19, significantly improve the quality of our services and the way we lead and manage them. I am confident that they will see significant changes and improvements, some of them completed, some of them requiring further time to embed.

There have been significant changes to our leadership teams at Board and sub-Board level, all supported with development programmes and a focus on listening to our service users and staff then acting on what we hear.

We have delivered a comprehensive action plan to address the concerns raised by the CQC covering many areas, but with a particular focus on the experience of our service users who use our crisis pathways and inpatient wards.

The way we deliver care and the environments we deliver them in have been improved significantly. Although there is still more to do to ensure our environments are at a standard we would want, hampered of course by COVID-19 restrictions.

However, we have plans in place and I expect to be reporting even more progress next year.

We have recruited more experienced staff in our challenged areas and most of them will now report that they have the right training, supervision and support to do their jobs well.

While our staff survey results are still resistantly disappointing, the one area that we did improve this year was in health and wellbeing. Staff recognised our focus in this area, the support on offer and that we want them to have a work life balance. This is particularly heartening through the pandemic when health and wellbeing has never been more important.

I am particularly proud that our staff responded to both the COVID-9 outbreak and our quality challenge. We did have outbreaks of COVID-19 infections on our wards which were handled safely and compassionately by our staff. Most of them were often isolated by the nature of the virus restrictions and all of us were still learning what impact it might have and how to manage it effectively. We were reviewed by the CQC and others through these outbreaks with good outcomes about our approach and care. The outbreaks were contained.

I could not leave this point without pausing to say that we did very sadly lose service users through the pandemic due to COVID-19 and one of our staff members. They will be remembered by all of us.

The things we have had to do to improve our environments and the surge in people requiring crisis help following the first lockdown have led to a significant pressure on our bed capacity and a need to send people further away if they require an inpatient bed. This is reflected nationally, but is a concern for us, and we continue to monitor the situation carefully and make plans accordingly. We are slowly seeing a gradual reduction in the need to send people away from Sheffield for inpatient care.

Through all of this we have managed to continue with our transformation projects, the standout this year being the development of the Primary and Community Transformation project. This innovative new way of working with our GPs, the voluntarily sector and others, will support more people to stay well and not require crisis care because we have been able to help them earlier in their mental health journey. It will stop people bouncing between services - something our services users often rightly complain about - and provide a much more rounded service for them. You can read more about the progress we have made later on in this report.

I could not end this review without mentioning how we have spent the public purse this year. You will see from our financial accounts that we have again balanced the books. It has been challenging, as we have spent extra money on staff and our environments to ensure that our improvement journey has been supported, but it is good to know we are going into the new financial year in a balanced position.

I also want to pay tribute to our corporate teams especially but not exclusively our IT team who transformed the way they work to help us continue to work with our service users and their families safely. They helped us all transform the way we work

overnight. It has really made a difference to making sure we could provide all our services despite the pandemic. We did not stop any of our services through COVID-19 and in some areas provided more, because other non-statutory services had no choice but to close during lockdown.

This has been a year we will all remember for so many reasons. While it has been challenging and for many heart-breaking, there are many positives. Our camaraderie, displays of compassion, the extra miles taken for our service users and the improvements we have made, despite the challenging context, are testament to our resilient and capable staff.

It gives me hope, motivation and enthusiasm for the year to come.

Who we are

We were initially established in 2003 as Sheffield Care Trust and on 01 July 2008, we were authorised to operate as Sheffield Health and Social Care NHS Foundation Trust.

As a membership-based organisation our Board of Directors are accountable to the communities that we serve mainly through our Council of Governors, and directly to our members at our Annual Members' Meeting.

Our Council of Governors consists of people who use our services, their carers, members of the public and our staff. They work alongside appointed governors from other Sheffield-based organisations with whom we work in close partnership, including:

- NHS Sheffield Clinical Commissioning Group
- Sheffield City Council
- Sheffield Hallam University
- University of Sheffield
- Sheffield Carers Centre
- MENCAP Sheffield
- Sheffield African and Caribbean Mental Health Association
- Pakistan Muslim Centre
- Sheffield Young Carers
- Sheffield Flourish
- Healthwatch Sheffield
- Sheffield Mind
- Rethink.

The diverse membership of our Council of Governors helps our Board of Directors ensure that our services are shaped by the people who live in the communities we serve.

As a Foundation Trust we have certain freedoms to develop and improve services and offer more choice to service users.

Our vision

Our vision is to improve the mental, physical and social wellbeing of the people in our communities.

We will do this by:

- working with and advocating for the local population
- refocusing our services towards prevention and early intervention
- continuous improvement of our services
- locating services as close to people's homes as we can
- developing a confident and skilled workforce
- ensuring excellent and sustainable services.

Our values

Our values form the guiding principles and behaviours for the way we work:

- respect
- compassion
- partnership
- accountability
- fairness
- ambition.

Our strategy

In April 2020, the Board of Directors approved the strategic priorities and key deliverables for the Trust for 2020/21.

The Trust's vision and strategic aims would be delivered through three strategic priorities which reflected the priorities from previous development work and the changing environment facing the Trust at the time.

The three strategic priorities for 2020/21 are:

- **COVID-19** - Getting through safely
- **Care Quality Commission** - Getting back to good
- **Transformation** - Changing things that will make a difference

Engaging with service users and carers is at the heart of everything we do. As we implement our strategy the experiences and views of service users, and those of their carers, will inform any changes we make.

Our purpose

Our purpose is to improve people's health, wellbeing and social inclusion so they can live fulfilled lives in their community.

We will achieve this by providing services aligned with primary care that meet people's health and social care needs, support recovery and improve health and wellbeing.

Our services

We have an annual income of approximately £153.7m and employ around 2,600 members of staff.

We provide mental health, learning disability, substance misuse and a range of specialist services to the people of Sheffield.

Our integrated approach to service delivery enables us to meet our service users' mental, physical and social care needs.

The wide range of our services includes:

- rehabilitation services for people with brain injuries and those living with the consequences of a long-term neurological condition
- services for adults with drug and alcohol misuse problems
- psychological therapies for people with mild and moderate mental health problems
- community-based mental health services for people with serious and enduring mental illness
- low-secure forensic inpatient services
- services that support people with a learning disability, their families and carers
- services that support people with dementia, their families and carers
- inpatient mental health services for adults and older people
- rehabilitation services for people with mental health illness
- specialist services including: eating disorders, adult autism, health services for homeless people and members of the traveller community, perinatal mental health services and gender identity services
- supported employment and health promotion
- teaching and research.

Some of our specialist services, such as our gender identity clinic and our autism service, are also available to people living outside of Sheffield. Sheffield residents make up about 94% of all service users we provide care and treatment for, and overall, we provide services to around 55,000 people a year.

Our main commissioning partners are NHS Sheffield Clinical Commissioning Group and Sheffield City Council who commission around 70% of our business.

We are also commissioned by NHS England to provide some of our services nationally.

How we provide our services

We often see individuals for short periods of time, providing advice and treatment which helps resolve the person's problems. For those with more serious, longer-term difficulties, we will support and work with them for a number of years.

With this in mind the services we provide, and the locations they are provided in, are tailored to suit the individual needs of our service users, their families and carers. That means that some of our services are provided in the community, to ensure we can provide support, care and treatment to service users close to their homes and help them to maintain their independence as much as possible.

We also provide a range of inpatient services for individuals who cannot be best supported within their community.

We deliver our services from around 40 sites across the city, which is mainly our own estate but many of our staff members work from partner organisations' premises, such as our Liaison Psychiatry team who are based at the Northern General Hospital. Staff work remotely and across all of Sheffield in people's homes, alongside the third sector and in the community.

Some of our support is provided on a one-to-one basis, such as our community based recovery services. Others, such as our Improving Access to Psychological Therapies (IAPT) service offer a flexible package of support, which can be provided individually or on a group basis from a range of community centres across the city.

Working in partnership is a huge part of the services we provide across the city.

We work closely with the Child and Adolescent Mental Health Services (CAMHS) within Sheffield Children's NHS Foundation Trust to ensure care is carefully co-ordinated as young people move into adulthood and need the ongoing support of our mental health services.

We also deliver integrated health and social care services for adults of a working age alongside Sheffield City Council.

At the heart of all of our services is a commitment to integrate care around people's mental and physical health needs, as well as their social care needs.

Throughout the pandemic we have maintained our clinical services, however, the way we have provided access to support, care and treatment has changed.

This ensured we were able to continue to deliver care safely for our service users and our staff. We have provided much more care remotely, either through telephone consultations or through video and virtual appointments and clinics, while ensuring we still met with individuals to provide community support when required.

All our community teams reassessed the needs of our service users to understand the best ways for them to receive their care in the community.

Equality of service delivery to different groups has been promoted and reviewed in a number of ways, some of which are highlighted in our Equality Report in Section 3.8.

We also publish detailed information about equality, diversity and inclusion on our website at www.shsc.nhs.uk/about-us/equality-diversity-and-inclusion

How we've performed

Our performance during 2020/21 has been measured against our three strategic priorities:

- **COVID-19:** Getting through safely.
- **CQC:** Getting back to good.
- **Transformation:** Changing things that will make a difference.

COVID-19: Getting through safely

The COVID-19 pandemic impacted on us all in so many ways. We all changed the way we lived our lives at home, with our families, friends, local communities and at work.

Our priority was to get through the year safely. This meant keeping services accessible, keeping them safe for patients and keeping them safe for our staff. As with the rest of the NHS and care providers it was a very challenging environment to ensure we kept everyone safe with the situation changing on a daily basis.

The key deliverable actions we set ourselves for the year were to:

- Mobilise our response to COVID-19 through clear plans
- Lead and manage safely through the surge phase
- Develop and deliver our plan for the recovery stage.

Reflecting on the year as a whole our staff did a tremendous job. Key highlights from the last year are summarised as follows.

We adapted and changed how we delivered care, support and treatment.

Throughout the pandemic we maintained our services, ensuring most of them stayed open and at all times our service users were able to get help and support. The way we delivered our services changed and at times there were challenges we faced to ensure timely access. This was mainly as a result of the need to ensure the safety of staff and service users. We undertook a series of actions to ensure and improve inpatient safety which resulted in a reduction in the number of available beds, however, at times ensuring we had enough staff to deliver safe care was challenging due to shielding and staff having to self-isolate. Our priority at all times was to continue to deliver assessments, care and treatment in a safe and therapeutic way.

During the first wave of the pandemic demand for services that provided access to new referrals reduced. This included our Improving Access to Psychological Therapies (IAPT) service and access points to our Single Point of Access (SPA), Older Adults Community Mental Health Team and Liaison Psychiatry. This was a direct impact of the reduced number of people contacting primary care services and self-referrals significantly reducing during the first lockdown. Referrals and numbers

accessing services have steadily increased since then and have returned to pre-pandemic levels.

Day-to-day contact with all of our service users wasn't possible within our community services. Through the year we significantly increased the ways we could support services users remotely, through telephone and online video appointments and clinics. This was very successful and was well received by a number of our service users. Due to its success telephone and online appointments will continue to be offered as a choice to our service users. All of our community services ensured service users were involved in discussions about the best way for them to continue to access support and treatment, and plans were adjusted to reflect the changing needs and preferences of individuals.

Demand for assessment and admissions to Section 136 Health Based Place of Safety beds did not drop at the beginning of the pandemic, and demand in this area has increased since April 2020. This reflects unmet need for people in distress in the community, which in part is related to the impact of the pandemic on the people we support. This increase is consistent with other services nationally. We have had a reduction in beds since March 2020, both permanent losses as a result of the eradication of dormitory accommodation and temporary reductions in bed numbers due to requirements to enable safe isolation and the need to maintain safe and therapeutic environments during a period of increased staff absence and vacancies. The direct impact of this for people in our care is the increased likelihood of being admitted to mental health services away from their home and local community services. We will continue to deliver our improvement plans to address this in 2021-22.

We adapted and changed how our staff worked and ensured they were supported.

The first wave of the pandemic had a significant impact on staff health, wellbeing and absence from work, together with an associated increase in carer's leave. As the year progressed the impact on staff sickness absence reduced and the total for the whole year was 5.66%, slightly down on the previous year.

The past 12 months were very challenging for our staff. They have done a tremendous job ensuring our services have remained open during COVID-19 and care has been delivered as safely as it could be. To strengthen our existing wellbeing support for our staff we introduced a free professional helpline for anyone affected by the COVID-19 pandemic and lunchtime health and wellbeing virtual support sessions for staff. We expanded our staff network groups to provide a space for staff to come together, share experiences and shape how we can work better together, launching a group for shielding staff to keep in touch while away from work.

Staff who are at risk or vulnerable to COVID-19 have been supported through individual risk assessments that ensure appropriate support and work adjustments are in place. Access to the COVID-19 vaccine has been a key step to improve staff safety. The vaccination programme within the Trust continues to prioritise staff within inpatient services, promote awareness of the vaccine and support individual staff to take informed choices. On 31 March 2021 56% of our staff have received their first

vaccination. As of 26 April 2021, 82.9% of staff have had at least one vaccine, with 71.4% having had both doses.

Despite the challenges we have faced we still have more to do. Ensuring staff continue to be well supported, have time and space to recover and feel part of our ongoing work to improve services remains crucial to our future. Our People Plan will deliver continued improvements through 2021-22. Our plan focuses on four key areas: health and wellbeing, recruitment and retention, workforce transformation, and leadership and talent.

We worked well together across the Trust and as part of the city-wide response. This ensured we were able to prioritise the essential delivery of PPE equipment to protect patients and staff in key service areas and ensured the safe distribution of essential supplies. With our partners across the NHS, social care and the voluntary and third sector we combined our efforts to support each other to prioritise and deliver care and support to those people who were most vulnerable.

All the hard work through the year, to ensure services remained accessible and to support staff was supported by effective management and operational control structures across the Trust. This ensured we were operating in line with best practice, and we were able to; adhere to national guidance; continually assess and manage our available workforce; understand and respond to the risks to staff health and safety; support the wellbeing of both staff and service users; effectively manage outbreaks and keep pace with emerging vaccination situation. Regular assurance reports were provided to the Board in respect of the updated position nationally and locally, the impact on our workforce, impact on service access and adherence to new guidance as issued.

CQC: Getting back to good

The key deliverables we set ourselves were to deliver our Care Quality Commission (CQC) action plans for:

- Our core services
- Being a ‘well-led’ organisation.

The Board of Directors approved our improvement plan with the CQC in April 2020. This plan detailed the range of actions we would take to deliver the immediate improvements required to improve our services, while establishing the approach we would take to sustain continuous quality improvements. We have addressed the critical areas of concern and we will continue to build on the progress made to deliver sustainable improvement.

Our improvement plan is led by the Executive Medical Director through a newly established ‘Back to Good’ Board and reports to the Quality Assurance Committee. The Back to Good Board’s purpose is to:

- monitor the implementation of improvement actions
- assess the timeliness and the impact of improvement actions

- facilitate the discussion about actions that are not delivering the intended outcomes and determine next steps.

Highlights of the progress we have made so far include:

- Earlier this year we still had a number of small dormitories on some of our wards. This meant that some patients shared their bedroom areas, and this impacted on their privacy and dignity. Over the past 12 months we eradicated all of the remaining dormitories so every patient now has an individual bedroom. We also made a number of improvements to our ward environments and seclusion facilities.

- We strengthened and improved the support provided to staff, helping them to deliver great care and support. We set improvement targets and have made progress toward achieving them. 63% of staff received regular supervision in line with the expectations of our policy, on average 94% had their annual appraisal during the year and 90.5% received the essential training they needed to support them to deliver safe and effective care.

- We improved and standardised how we assessed and met the physical health needs of people on our inpatient wards. We have adopted and implemented NEWS2, a best practice assessment tool, across our wards.

- We have strengthened the support provided to our inpatient teams by increasing the number of senior nursing staff available within each ward team. The increased presence of more experienced staff supports the nursing staff to deliver safe and effective care.

- We have reviewed and strengthened our governance systems to assess, monitor and improve the quality of care and services across the Trust. This ensures each team is supported effectively, and that issues that may impact on care are identified and addressed. As a result the Board of Directors is able to discharge its duties to ensure the delivery of good quality care.

The improvements made through the year were reviewed and recognised by the CQC. The CQC made a number of unannounced and focussed visits to re-inspect three services - our acute inpatient services, the crisis and health based place of safety and wards for older people with mental health problems. These visits took place in August 2020 and aimed to look in detail at the progress we had made in addressing areas of concern identified in the Section 29A warning notice the Trust was issued. The results of these inspections were published on 22 October 2020.

The CQC recognised and confirmed that they were satisfied that we have made significant improvements over the concerns they raised as part of the warning notice and as a result the Section 29A warning notice was removed. This was a positive position which recognised the improvements made and provided the Board with assurance that our improvement plan was having the required impact in improving and delivering safe and effective care.

Our improvement plan for 2021-22 has been shaped by the significant progress that we have made this year, together with our ongoing commitment to deliver outstanding care, create a great place to work and improve how we use our resources. We have been working hard to increase clinical leadership, remove barriers to change, empower staff, improve our systems, processes and governance, and develop leaders throughout the Trust.

During 2021-2022 we will continue to deliver continuous and sustainable improvement by:

- Strengthening our approach to quality improvement and organisational development with clear patient centred approaches underpinning the work of each member of staff, our teams and the Board of Directors. This will ensure, having delivered 'good' services, that we continue our improvement journey to delivering 'excellent' services.
- Using information effectively to underpin our approach and the decisions we make. We will triangulate insight from patient and staff stories and feedback, performance and benchmarking data, and outcomes and learning from improvement action already taken.
- Focussing on staff wellbeing, improving staff experience and developing our leadership skills at all levels of our organisation.

We will continue to implement our improvement plan to ensure we have addressed the remaining areas of concern identified by the CQC.

Next year our priorities will be to:

- Finalise ward and seclusion room improvements
- Continue to eradicate ligature anchor points
- Implement our physical health strategy
- Continue to improve the staffing skill mixes and numbers within teams.

Transformation: Changing things that will make a difference

To support the improvements we needed to make we changed how we delivered and provided our services, and the way we work across the Trust.

The Board of Directors identified significant changes that were required across care pathways, the way care was organised, key workforce transformation needs, the appropriateness of our estate and the effectives of our patient information systems.

The key deliverables we set ourselves were to:

- Implement a new primary and community mental health service across four Primary Care Networks for adults and older adults
- Implement our Acute Care Modernisation Plan and improve pathways and experiences across inpatient and community services

- Develop a new care model for forensic and secure services
- Deliver our People Plan to support staff to delivery high quality care
- Move our headquarters out of Fulwood House
- Replace Insight and implement a new electronic patient record
- Improve priority environments where we deliver care and where our staff work.

Work has progressed in each of these areas, however, we did not make the progress we planned to make in many important areas. This was mainly due to the impact of COVID-19 and the need to prioritise ensuring services were able to continue safely. The learning from managing and delivering services through the pandemic, and from delivering our CQC improvement plan also bought new insight and a renewed appreciation of what we needed for the future. We have taken time to review and re-appraise many of our transformation plans to ensure we have the right solutions in place.

The transformation plans that we have taken the time to review and re-plan are:

- Our Acute Care Modernisation Plan
- The development of a new care model for forensic and secure services across South Yorkshire and Bassetlaw
- Moving our headquarters out of Fulwood House
- Replacing Insight and implementing a new electronic patient record.

Through the year the following progress was made:

- Successful implementation of a new primary and community mental health service across four Primary Care Networks for adults and older adults
- Development of a new community forensic service in Sheffield
- Agreed the planned sale of Fulwood House with a buyer which will be completed during 2021/22. This will raise funds in 2021/22 that will be re-invested into improving our inpatient and community facilities.

Our plans for 2021-22 will continue to deliver the changes required. Our plans will:

- Extend the new primary and community mental health service from four to 15 Primary Care Networks for adults and older adults.
- Implement our plans for the development of our community mental health teams
- Deliver our People Plan to support staff to deliver high quality care
- Procure a new electronic patient record
- Implement a provider collaborative to support a new care model for forensic services across South Yorkshire and Bassetlaw
- Move our headquarters out of Fulwood House
- Implement our Acute Care Modernisation plan to remove dormitories, improve seclusion facilities and confirm the plan for our future inpatient estate.

Challenges and risks we face

The results of our CQC inspection in April 2020, our inadequate rating and being placed in special measures reflected the challenges and improvements we needed

to make. We have addressed the critical areas of concern and we will continue to build on the progress made to deliver sustainable improvement.

It has been a very challenging year for our staff. They have done a tremendous job ensuring our services have remained open during COVID-19 and care has been delivered as safely as it could be. We know that the experience of staff working in the Trust is still not as good as we want it to be. This is demonstrated by our national NHS Staff Survey Results for 2021, benchmarking information and the discussions we have had with staff over the last year. We also have significant recruitment challenges, particularly in nursing and will need to recruit more staff and increase diversity within our workforce to support the planned expansion in services to meet the targets in the NHS Long-Term Plan. Without the right numbers of staff in the right roles we will not be able to deliver high standards of care, expand our services and ensure our staff have valued and manageable jobs that enable them to be the best they can be. We will therefore continue the implementation of our People Plan which focuses on four key workstreams; health and wellbeing, recruitment and retention, workforce transformation, and leadership and talent.

Our digital capabilities and infrastructure do not yet support effective patient care and modern ways of working. We will therefore align ourselves to the local development of shared care records, develop an interim operational plan for our current electronic patient record system (Insight) that minimises changes to it and provides a way to deliver improved digital services. This will support the delivery of safe and effective care and provide a foundation for the move to a new electronic patient record system. At the same time, we will develop our digital strategy to support delivery of continued service improvements over the next five years.

Our estate is not fit for purpose in many important areas. The environments in our wards and our community bases do not help with the delivery of therapeutic care, often with little space, poor light, tired décor and lack of important facilities. Some of our buildings are no longer able to support the delivery of modern, safe and therapeutic care. The facilities to support staff while at work, such as rest areas and showering facilities, are limited in some of our buildings. This reduces the ability of our staff to deliver great care, impacting on the experience and outcomes of our service users. Our forthcoming Estates Strategy will address this in the key areas of our inpatient environments, our community-based facilities and the general décor of our buildings.

Demand for services is expected to increase in a range of ways because of the COVID-19 pandemic and in line with the NHS Long-Term Plan improvements. We will develop our approaches to demand and capacity management, expand services in the areas of primary and community care, perinatal services, IAPT and our ability to deliver effective crisis support and home treatment care across the 24-hour period.

Our crisis care and recovery services are working under high levels of pressure which impacts on their effectiveness and the outcomes and experiences of our service users and our staff. Our plans will see the development of new services

along with better support to staff to ensure demand, capacity and productivity are well managed.

Capacity to handle risk

Effective risk management ensures that the Trust as a whole is able to manage all key risks, clinical and non-clinical, providing confidence that the Trust will achieve its objectives.

The Board of Directors has overall responsibility for:

- ensuring robust systems of internal control are in place and are appropriately resourced
- encouraging a culture whereby risk management is embedded across the Trust
- routinely considering risks and collectively being assured that risks are being effectively managed.

Over the last year we have reviewed and made substantial changes to improve and strengthen our governance arrangements as part of our well-led development plan.

Our focus has been to ensure all parts of our organisation are better aware of the quality, safety and effectiveness of the care we provide and that the right decisions are taken by the right people, at the right time, to maintain and improve quality.

The Board of Directors, the executive team and senior leadership of the Trust have clear lines of accountability and a renewed focus on supporting our staff to deliver the best care they can.

We now have a clear and consistent approach to reviewing how we perform, responding to new challenges and ensuring that our improvement plans are delivered.

This is delivered through the following governance systems:

- **Board committees** – A reconstituted Board committee structure ensures Board oversight of performance and delivery of our plans in respect of quality, people, risks, transformation and finance.
- **Performance reviews** – All operational services have a consistent and established integrated performance and quality review framework that ensures day-to-day performance is reviewed. The executive team reviews performance of all departments periodically through the year.
- **Clear improvement priorities** – Priorities have been developed, agreed and are represented in our delivery plans. These priorities will ensure clarity of purpose and that each improvement priority has a defined timeframe, milestones and agreed metrics to ensure we can understand the progress made, outcomes delivered and agreed governance oversight.

- **Managing risks to the delivery of safe and effective services** – The Board Assurance Framework, alongside our corporate and service level risk registers ensure risks are identified, escalated and managed effectively.
- **Ensuring the delivery of our plan** – We have put in place robust arrangements to track progress against our Annual Operational Plan on a monthly basis and report progress against the plan to our Finance and Performance Committee. Our monitoring arrangements are also explicitly linked to the Board Assurance Framework. We will keep this plan under review and take corrective action where required.

Going concern

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future.

For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Details of any overseas operations

The Trust had no overseas operations during 2020/21 in respect of the provision of health care services.

We are the main UK partner of the Gulu-Sheffield Mental Health Partnership alongside other NHS trusts in Sheffield, Manchester and London, as well as the University of Sheffield.

We have been working with a service user and carer group, Mental Health Uganda Gulu Branch (MHUGB) and Gulu Regional Referral Hospital (GRRH) since 2012.

All of the funding for the work of the partnership is external to the Trust.

Closing statement

This Performance Report has been approved by the Directors of Sheffield Health and Social Care NHS Foundation Trust.

Jan Ditheridge
Chief Executive
Date: Wednesday 09 June 2021

Section 3.0 Accountability Report

3.1 Directors Report

3.1.1 The Board of Directors

The Board of Directors provide a wide range of experience and expertise which is essential to the effective governance of the Trust. They provide strategic direction for the Trust and its members demonstrate the leadership and scrutiny that enables the organisation to fulfil its ambition and make decisions regarding the needs of the people it supports.

There were several changes to the non-executive and executive team during the year.

Mike Potts was appointed as interim Trust Chair in August 2020, replacing Jayne Brown OBE.

Michelle Fearon left her role as Chief Operating Officer to take a new role as Programme Director for South Yorkshire and Bassetlaw Adult Secure Care Provider Collaboration.

Beverley Murphy joined us on secondment as Improvement Director and following a thorough recruitment process involving local partners and NHS England and NHS Improvement she was appointed as Executive Director of Nursing, Professions and Operations.

In January 2021, Caroline Parry was appointed to the role of Executive Director of People.

David Walsh was recruited to the role of Director of Corporate Governance and commenced in April 2020.

One Non-Executive Director was recruited during 2020/21, with Anne Dray joining us. The Non-Executive Director position previously allocated to a local authority appointment remained vacant and open recruitment for this post started on 05 March 2021.

The Board is composed of Executive Directors, Non-Executive Directors and Directors who sit on the board in a non-voting capacity.

At the end of 2020/21, the Board of Directors comprised five Non-Executive Directors including the Chair, one Associate Non-Executive Director, five Executive Directors including the Chief Executive and the Director of Corporate Governance/Board Secretary.

3.1.2 The Non-Executive Team

- Mike Potts (Chair)
- Richard Mills (Vice-Chair)
- Sandie Keene CBE (Senior Independent Director)
- Anne Dray

- Heather Smith
- Professor Brendan Stone (Associate)

3.1.3 The Executive Team

- Jan Ditheridge (Chief Executive)
- Beverly Murphy (Executive Director of Nursing, Professions and Operations)
- Dr Mike Hunter (Executive Medical Director)
- Phillip Easthope (Executive Director of Finance)
- Caroline Parry (Executive Director of People)

Non-voting directors

- David Walsh (Director of Corporate Governance and Board Secretary)

All Board members use their expertise, experience and interest to help set the strategic direction of the Trust, as well as to monitor its management and performance.

3.1.4 Directors' statement as to disclosure to the auditors

For each individual who was a director at the time that this Annual Report was approved, so far as the directors are aware, there is no relevant audit information of which the Trust's auditor is unaware.

The directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

3.1.5 Accounting policies statement

Accounting policies for pensions and other retirement benefits are set out in the Annual Accounts in Section 5.0 of this report and details of senior employees' remuneration can be found in the Remuneration Report in Section 3.2 of this report.

3.1.6 Our auditors

Our external audit function is carried out by KPMG. A full competitive tender process was carried out during 2019 to ensure compliance with regulator requirements. The outcome of the tender process, following a detailed review process was the recommendation to the Council of Governors for the appointment of KPMG, who had previous carried out the function for a number of years.

This decision was approved on 12 December 2019 for the commencement of the contract on 01 April 2020, for an initial period of three years, with an option to extend to for a further year.

3.1.7 The role of the Board of Directors

The responsibility for exercising the powers of the Trust rests with the Board of Directors. These powers are set out in the National Health Service Act, 2006 and are subject to the restrictions set out in the Trust's terms of authorisation.

The Board is responsible for:

- Directing and supervising the organisation's affairs
- Providing proactive leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed
- Setting the Trust's strategic aims and ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives
- Overseeing the organisation's progress towards attaining its strategic goals
- Monitoring the operational performance of the organisation
- Promoting the success of the organisation so as to maximise the benefits for the members as a whole and for the public.

The Board may delegate any of the powers conferred upon it to any committee of directors or to an Executive Director. The Standing Orders of the Board of Directors provide the way the Board may arrange the delegation of its powers. The 'Scheme of Reservation and Delegation of Powers' (which forms part of the Board of Directors' Standing Orders) sets out, in detail, those powers which the Board has reserved to itself and those it has delegated and to whom.

The Chair of the Trust presides over the meetings of the Board of Directors and the Council of Governors. The Chair is responsible for:

- Providing leadership to the Board of Directors and the Council of Governors
- Ensuring that the Board of Directors and the Council of Governors work effectively together
- Enabling all Board members to make a full contribution to the Board's affairs and ensuring that the Board acts as an effective team
- Leading the Non-Executive Directors through the Board of Directors' Remuneration and Nominations Committee in setting the remuneration of the Chief Executive and (with the Chief Executive's advice) the other Executive Directors.

The Senior Independent Director is responsible for leading the Non-Executive Directors in the performance evaluation of the Trust Chair. The Trust Chair is responsible for carrying out the performance evaluation of the Non-Executive Directors. Both processes are overseen by the Council of Governors' Nominations and Remuneration Committee.

During 2020/21, the Board met every month except for July 2020. Open Board of Directors meetings were held in January and March 2021 at which meetings were open (in part) to members of the public and the press. There was one Board of Directors strategy meeting which took place in February 2021. Elements of the

Board's business that are of a confidential nature or commercially sensitive are transacted in private and the Board has been very open about the need to do this.

The Board of Directors takes account of the NHS Constitution in its decisions and actions, as they relate to service users, the public and staff of Sheffield Health and Social Care NHS Foundation Trust. The principles and values set out in the NHS Constitution are reflected in the organisation's strategy, objectives, vision and values. The Board of Directors is compliant with the principles, rights and pledges set out in the NHS Constitution as they apply to mental health service providers.

3.1.8 Attendance at Board of Directors meetings

A full list of all the directors who have served on the Board during 2020/21, including their attendance at the Board's meetings, is set out below.

Board members with voting rights

Name	Position	Term	Attendance
Jayne Brown OBE	Chair	Four year term ending 30 June 2020	4/4
Mike Potts	Chair	In role from 01 August 2020.	8/8
Ann Stanley	Non-Executive Director	Three year term ending 31 October 2017 with 13 month extension ending 30 November 2018, further extended to 31 May 2019, 31 July 2019 and 31 July 2020. Left role on 31 October 2020.	7/7
Richard Mills	Non-Executive Director	Three year term ending 30 November 2018 extended to 31 May 2019, further extended to 31 July 2019. Second term commenced 01 August 2019 running to 30 November 2023.	11/12
Sandie Keene CBE	Non-Executive Director / Senior Independent Director	Four year term ending 31 March 2022.	11/12
Heather Smith	Non-Executive Director	Four year term ending 31 July 2023.	12/12
Anne Dray	Non-Executive Director	Joined 01 November 2020. Four year term ending on 31 October 2024.	5/5

Jan Ditheridge	Chief Executive	N/A	12/12
Clive Clarke	Deputy Chief Executive	In role until 07 September 2020.	1/1
Phillip Easthope	Executive Director of Finance	N/A	12/12
Debra Gilderdale	Interim Director of Nursing and Professions	Joined in May 2020 and left role in July 2020.	2/2
Liz Lightbown	Executive Director of Nursing and Professions	In role until 20 September 2020.	0/5
Beverley Murphy	Executive Director of Nursing and Professions (30 July 2020 to 31 August 2020) Executive Director of Nursing, Professions and Operations (from 01 September 2020)	In position from 30 July 2020.	8/8
Mike Hunter	Executive Medical Director	N/A	12/12
Caroline Parry	Executive Director of People	In position from 11 May 2020.	8/8
Michelle Fearon	Chief Operating Officer	Left role in August 2020.	4/4

Non-voting capacity or associates in attendance

Name	Position	Term	Attendance
Professor Brendan Stone	Associate Non-Executive Director	Four year term ending 31 July 2023.	10/12
Clive Clarke	Deputy Chief Executive	In role until 07 September 2020.	3/4
Caroline Parry	Director of People	Left role on 10 May to start new role as Executive Director of People.	3/3
Dean Wilson	Associate Director of Human Resources	Left role on 30 June 2020.	1/4
David Walsh	Director of Corporate Governance (Board Secretary)	Joined 01 April 2020.	12/12
Beverley Murphy	Improvement Director	Started in role 01 June 2020 and started new role on 30 July 2020.	2/2

3.1.9 The Management Team

The Board of Directors delegates the day-to-day management of the operational activities of the Trust to directors who oversee directorates, services and teams across the organisation.

In response to the COVID-19 pandemic a Gold, Silver and Bronze Command structure was established to provide oversight and escalation routes for decision making.

These groups were stood up and down in frequency during the different phases of the pandemic, originally meeting daily, and then moving three times a week and then to one day a week.

This structure allowed practical decisions to be made at ground level (Bronze) all the way up to executive level (Gold) to quickly enable to the Trust to react to the ever changing situation.

3.1.10 Board Committees

The Board has several committees to whom it delegates authority to carry out some of its detailed work.

The Quality Assurance Committee is responsible for providing assurance to the Board on the effectiveness of the Trust's systems and processes for safeguarding and improving the quality of the Trust's services.

The Finance and Performance Committee is responsible for ensuring that the Trust's finances are managed within the allocated resources to deliver an effective and efficient service.

The People Committee is responsible for providing assurance to the Board on the effectiveness of the Trust's systems and processes for supporting employees in the provision and delivery of high quality, safe service user care and ensuring that the Trust is meeting its legal and regulatory duties in relation to its employees.

A new Mental Health Act Committee was established in March 2020 but has not formally met yet.

The Audit and Risk Committee and the Remuneration and Nomination Committee are described as follows.

3.1.10.1 Audit and Risk Committee

Membership of the Audit and Risk Committee comprises three independent Non-Executive Directors. The committee is chaired by Anne Dray who has recent and relevant financial experience, which fulfils the requirement for at least one Non-Executive member to have such experience.

The Audit and Risk Committee provides the Board of Directors with an independent and objective review of the system of internal control and overall assurance process associated with managing risk. It receives annual reports from each of the other Board committees; these reports in turn inform the annual report of the Audit and Risk Committee which is presented to the Board of Directors at the end of each financial year. This allows the Audit and Risk Committee to discharge its responsibility for providing assurance to the Trust Board in relation to all aspects of governance, risk management and internal control. These assurances and this oversight form the basis for the Chief Executive's Annual Governance Statement.

The committee is responsible for commissioning and reviewing work from independent external and internal audit services, counter fraud services and other bodies as required.

The committee's work in undertaking these responsibilities is outlined in an annual report to the Board.

The committee's meetings are attended, in accordance with the agenda, by the internal and external auditors, local counter fraud specialist, the Trust's Executive Directors, the Director of Corporate Governance, Head of Clinical Governance and

Deputy Director of Finance. Other directors and senior managers attend when invited by the committee. The Chief Executive and the Trust Chair attend the meeting at which the annual accounts are presented.

Both the internal and external auditors have the opportunity to meet informally with Audit and Risk Committee members (without executives present) to discuss any concerns or issues relating to the performance of management.

Copies of the terms of reference of the Audit and Risk Committee can be obtained on the Trust's website at https://www.shsc.nhs.uk/about-us/board-directors/board-directors-committees

The committee has met on six occasions during 2020/21 and discharged its responsibilities as set out in the terms of reference.

Details of members' attendance at its meetings are as shown in the table below:

Name	Position	Number of meetings attended
Ann Stanley	Committee Chair and Non-Executive Director (until November 2020)	5/5
Anne Dray	Committee Chair and Non-Executive Director (effective from November 2020	1/1
Sandie Keene	Non-Executive Director	6/6
Richard Mills	Non-Executive Director	6/6

Significant issues considered by the committee

The Audit and Risk Committee has an annual review cycle in place in relation to reviewing and considering effectiveness and on-going compliance.

Significant activity considered by the committee during 2020/21 included:

- Annual accounts
- Annual report
- Annual Governance Statement
- Head of Internal Audit Opinion
- External Audit Opinion and annual reporting
- Counter-Fraud, Bribery and Corruption Annual Report
- Self-certification of compliance with licence conditions

- Losses and Special Payments Annual Report
- Annual reports for other board committees
- Receipt of Register of Interests, Gifts and Hospitality
- SIRO Annual Report
- Annual committee self-assessment
- Regular reporting from 360 Assurance (internal audit), including the annual Audit Plan, and KPMG (external audit)
- Regular reporting and monitoring of the Board Assurance Framework and Corporate Risk Register
- Pre-Board consideration of the Well-Led Development Plan
- Freedom to Speak Up quarterly reporting
- Reporting on information governance and security breaches, with specific consideration to the serious incident in relation to the loss of documentation on the Insight system
- Emergency planning and preparedness, including EPRR compliance, EU Exit and COVID-19
- Policy governance – including both the ratification of policy approvals within the committee's area of responsibility and the approval of a new Policy Framework
- Review of committee governance – including initial consideration of proposed changes to development of new structure below committee including approval of the terms of reference.

External Audit

For the financial year ending 2020/21, the Trust's external audit function was carried out by KPMG.

The statutory fee for the 2020/21 audit was £78,785 plus VAT.

The effectiveness of the external audit function is assessed annually by the members of the Audit and Risk Committee utilising the methodology provided for such an evaluation by The Audit Committee Institute. For 2020/21 this was carried out as part of a self-assessment questionnaire of members.

KPMG has carried out no other services for the Trust during the financial year 2020/21.

Internal Audit

The Trust's internal audit function is carried out by 360 Assurance. The annual audit plan is derived following an overarching risk assessment and is translated into the annual internal audit operational plan and three-year strategic plan.

The internal audit plan was developed through discussion with members of the Audit and Risk Committee, the executive team and other directors and a review of the Board Assurance Framework to identify a range of key risks, including those affecting the health sector generally.

Reviews were identified across a range of areas including financial management, information management and technology, performance, clinical quality, people management and governance and risk.

A report is taken to every Audit and Risk Committee meeting detailing progress against the plan and drawing attention to any concerns.

The Audit and Risk Committee reviewed the performance and value for money of the internal audit function during 2020/21.

3.1.10.2 Remuneration and Nomination Committee

The Remuneration and Nomination Committee of the Board of Directors comprises all the Non-Executive Directors. The committee is chaired by Mike Potts, the Trust Chair.

The committee is responsible for determining the remuneration and terms and conditions of service of the Executive Directors (including the Chief Executive) in order to ensure that they are properly rewarded having regard to the Trust's circumstances.

Full details of the Remuneration and Nomination Committee are provided in Section 3.2 of this report.

3.1.11 Executive and Non-Executive Directors' qualifications and experience

Jayne Brown OBE, Chair

Jayne has more than 25 years' NHS experience, including 13 years as a Chief Executive. She is the director of two limited companies, the vice-chair of a community voluntary service and a carer.

Jayne has a BA (Hons) in Politics and Modern History as well as a Masters Degree in Public Health, a Diploma in Strategic Health Service Management and a Coaching Diploma. She is a graduate of the Institute of Personnel and Development.

Jayne was awarded an OBE in 2004 for services to the NHS.

Tenure of office
01 July 2016 to 30 June 2020.

Mike Potts, Chair

Mike joined the Trust on 01 August 2020 as our new interim Chair. He has a wealth of leadership and management experience in the NHS.

He has been working with Boards for around 20 years and was previously Chief Executive at Calderdale, Kirklees and Wakefield Primary Care Trust Cluster. Mike has also worked in commissioning services in South and West Yorkshire. Among his more recent roles, he supported a number of health and social care systems achieve greater integration and agree an action plan following a Care Quality Commission review of how they support older people.

Tenure of office

Started 01 August 2020.

Richard Mills, Non-Executive Director
(Vice Chair and Chair of the Finance and Performance Committee)

Richard has more than 40 years senior management experience in the NHS, charitable, independent and public sector organisations, including Board level positions in NHS organisations.

Richard was an NHS manager and director from 1979-2012, working in the London and Thames Valley area at Hospital, Health Authority and Primary Care Trust levels.

He was the Chief Executive of the Intensive Care National Audit and Research Centre (ICNARC) 2014-2015 and was a management consultant from 2012 to 2019.

Richard is also a member of the Quality Assurance Committee and Audit and Risk Committee.

Tenure of office
01 December 2015 to 30 November 2018, extended to 31 July 2019. Second term of office commenced 01 August 2019 and will run to 30 November 2023.

Ann Stanley, Non-Executive Director
(Chair of the Audit and Risk Committee)

Ann is a qualified accountant by profession and has served as a senior finance executive in the public, voluntary and commercial sectors. Her experience includes working in Brussels for the European Communities (she is a fluent French speaker) and in London for the BBC.

Ann has also worked as a senior finance executive in Higher Education and as a Group Accountant for HM Prison Service.

She is a fellow of the Chartered Institute of Certified Accountants (FCCA). She is also a member of the Trust's Finance and Performance Committee and a member of the People Committee.

Tenure of office
01 November 2014 to 30 November 2018, extended to 31 July 2020. Tenure ended 31 October 2020.

Sandie Keene CBE, Non-Executive Director
(Senior Independent Director and Chair of Quality Assurance Committee)

Sandie began her career as a social worker and her early work was in South Yorkshire local authorities. She retired in 2014 after eight years as Director of Adult Social Services in Leeds. She was President of the Association of Directors of Adult Social Services (ADASS) in 2013/14 and was awarded a CBE in 2016.

After retiring Sandie worked with the Local Government Association (LGA) to support health and social care improvement. As an associate with the LGA she has developed tools to support integrated health and social care.

Additionally, she is Independent Chair of a Safeguarding Adults Board and the Sheffield Diocesan Safeguarding Panel and a trustee of a national housing association.

Sandie is a member of the Audit and Risk Committee.

Tenure of office
01 April 2018 to 31 March 2022.

Heather Smith, Non-Executive Director
(Chair, People Committee)

Heather joined the Trust on 01 August 2019. Her previous job was Principal of Sheffield College and she worked in education in Sheffield (where she lives) for over 33 years until her retirement.

Since retirement Heather has undertaken advisory and coaching support work with colleges around the country, as well as working on a voluntary basis with a local organisation which is focussed on reducing food waste and promoting sustainability. Heather's work in education has many links with the goals of the Trust. One of her early management roles was the introduction of pathways to employment and

apprenticeships with the NHS in Sheffield, a project which gained several national awards and still exists today. She is a passionate supporter of the need for city-wide organisations to work together collaboratively in order to improve lives and promote social justice and equality.

Heather's interest and expertise lies in organisational development and transition, culture change and improvement management.

Heather is a member of the Quality Assurance Committee.

Tenure of office
01 August 2019 to 31 July 2023.

Anne Dray, Non-Executive Director
(Chair of the Audit and Risk Committee)

Anne is a graduate of the University of Sheffield and is a member of the Chartered Institute of Public Finance and Accountancy. She undertook her professional accountancy training at Trent Polytechnic in Nottingham. She has worked in the NHS for nearly 40 years and has been a Board level director for most of the past 28 years.

Anne has worked across different health systems in both provider and commissioning organisations and at local and regional level.

She has held a wide range of positions including Director of Finance and Information, Director of Performance, System QIPP and Transformation Director, Director of Development, Programme Director, Transition Programme Director and Chief Executive. She is also a Non-Executive Director at Nottingham City Care Partnership.

Tenure of office
01 November 2020 to 31 October 2024.

Jan Ditheridge, Chief Executive
Jan joined the Trust as its Chief Executive on 02 March 2020 following seven years as Chief Executive of Shropshire Community Health NHS Trust. She is an experienced strategic leader with a background encompassing a broad variety of clinical, operational and leadership roles across health, social care and the private sector.

She has a wealth of expertise in the areas of transformation, delivery, clinical quality and effective performance management. Jan is dual qualified as a Registered General and Mental Health Nurse and has an MBA.

Clive Clarke, Deputy Chief Executive

Clive was appointed as an executive director of the Trust in 2008. A qualified social worker, Clive brings more than 29 years' experience in health and social care provision. He served as Director of Adult Mental Health Services and as Head of Social Services in Sheffield Care Trust.

From March 2013 Clive was our Deputy Chief Executive and in 2016 he became the Trust's Executive Director of Operations. Clive was a participant in the 2001 King's Fund Top Managers Leadership Programme.

Clive was appointed as the Trust's Interim Chief Executive on 01 October 2019 to 01 March 2020. He left the Trust on secondment to NHS Improvement on 07 September 2020.

Phillip Easthope, Executive Director of Finance

Phillip has been the Trust's Executive Director of Finance since January 2016, following a period as the Trust's Interim Executive Director of Finance from March 2015. Prior to his appointment, he was the Trust's Deputy Director of Finance since 2012 and has more than 20 years of experience in NHS finance.

Phillip is a Fellow of the Association of Chartered Certified Accountants and has completed the NHS Strategic Financial Leadership Programme.

Phillip held the role of the Interim Deputy Chief Executive on from 01 October 2019 to 01 March 2020.

Debra Gilderdale, Interim Director of Nursing and Professions

Debra joined the Trust as Interim Director of Nursing and Professions in May 2020 to provide cover for the role. She joined us at the height of COVID-19 and supported the nursing teams closely as well as becoming our Director of Infection Prevention and Control. She also led the rapid improvement programme on our acute wards.

Debra left the Trust in July 2020.

Liz Lightbown, Associate Director of Nursing, Professional Standards and Policy

Liz Lightbown joined the Trust in April 2010, initially on secondment. She was subsequently appointed on a permanent basis in April 2011. She is a Registered Mental Health Nurse and holds a Bachelor of Science Degree in Behavioural Sciences, a Masters Degree in Health Planning and Financing, and a Diploma in Public Health. She was a participant on the King's Fund National Nursing Leadership Programme and is Prince 2 (Project Management) qualified.

Liz is currently the Trust's Associate Director of Nursing, Professional Standards and Policy having served as Executive Director of Nursing and Professions until 20 September 2020.

Since April 2012 Liz has been the executive lead for the Trust's international health partnership with Gulu Regional Referral Hospital in Northern Uganda and was the Trust's Chief Operating Officer from 2012 to 2016.

Dr Mike Hunter, Executive Medical Director

Mike was appointed as the Trust's Executive Medical Director in October 2016. He has been a Consultant Psychiatrist for many years and was previously Clinical

Director of Acute and Inpatient Services and Community Services at the Trust. His responsibilities include quality improvement, patient safety, clinical governance, medical leadership, medical education and service user engagement.

Mike trained in Sheffield, first in medicine and then in psychiatry. He is a Consultant Psychiatrist with a background in rehabilitation and assertive community treatment. He also has a role as a National Speciality Advisor at NHS England and NHS Improvement.

Beverly Murphy, Executive Director of Nursing, Professions and Operations

Beverley joined us on secondment as Improvement Director in June 2020 from South London and Maudsley NHS Foundation Trust where she had been Director of Nursing and Chief Operating Officer.

On 30 July 2020 she was appointed our Executive Director of Nursing and Professions and was made Executive Director of Nursing, Professions and Operations on 01 September 2020.

Beverley has worked as a Mental Health Nurse for over 36 years and has held a range of senior nursing and quality governance roles across the NHS. She has managed acute mental health wards and specialised for some years in eating disorders and in a nurse-led service in the community.

Beverley's responsibilities include nurse and professions leadership, clinical quality governance, clinical standards and the delivery of care services.

Caroline Parry, Executive Director of People

Caroline was appointed our Executive Director of People in December 2020 and brings with her previous experience from the civil service, higher education, the third sector and a number of NHS Trusts. Caroline was previously our Deputy Director of Human Resources, a role she started in November 2015.

Caroline's responsibilities include supporting our staff, engagement with our teams and service users and organisational development.

Michelle Fearon, Director of Operations and Transformation

Michelle Fearon joined the NHS in 1997 and has worked in a variety of clinical services' managerial and corporate support function roles; across mental health, learning disabilities, substance misuse and specialist community health care services.

Her substantial role is as Director of Operations and Transformation. For the period December 2019 to March 2020, Michelle acted into the joint Interim Chief Operating Officer post, with operational responsibility for all of the Trust's clinical services with the exception of Clover Group.

She graduated from the NHS Leadership Academy's Executive Development Programme in 2017, in addition to undertaking a number of academic and professional development programmes over the years.

Michelle held the post of Chief Operating Officer until August 2020 when she moved into the role of Director of Operations – System Improvement at South Yorkshire and Bassetlaw Adult Secure Care Provider Collaboration.

3.1.12 Directors' interests

Members of the Board of Directors must declare any interests which might create, or be seen to create a conflict or potential conflict between their personal or private interests and those of the organisation or their duties as members of the Board of Directors. They are also required to declare any conflicts of interest that arise in the course of conducting Trust business, specifically at each meeting of the Board.

The Register of Interests is maintained by the Director of Corporate Governance and is available for inspection by members of the public on the Trust's website at www.shsc.nhs.uk/about-us/board-directors

3.1.13 Board evaluation

The Board of Directors assesses its own performance and effectiveness, ensuring that it complies fully with its statutory and regulatory functions and duties. An 18-month Board development programme commenced in July 2020 focussing on the CQC's 'Well-Led' responsibilities, with specific sessions also held for a wide number of areas including:

- Equality, diversity and inclusion
- Developing an inclusive culture
- Board team work, roles and responsibilities
- Partnerships - South Yorkshire and Bassetlaw Integrated Care System, Sheffield Accountable Care Partnership, South Yorkshire and Bassetlaw Mental Health and Learning Disabilities and Autism Alliance
- Strategy - including our overall strategy and Clinical and Social Care Strategy (several sessions from January 2021)
- Risk management and risk appetite
- Board Assurance Framework
- Health and Safety of Boards
- Freedom to Speak Up self-assessment.

In addition, the Board and Council of Governors participated in a joint development session related to providing effective challenge. It has also critiqued and refreshed the Board Assurance Framework and the Trust's risk appetite.

All Executive and Non-Executive Director appointments are made in compliance with Condition G4 of the Provider Licence 'Fit and Proper Persons' requirements and these are reviewed on an annual basis.

Appraisals took place for those Non-Executive Directors who had been in post through the year. The Council of Governors and Board members were individually invited to comment on the performance of each Non-Executive Director. This

information was fed into the appraisal process led by the Trust Chair with support from the Lead Governor and a further governor member of the Nominations and Remuneration Committee. In addition, appraisal of the Trust Chair took place led by the Senior Independent Director and supported by the Lead Governor and a stakeholder governor. Guidance published by NHS England and NHS Improvement in September 2019 on the appraisal of NHS Chairs was adopted. All Governors, Board members and external stakeholders were invited to provide feedback on the Chair's performance which fed into the appraisal process.

The evaluation of the performance of the Executive Directors was carried out by the Chief Executive during a monthly one-to-one meeting and annual reviews with them.

The evaluation of the Chief Executive's performance was carried out by the Trust Chair in their one-to-one meetings. The performance of the Chief Executive, Executive Directors and the Director of Human Resources was also discussed by the Remuneration and Nominations Committee.

The Board is satisfied that the composition of its membership is balanced, complete and appropriate and this can be seen in the biographical details of Board members.

3.1.14 Keeping informed of the views of governors and members

The Board of Directors ensures it is kept informed of the views of governors and members in a number of ways, including:

- Private meetings between the Chair and governors if required
- Attendance at Council of Governors' meetings
- Receiving reports on the outcome of consultations with governors, for example on business planning
- Updates provided by the Chair and directors at Board meetings
- Governors are encouraged to attend public meetings of the Board of Directors.

The Senior Independent Director is also available to governors if they have concerns regarding any issues which have not been addressed by the Chair, Chief Executive or other usual business arrangements.

In general, regarding attendance at meetings of the Council of Governors:

- The Chair attends all meetings
- The Non-Executive Directors attend all meetings
- The Chief Executive attends all meetings
- Other Executive Directors and Trust staff attend meetings, if required, for example to deliver reports, or as observers.

The Council of Governors also has powers to require attendance of a director at any of its meetings, under paragraph 26 (2) (aa) of Schedule 7 of the National Health Service Act 2006, for the purpose of obtaining information on the Foundation Trust's performance of its functions or the directors' performance of their duties.

The Council of Governors did not exercise these powers during 2020/21.

3.1.15 NHS Improvement's well-led framework

NHS Improvement's well-led framework is structured around eight characteristics of a well-led organisation as shown below:

Leadership capacity and capability

Overall leadership is provided by the Board of Directors. The biographies of Board membership demonstrate they are highly experienced and from a broad range of professional backgrounds and the composition of the Board is regularly reviewed. All Board members are subject to an annual appraisal. Governors are actively involved in the appraisal of Non-Executive Directors.

The Trust has a clear policy for the appraisal for its staff and monitoring of the appraisal of senior leaders within the organisation. There is a clear leadership, accountability and governance structure within the organisation and through this assurance on quality and safety of the operational clinical services is provided to the Quality Assurance Committee.

Clear vision and credible strategy to deliver high quality, sustainable care

Our strategic objectives enable us to achieve our vision. The business plan to deliver our strategic direction is refreshed each year and takes into account changes to the internal and external environment and the views of stakeholders. Through this process, strategic priorities, including quality priorities are identified and agreed.

Any risks to the delivery of strategic objectives are recorded in the Trust's Board Assurance Framework which is reviewed quarterly by the Board and Board committees, as well as monthly by Executive Directors.

There are a number of strategies including the Quality Improvement and Assurance Strategy, Service User Engagement and Experience Strategy, Carers and Young Carers Strategy, People Strategy, Organisational Development Strategy and Estates Strategy that support the delivery of our strategic direction, all of which have clear outcome measures which are monitored by the appropriate Board committee.

Culture of high quality, sustainable care

We promote an organisational culture that is open, fair and transparent. We encourage our staff to be responsive and take an open approach towards identifying and understanding potential risks and responding to them. This includes requirements to report unsafe acts, untoward incidents or near misses using our incident reporting process.

We endeavour to underpin all we do through the application of our values of respect, compassion, partnership, accountability, fairness and ambition. We employ values-based recruitment for all staff and our Quality Improvement and Assurance Strategy supports a philosophy of continuous improvement and a model of co-production with our service users in the design and delivery of services.

Clear responsibilities, roles and systems to support good governance and management

Clarity of roles and responsibilities within our governance arrangements are provided in:

- the Constitution including the Schedule of Matters Reserved by the Board
- Standing Orders, Reservation and Delegation of Powers, incorporated in the Scheme of Delegation and Standing Financial Instructions
- the Scheme of Delegation of functions included in the Mental Health Act code of practice
- the terms of reference for Board committees and operational committees
- our programme and project management arrangements.

There are a number of systems to support good governance including:

- the Insight clinical record system
- the Ulysses Risk Management System which enables us to manage and report incidents, record risks and supports our serious incident processes
- the e-rostering system which supports safe staffing in our services
- the patient acuity tool which supports staffing numbers and skill mix to maintain effective care and safe staffing.

Clear processes to manage risk, issues and performance

The key systems and processes in place for managing risks, issues and performance are aligned to our governance structure: the Board, its committees, the executive team and clinical management groups, wards and teams.

In year, our internal auditors audited strategic risk management, the outcome of which informed revisions to our Risk Management Strategy and the development of a plan of actions for its roll-out including training for staff. The new Risk Management Strategy was developed towards the end of 2020-21, and approved shortly after year end by Board in May 2021.

Appropriate and accurate information being effectively processed, challenged and acted upon

Our performance metrics and their targets are reviewed and refreshed each year as part of our business planning processes. Benchmarking and other external sources of information are used as appropriate and when available. Evidence of information being challenged and acted upon is provided in the minutes of Board and its committees which are available to the public.

The Data and Information Governance Board oversaw the Trust's statutory duties and assured quality in regard to data and information, with oversight of information governance under the remit of the Audit and Risk Committee.

People who use services, the public, staff and stakeholders are engaged and involved to support high quality sustainable services

There are a broad range of measures in place to enable us to effectively engage. Primarily these are:

- our Council of Governors
- engagement with our membership
- the work of our Engagement and Experience Team
- Microsystems
- formal consultations on service reconfigurations and change
- national patient survey
- Care Opinion
- quality of experience questionnaire
- Friends and Family Test
- our involvement in the South Yorkshire and Bassetlaw Integrated Care System
- our partnerships with commissioners
- membership and participation in local partnership boards
- membership and participation in local safeguarding boards
- engagement with Healthwatch Sheffield.

Using our Foundation Trust status to develop services and improve patient care

Foundation Trust status enables us to engage governors and members, who represent the communities that we serve, in the development of our services and the improvement of care.

You can find more detail on our approach to well-led services in the Annual Governance Statement in Section 3.7.

3.1.17 Working with commissioners, partners and stakeholders

Our commissioners

As an NHS Foundation Trust, we provide a range of services, covering direct care services, training, teaching and support functions. The main commissioners of our clinical services are NHS Sheffield Clinical Commissioning Group, Sheffield City Council and NHS England. Housing associations commission our residential care services.

Our non-service user care services are commissioned by NHS Sheffield Clinical Commissioning Group, other NHS foundation trusts, NHS trusts and Whole Government Accounts (WGA) organisations, along with other NHS Clinical Commissioning Groups.

NHS England and NHS Clinical Commissioning Groups commission education, training, research and development from us.

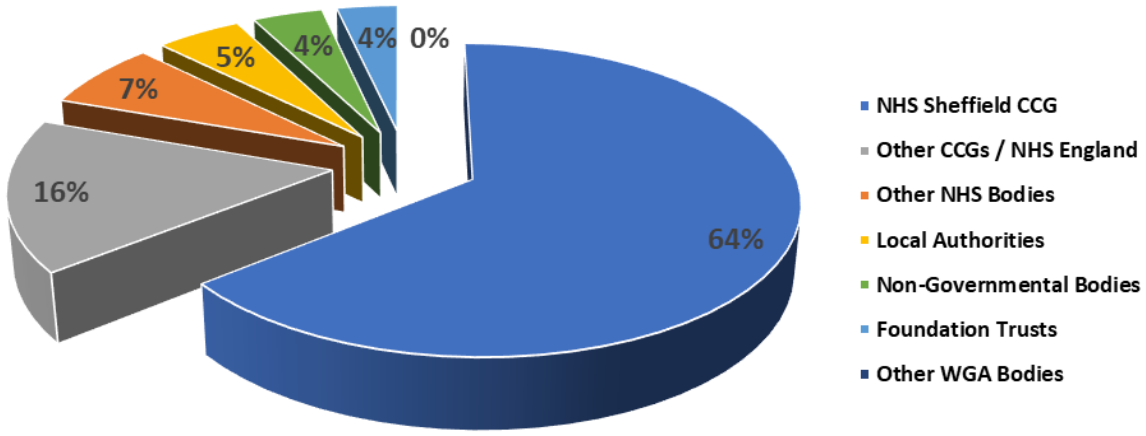
How we work with our partners

We work in partnership with the main organisations that commission our services, namely NHS Sheffield Clinical Commissioning Group and Sheffield City Council. This allows us to understand the health and social care needs of the wider population, to influence the commissioning approach taken and to develop new services for the benefit of the people of Sheffield. We have a well-established governance structure across Sheffield and agree each year a single transformation programme for the city between the Trust and its main commissioners.

We work in partnership with the other health and social care organisations in Sheffield as we collaborate to provide the best services for the people of Sheffield. There is a clear drive to change the way services are provided in Sheffield to deliver real improvements in community care and support for individuals' health and social care needs. We are a key member of the South Yorkshire and Bassetlaw Integrated Care System (ICS), which sees organisations across our region working collaboratively to improve healthcare. Our role in the ICS has enabled us to bid for funding for new services, including our new primary care based mental health service and the QUIT smoking cessation project. We also work in partnership with a diverse group of interested parties across the public and third sector, voluntary and local community groups. This allows us to develop better relationships with other organisations who support people in Sheffield and fosters better collaborative

working between us. We use these opportunities to promote the needs and interests of the people that we serve and to reduce some of the barriers individuals can often experience in accessing the services that they need.

3.1.18 Total income by commissioner



3.1.19 Consultations

Formal consultations we have completed

We have not undertaken any formal consultations during the year about proposed service changes.

Formal consultations we have in progress

At the time of confirming this report there were no formal consultations in progress.

3.1.20 Council of Governors

3.1.20.1 The role of the Council of Governors

Governors play a vital role in governance arrangements of the Trust. They primarily carry out their role through the meetings of the Council of Governors of which there were five in 2020/21.

One meeting in April 2020 was cancelled due to COVID-19. Please see Table 1 in Section 3.1.20.2 for a breakdown of the number of meetings attended by each governor.

From May, and in line with national guidance, our Council of Governor meetings were held virtually on Microsoft Teams. Governors that were unable to participate virtually, and were not required isolate due to shielding, were offered the opportunity to attend in person in a socially distanced room and with the use of personal protective equipment.

All meetings of the Council of Governors are open to members of the public, except in instances where there are confidential matters which need to be discussed. In

these circumstances members of the public are excluded for the confidential items only.

While responsibility for the Trust's management and performance rests with the Board of Directors, the Council of Governors has specific decision-making powers conferred upon it by the Health and Social Care Act 2012 and the Trust's Constitution. These include:

- Holding the Non-Executive Directors both individually and collectively to account for the performance of the Board of Directors
- Holding the Board of Directors to account for the effective management and delivery of the organisation's strategic aims and objectives
- To be consulted by directors on future plans, including any significant changes to the delivery of the Trust's business plan, and offer comment on those plans
- Receiving the annual accounts, any auditor report regarding the accounts, and the annual report
- Deciding whether any private patient work undertaken by the Trust would significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England, or performing the Trust's other functions
- Approving any proposed increases in non-NHS income of 5% or more in any financial year. Approval means that at least half of the governors taking part in the vote agree with the increase
- Approving 'significant transactions'
- Approving an application by the Trust to enter in to a merger, acquisition, separation or dissolution. In this case, approval means at least half the Governors taking part in the vote agree with the amendments
- Approving amendments to the Constitution.

The Council of Governors also plays an equally important role in the governance of the Trust by:

- Assisting the Board of Directors in setting the strategic direction of the Trust
- Monitoring the activities of the Trust with a view to ensuring these are being carried out in a manner that is consistent with the Trust's Constitution and its terms of authorisation
- Representing the interests of members and partner organisations
- Providing feedback to members
- Developing the Trust's membership strategy

- Contributing to constructive debate regarding the strategic development of the Trust and any other material and significant issues facing the organisation
- Building and maintaining close relations between the Trust's constituencies and stakeholder groups to promote the effective operation of the Trust's activities.

In undertaking the above, the Council of Governors ensures that the Board of Directors is held to account by the Trust's key stakeholders.

The Engagement Policy which defines the relationship between the Board and Council sets out clearly the roles and responsibilities of each including that of the Chair, Chief Executive, Lead Governor, Senior Independent Director and governors. Any disputes are resolved in accordance with the Trust's Constitution. The Engagement Policy provides further guidance on action to take dependent upon the nature of the dispute.

3.1.20.2 Composition of the Council of Governors

The Council of Governors comprises 44 seats, 33 of which are elected from the membership. Governors are elected for a three-year term and can hold this position for a total of three terms. Eleven of the seats are for appointed governors from organisations with whom the Trust works (stakeholder organisations). These positions also have a three-year term.

The Council of Governors is chaired by Mike Potts who is also the Chair of the Board of Directors. It is the Chair's responsibility to ensure that governors' views are represented at the Board of Directors and that information from the Board is fed back to the Council. The Chair fulfils this responsibility through regular communication with governors as well as providing updates at each Council meeting. The Chair also gives governors the opportunity to meet on a one-to-one basis.

It is a requirement of the regulator, NHS Improvement, that all Foundation Trusts have a Lead Governor. On 12 December 2019 Terry Proudfoot was elected as the Lead Governor with effect from 01 January 2020 and remains Lead Governor for a two-year period

Five Council of Governors meetings took place during 2020/21. The individual attendance of each governor is shown in the table on the next page which also shows a breakdown of seats on the Council and associated governors throughout the year, including their term of office.

Table 1

Name	Constituency	Elected or appointed	Date appointed	Term ends	Meetings attended
Tony Clayton	Public South East	Elected	01.08.2020	Resigned 25.1.21	2/3
Chris Digman	Public South East	Elected	01.08.2020	31.07.2023	3/3
Jules Jones	Public South East	Elected	01.07.2017	30.06.2020	0/2
Steve Hible	Public North East	Elected	01.07.2019	30.06.2022	5/5
Ahmed Ibrahim	Public North East	Elected	01.07.2019	30.06.2022	2/5
Angela Barney	Public South West	Elected	01.07.2018	30.06.2021	5/5
Ben Duke	Public South West	Elected	01.08.2020	31.07.2023	3/3
Sylvia Hartley	Public North West	Elected	01.08.2020	31.07.2023	4/5
Margaret Spencer	Public North West	Elected	09.08.2019	08.08.2022	1/5
Adam Butcher	Service User	Elected	01.07.2016	30.06.2022	4/5
Nev Wheeler OBE	Service User	Elected	01.09.2020	31.08.2023	0/3
Tyrone Colley	Service User	Elected	01.07.2011	30.06.2020	0/2
Lee Coxon	Service User	Elected	01.07.2018	30.06.2021	0/5
Jonathan Hall	Service User	Elected	01.07.2019	30.06.2022	4/5
Nick Hall	Service User	Elected	01.07.2018	30.06.2021	2/5
Toby Morgan	Service User	Elected	01.07.2018	30.06.2021 Resigned 19.2.21	2/5
Rebecca Lawlor	Service User	Elected	01.09.2020	31.08.2023	3/3
Terry Proudfoot	Service User	Elected	01.07.2016	30.06.2022	5/5

Name	Constituency	Elected or appointed	Date appointed	Term ends	Meetings attended
Kate Steele	Service User	Elected	01.07.2018	30.06.2021	5/5
Joan Toy	Service User	Elected	01.07.2016	30.06.2022	2/5
Billie Critchlow	Carer	Elected	01.07.2016	30.06.2022	4/5
Liz Friend	Carer	Elected	01.07.2019	30.06.2022	4/5
Sue Roe	Carer	Elected	01.07.2013	30.06.2022	4/5
Varria Russell-White	Carer	Elected	01.07.2019	30.06.2022	2/5
Maggie Young	Allied Health Professionals	Elected	01.07.2017	30.06.2020	2/2
Janet Sullivan	VCFS (MENCAP)	Appointed	01.07.2011	30.06.2020	1/1
Natasha Wilson	Young Service User/Carer	Elected	01.08.2020	31.07.2023	2/3
Sue Highton	Staff Side	Elected	01.07.2011	30.06.2020	1/1
Mark Goodwin	Staff Social Work	Elected	05.07.2019	04.07.2022	2/5
Liz Carthy	Staff Psychology	Elected	01.07.2018	30.06.2021	4/5
Julian Davis	Staff Nursing	Elected	01.07.2019	30.06.2022	2/5
Dr Nusrat Mir	Staff Medical	Elected	01.07.2018	30.06.2021	4/5
Adam Rodgers	Staff Clinical Support	Elected	01.08.2020	31.08.2023	4/5
Bradley Wass	Staff Central Support	Elected	01.07.2019	30.06.2022	1/5
Amber Wild	Staff AHP	Elected	01.08.2020	Resigned 12.2.21	2/3
Cllr Adam Hurst	Appointed – Local Authority	Appointed	05.09.2014	04.09.2023	4/5

Name	Constituency	Elected or appointed	Date appointed	Term ends	Meetings attended
Cllr Josie Paszek	Appointed – Local Authority	Appointed	04.02.2015	03.02.2021	2/5
Cllr Steve Ayris	Appointed – Local Authority	Appointed	05.07.2017	04.07.2021	5/5
Fay Colphon	Appointed – SACMHA	Appointed	24.04.2018	23.04.2021	5/5
Muhammad Ali	Appointed – PMC	Appointed	24.01.2020	23.01.2023	0/5
Dave Swindlehurst	Sheffield MENCAP	Appointed	01.07.2020	30.06.2023	4/4
James Barlow	Appointed – Sheffield Carers Centre	Appointed	22.01.2019	21.01.2022	3/5
Mark Gamsu	Appointed – NHS Sheffield CCG	Appointed	15.05.2017	14.05.2020	5/5
Scott Weich	Appointed – University of Sheffield	Appointed	05.09.2017	04.09.2023	5/5
Julie Marsland	Staff Side	Appointed	01.07.2020	30.06.2023	3/4
Susan Wakefield	Appointed – Sheffield Hallam University	Appointed	08.09.2016	07.09.2022	4/5

The attendance of directors at Council of Governor meetings is shown below.

Table 2

Name	Title	Total
Mike Potts	Trust Chair	4/4
Richard Mills	Non-Executive Director and Vice Chair	5/5
Sandie Keene CBE	Non-Executive Director and Senior Independent Director	5/5
Anne Dray	Non-Executive Director	2/2
Heather Smith	Non-Executive Director	5/5
Professor Brendan Stone	Associate Non-Executive Director	1/5
Jan Ditheridge	Chief Executive	5/5
Phillip Easthope	Executive Director of Finance	1/5
Dr Mike Hunter	Executive Medical Director	3/5
Beverly Murphy	Executive Director of Nursing, Professions and Operations	3/4
Caroline Parry	Executive Director of People	3/4
David Walsh	Director of Corporate Governance	5/5
Jayne Brown	Chair (left 31.07.2020)	1/2
Sandie Keene	Non-Executive Director	5/5
Ann Stanley	Non-Executive Director (left 31.10.2020)	2/3
Clive Clarke	Acting Chief Executive (until 01.03.2020) Deputy Chief Executive (02.03.202 – 06.09.2020) Secondment to NHS Improvement (07.09.2020 – present)	1/2
Liz Lightbown	Executive Director of Nursing and Professions	0/3
Dean Wilson	Associate Director of Human Resources (left 30.06.2020)	0/1
Fleur Blakeman	Intensive Support Director NHS England and NHS Improvement	1/3
Rita Evans	Director of Organisational Development	1/3

3.1.20.3 Changes to the Council of Governors

In 2020/21 elections were held for 12 vacancies in nine constituencies.

Constituency	Number of candidates	Successful candidates	Declaration date	Term start date
Public Sheffield South East	2	Chris Digman Tony Clayton	28/08/2020	01/08/2020
Public Sheffield North West	1	Sylvia Hartley	28/08/2020	01/08/2020
Public Sheffield South West	1	Ben Duke	28/08/2020	01/08/2020
Public Rest of England	1	0	28/08/2020	N/A
Service Users	2	Rebecca Lawlor Nev Wheeler OBE	28/08/2020	01/09/2020
Staff – AHP	1	Amber Wild	28/08/2020	01/08/2020
Staff – Clinical Support	1	0	28/08/2020	N/A
Staff – Support Work	1	Adam Rogers	28/08/20	01/08/2020

3.1.20.4 Governor activities in 2020/21

3.1.20.4.1 Holding to account

Throughout the year governors have undertaken several activities which enable them to fulfil their statutory duties, represent members and the public and hold the Trust to account.

The foundation of their success is dependent upon their relationship with the Board. The Board takes specific steps to cement its relationship with the Council of Governors in addition to the action it takes throughout the year to ensure that it fully understands the views of Governors. In 2020/21 Non-Executive Directors continued to share significant issues from Board committees and providing assurance as to how they are being addressed.

Along with the Chief Executive and Non-Executive Directors, other Board members and Trust officers attend Council meetings when appropriate.

According to the Health and Social Care Act 2012, it is the role of the Council of Governors to ensure that the Trust operates within its terms of authorisation. The

Trust must furnish governors with sufficient information to give assurance on the safety, quality and cost effectiveness of its services. This is undertaken through a variety of methods including performance reports to every Council meeting, annual reviews with the Board of Directors and through regular dialogue with Non-Executive Directors.

To further strengthen the Board's accountability and increase its scrutiny, governors are invited to ask questions of the Board at each meeting. The responses to these are formalised in the minutes of Council meetings. Governors have used this mechanism to raise questions on the following topics:

- Access to primary care for people who are not British citizens
- Restraint of people with a learning disability
- The number and impact of flexi staff on services and quality
- Trust mergers
- Disposal and recycling of electrical equipment
- Numbers of qualified nursing staff and Trust plans for succession planning and retirement support
- Inpatient care and the ability to meet demand
- How community services support inpatient demand
- Out-of-area placements for inpatient care
- Sale of personal medical data
- Response to COVID-19
- Suicide bereavement service

3.1.20.4.2 Forward plans

Governor's views on the Trust's forward plans are sought each year along with the views of staff, service users and other stakeholders.

A session took place with governors in October 2020 to seek views on the Trust's strategic direction which helped to shape the Trust's refreshed aims and objectives.

3.1.20.4.3 Other activities

Governors participated in a governor development programme provided by Charis Consultants Ltd.

In addition to their statutory duties, governors were involved in a number of other areas of the Trust including 15 Steps, interviews for key positions and involvement in service development programmes. Through their wider interests, the governors were able to bring a broader spectrum of views to Council.

Governors are required to declare any material or financial interests in the Trust. A copy of the register of interests is available on the Trust's website at www.shsc.nhs.uk/get-involved/council-governors

3.1.20.4.4 The Nominations and Remuneration Committee of the Council of Governors

The appointment of the Trust Chair and other Non-Executive Directors is the responsibility of the Council of Governors. The process of selecting suitable candidates to be recommended for appointment by the Council is delegated to a committee of the Council of Governors known as the Nominations and Remuneration Committee (NRC). In addition, the NRC has responsibility for monitoring the performance evaluation of the Trust Chair and the Non-Executive Directors. It is the responsibility of the Council of Governors to both appoint and remove Non-Executive Directors. Termination requires the approval of three-quarters of the members of the whole Council of Governors pending a formal process involving a number of rigorous elements.

Over the past 12 months the committee has met twice, on 20 July 2020 and 21 January 2021.

The Trust's Chair presides over the meetings except in circumstances where there would be a conflict of interest or regarding the appointment of the Trust Chair in which case the Reserve Chair, who is a member of the Council and Lead Governor, presides. There were two meetings of the Nominations and Remuneration Committee during 2020/21 and attendance of committee members is shown in the table below.

Name	Position	Attendance
Jayne Brown OBE	Chair (left 31 July 2020)	0/1
Mike Potts	Chair (started 01 August 2020)	1/1
Terry Proudfoot	Lead and Service User Governor	2/2
Sylvia Hartley	Public Governor	1/2
Adam Hurst	Appointed Governor	2/2
Adam Butcher	Service User Governor	2/2
Billie Critchlow	Carer Governor	2/2
Maggie Young	Staff Governor (term ended 28 August 2020)	1/1
Jules Jones	Public Governor (term ended 28 August 2020)	0/1
Tony Clayton	Public Governor (resigned 25 January 2021)	0/1

3.1.21 Membership

Foundation Trust status gives the advantage of being closely influenced by the people who live in the communities that we serve. This is reflected in the diversity of the constituencies into which our membership base is divided.

3.1.21.1 Constituencies, eligibility criteria and membership numbers

There are three elected membership constituencies, each of which has a number of classes within. The table details each one and its eligibility criteria and where applicable, the number of members in the class as at 31 March 2021.

Constituency	Class	Number of members	Criteria
Public	South West	2,656	Must live in the following electoral wards: Gleadless Valley, Dore and Totley, Fulwood, Graves Park, Nether Edge, Ecclesall, Beauchief and Greenhill or Crookes.
Public	South East	2,347	Must live in the following electoral wards: Darnall, Manor Castle, Arbourthorne, Richmond, Birley, Mosborough, Beighton or Woodhouse.
Public	North West	1,980	Must live in the following electoral wards: Stocksbridge and Upper Don, Stannington, Hillsborough, Walkley, Broomhill or Central.
Public	North East	2,395	Must live in the following electoral wards: West Ecclesfield, East Ecclesfield, Southey, Firth Park, Burngreave, Shiregreen and Brightside.
Public	Rest of England	539	Any area within England outside of the Sheffield electoral wards.
Service user	Service user	913	Must have received a service or services from the Trust within the last five years.
Service user	Carer	608	Must have cared for someone who has received a service from the Trust in the last five years.
Service user	Young service user or carer	76	A service user or carer but must be 35 years old or younger.
Staff	Allied Health Professional	139	Must have either worked for the Trust continuously for at least 12 months or have a contract of no fixed term.
Staff	Central support	255	

Constituency	Class	Number of members	Criteria
Staff	Clinical support	502	
Staff	Medical and clinical	88	
Staff	Nursing	612	
Staff	Psychology	329	
Staff	Social work	8	
Staff	Support work	386	
Appointed	Stakeholder organisation: PMC	N/A	N/A
Appointed	Stakeholder organisation: SACMHA Health and Social Care		
Appointed	Stakeholder Organisation x 2		
Appointed	Local Councillors x 3		
Appointed	Staff Side		
Appointed	Sheffield Hallam University		
Appointed	University of Sheffield		
Appointed	NHS Sheffield CCG		

At the end of March 2021 there were 11,530 members (excluding staff).

3.1.21.2 Developing a representative membership

As a successful foundation trust, it is our aim to maintain and further develop a membership that involves and reflects a wide representation of our local communities. We have set out how we intend to do this through our membership strategy. As well as defining the membership, this strategy outlines how we plan to:

- Benefit from being a membership-based organisation
- Communicate with and support the development of its membership
- Make sure that the membership is reflective of Sheffield's diversity
- Provide opportunities for our members to become involved with the Trust in ways that suit their needs and wishes.

Some of the actions identified to achieve these four points are:

- Publicising widely the opportunities and benefits of membership
- Recruiting members from across the whole community
- Targeting hard to reach groups specifically
- Developing and supporting effective channels of communication and engagement between Governors and members
- Ensuring membership is a worthwhile experience for individuals by engaging individuals in a manner of their choice.

3.1.21.3 Membership recruitment and engagement

In line with the Trust's membership strategy to both recruit and engage members from across Sheffield, governors and staff participate in several community events, specifically targeting ones in areas of the city with a high ethnicity and targeting specific groups such as people with a learning disability. This was halted in 2020 due to restrictions in place from COVID-19.

The Trust held a successful online Annual Members' Meeting in 2020 which more than 200 staff and members attended. The event provided an opportunity for members to learn more about the Trust and its services. Governors presented a report on their activities to members.

The Trust maintains a public profile, with the primary focus of communication via social media the focus of which remains on issues important to members and the provision of information regarding all aspects of the Trust's services. The Trust's website provides members with updated information and ease of access in communicating with both the Trust and governors. The Trust makes use of social media platforms to promote, inform and engage members and the public.

If you want to contact your governor, you can telephone 0114 2718825, email governors@shsc.nhs.uk or write to:

The Council of Governors
FREEPOST
Sheffield Health and Social Care NHS Foundation Trust

3.1.22 Political or charitable donations we have made

The Trust has not made any political or charitable donations during the year 2020/21 as it is not lawful for an NHS Foundation Trust to make such donations.

3.1.23 Cost allocation and charging guidance

The Trust complies with the cost allocation and charging guidance issued by HM Treasury in 'Managing Public Money', in that we seek to set charges that recover full costs, calculating costs on an accruals basis, including overheads, depreciation and the cost of capital.

3.1.24 Income disclosures

In 2020/21, we met the requirement that 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 as defined under section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

All net income from the provision of goods and services for other purposes has been reinvested back into frontline healthcare for the benefit of service users.

3.1.25 The Better Payments Practice Code

The Better Payments Practice Code target is to pay all non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The disclosure is completed on the basis of total bills paid. The calculations are carried out excluding invoices in dispute.

The Trust pays very few NHS bodies, making percentage compliance for NHS bodies challenging. However, we achieved 100% compliance throughout 2020/21 by both number and value.

Performance for non-NHS bodies is 98% by number and 99% by value.

The Trust is also signed up to the Prompt Payment Code administered by the Chartered Institute of Credit Management of behalf of the Department for Business Innovation and Skills. Code signatories undertake to pay suppliers on time within the terms agreed, give clear guidance to suppliers and encourage good practice through their supply chains. Signatories also undertake to pay suppliers within a maximum of 60 days and to work towards adopting 30 days as the norm.

There is no liability accruing in the year 2020/21 under the legislation as a result of late payments.

Jan Ditheridge
Chief Executive
Date: Wednesday 09 June 2021

3.2 Remuneration Report

Annual statement on remuneration

The Remuneration and Nominations Committee has met on nine occasions during the year and considered the following matters:

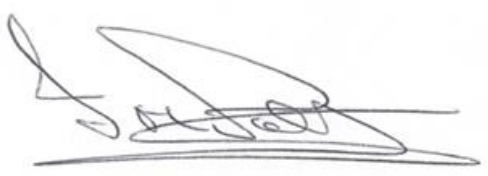
- Executive Director portfolios (08 April 2020)
- Appointment of Interim Executive Director of Nursing and Professions (30 April 2020)
- Appointment of Improvement Director (29 May 2020)
- Interim executive arrangements for human resources (23 June 2020)
- Terms of Reference for the committee (23 June 2020)
- Departure of Director of Human Resources (02 July 2020)
- Executive Director portfolios, interim arrangements and secondment of the Deputy Chief Executive (30 July 2020)
- Nursing leadership changes (17 September 2020)
- Appointment of Executive Director of People (30 December 2020)
- Appointment of Executive Director of Nursing, Professions and Operations (16 March 2021)
- Executive pay review (16 March 2021).

No significant changes to existing levels of executive pay were made beyond national recommendations. Two new executive posts were established, with pay for each taking into account national benchmarking and modelling. The establishment of these roles reflected organisational changes linked to improvements being made in the leadership of the Trust.

The new posts which were different from predecessor roles vacated by departures were:

- Executive Director of People
- Executive Director of Nursing, Professions and Operations.

Signed



Mike Potts
Chair
Chair of Remuneration and Nomination Committee

Date: Wednesday 09 June 2021

Executive Directors' remuneration

The Remuneration and Nominations Committee of the Board of Directors comprises of the Non-Executive Directors. The committee is chaired by Mike Potts, the Trust Chair. The committee is responsible for determining the remuneration and terms and conditions of service of the Executive Directors (including the Chief Executive) in order to ensure that they are properly rewarded having regard to the Trust's circumstances.

The Chief Executive attends the committee's meetings in an advisory capacity. The Executive Director of People and the Director of Corporate Governance (Board Secretary) attend the committee's meetings to provide advice and professional support to its members.

The committee met on nine occasions during 2020/21 and members' attendance is as shown below:

Name	Position	Attendance
Jayne Brown OBE	Committee Chair and Trust Chair (until 30 June 2020)	6/6
Mike Potts	Committee Chair and Trust Chair (from 01 August 2020)	3/3
Richard Mills	Vice Chair and Non-Executive Director	9/9
Ann Stanley	Committee Member and Non-Executive Director (term ended on 31 July 2020)	5/6
Anne Dray	Committee Member and Non-Executive Director (joined the Trust on 01 November 2020)	2/2
Sandie Keene CBE	Committee Member and Non-Executive Director	8/9
Professor Brendan Stone	Committee Member and Associate Non-Executive Director	1/9
Heather Smith	Committee Member and Non-Executive Director	9/9
Dean Wilson	Associate Director of Human Resources (left the Trust on 30 June 2020)	1/1
Caroline Parry	Executive Director of People (started role 11 May 2020)	4/5*

*Caroline Parry declared an interest in an item at three of the committee's meetings so is not classed as being eligible to attend those three meetings. An interest was declared in an item during a fourth meeting and Caroline left for the appropriate item but is still classed as having attended the meeting.

The committee meets at least once a year to decide on the appropriate remuneration and terms and conditions of service of the executive directors. These terms and conditions are determined by the committee and include all aspects of remuneration, provisions for other benefits (such as pensions and cars) and arrangements for termination of employment or other contractual terms.

The committee is responsible for monitoring the performance of the Chief Executive, based on an annual review provided by the Trust Chair, and of all the other executive directors based on an annual report provided by the Chief Executive.

During 2020/21, the committee has delivered its key responsibilities as set out in the terms of reference, including:

- consideration of executive portfolios and executive appointments or exit arrangements, and remuneration thereof. This reflects the changes in staffing in the executive team, including the interim and substantive Executive Director of People, interim and substantive Executive Director of Nursing, Professions and Operations, Improvement Director and Director of Strategy
- Annual business such as the consideration of the committee's annual report.

The executive directors are on permanent contracts, and six months' notice is required by either party to terminate the contract.

The only contractual liability on the Trust's termination of an executive's contract is six months' notice. Any other liability, such as unfair dismissal compensation, would depend on the circumstances of the case.

The table provides details of current executive directors' contracts:

Executive director	**Date of contract**
Jan Ditheridge	March 2020
Clive Clarke	April 2003*
Dr Mike Hunter	October 2016
Liz Lightbown	April 2011 to September 2020
Phillip Easthope	January 2016
Beverley Murphy	March 2021
Caroline Parry	May 2020
Michelle Fearon	October 2017 to August 2020

*Clive Clarke is currently on secondment to NHS Improvement

The Chief Executive undertakes annual appraisals with all executive directors, and progress on objectives is assessed at monthly one-to-one meetings with each executive director.

The Chief Executive reports the outcomes of these appraisals to the Board's Remuneration and Nomination Committee. The Chief Executive's own performance is monitored by the Chair at regular one-to-one meetings, and he is subject to annual appraisal by the Chair who reports the outcome of the appraisal to the Board's Remuneration and Nomination Committee.

The Board's Remuneration and Nomination Committee reviews the remuneration of Executive Directors annually, taking into account information on remuneration rates for comparable jobs in the National Health Service.

The executive directors' remuneration levels are referenced to the Chief Executive's level of remuneration and any increases determined for the Chief Executive. Performance related pay is not applied under current arrangements.

The salary of the Chief Executive is benchmarked annually for review alongside other similar roles across the NHS and specifically both regionally, and against other mental health trusts.

The salary component for executives supports the short and long-term strategic objectives of the Trust as it assists us in attracting and retaining senior managers who have the necessary skills and experience to lead the Trust and take forward the identified objectives. The salary is paid through our normal payroll processes. There is no specified maximum on the level of remuneration which could be paid but account would be taken of available benchmarking information and the relationship with the salaries available to other staff. There is provision, on termination of the contract, for the non-payment of salary in lieu of outstanding leave.

Two members of the executive team attract a salary exceeding the £150,000 threshold warranting specific mention – these are the Chief Executive and the Executive Medical Director. Full consideration was given to their salaries at the Remuneration and Nominations Committee meeting held on 16 March 2021. Any changes in salary have reflected national recommendations.

Non-Executive Directors' remuneration

There is a Nominations and Remuneration Committee of the Council of Governors whose responsibility, among others, is to make recommendations to the Council of Governors on the remuneration, allowances and other terms and conditions of office of the Chair and all non-executive directors. It is for the Council of Governors, in general meeting, to determine the remuneration, allowances and other terms and conditions of office of the Chair and the non-executive directors, taking into account the recommendations made to it by the Nominations and Remuneration Committee.

It is the responsibility of the Council of Governors' Nominations and Remuneration Committee to monitor the performance of the Chair and non-executive directors. The committee may, in appropriate cases, or, if specifically requested by the Council of Governors to do so, report its findings to the Council. Details of the activities of the Nominations and Remuneration Committee for the past year are reported on in Section 3.1.20.4.4 of this report.

Details of the remuneration paid to all of the Directors during 2020/21 are shown in Table A on the following page. The policies applied, and descriptions of these policies are included in Table B. The Non-Executive Directors' duration of office is reported in Section 3.1.8 of this report.

Directors' remuneration and pension entitlements

All executive directors, other than Dr Mike Hunter, are contributing members of the NHS-defined benefit pension scheme and are eligible for a pension of up to half of final salary on retirement. The scheme provides a lump sum of three times the final salary on retirement. Executive directors in the scheme receive the same benefits as other staff members. The 'Pension Benefits' Table C provides details of the current pension and lump sum position for each director.

Table A – Salaries and allowances

Name and title	Period 01.04.20 to 31.03.21							Period 01.04.19 to 31.03.20						
	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Report Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Report Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
J Brown OBE, Chair (up to July 2020)	10-15	0				0	10-15	35-40	0					35-40
M Potts, Chair (from August 2020)	25-30	0				0	25-30	10-15	0					10-15
P Stanley, Non-Executive Director (up to October 2020)	5-10	0				0	5-10	10-15	0					10-15
O Blake, Non-Executive Director (up to December 2019)	0	0				0	0	5-10	0					5-10
R Mills, Non-Executive Director	10-15	0				0	10-15	10-15	0					10-15
Prof. L Serrant OBE, Non-Executive Director (up to July 2019)	0	0				0	0	0-5	0					0-5
S Keene CBE, Non-Executive Director	10-15	0				0	10-15	10-15	0					10-15

Name and title	Period 01.04.20 to 31.03.21							Period 01.04.19 to 31.03.20						
	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Report Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Report Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
H Smith, Non-Executive Director (from August 2019)	10-15	0				0	10-15	5-10	0					5-10
Anne Dray, Non-Executive Director (from November 2020)	5-10	0				0	5-10	5-10	0					5-10
Prof. B Stone, Associate Non-Executive Director	5-10	0				0	5-10	5-10	0					5-10
K Taylor, Chief Executive (up to September 2019)	0	0				0	0	75-80	0				42.5-45.0	120-125
J Ditheridge, Chief Executive (from March 2020)	165-170	0				112.5-115.0	280-285	10-15	0				0	10-15
C Clarke, Executive Director of Operations and Social Care Lead (up to September 2020)	55-60	0				15.0-17.5	70-75	140-145	0				55.0-67.5	195-200
P Easthope, Executive Director of Finance	120-125	0				22.5-25.0	145-150	125-130	0				45.0-47.5	170-175

Name and title	Period 01.04.20 to 31.03.21							Period 01.04.19 to 31.03.20						
	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Report Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Report Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr M Hunter, Executive Medical Director	185-190	0				0	185-190	180-185	0				0	180-185
B Murphy, Executive Director of Nursing, Professions and Operations (from September 2020*)	115-120	0				0	115-120	0	0				0	0
L Lightbown, Executive Director of Nursing, Professions and Care Standards (up to September 2020)	45-50	0				15.0-17.5	65-70	115-120	0				87.5-90.0	205-210
D Gilderdale, Executive Director of Nursing, Professions and Care Standards (May 2020 – July 2020)	30-35	0				0	30-35	0	0				0	0
C Parry, Executive Director of People (from May 2020)	80-85	0				20.0-22.5	100-105	30-35	0				7.5-10.0	40-45

Name and title	Period 01.04.20 to 31.03.21							Period 01.04.19 to 31.03.20						
	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Report Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to the nearest £100)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Report Bonuses (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
M Fearon, Joint Executive Director of Operations and Social Care Lead (December 2019 – August 2020)	40-45	0				17.5-20.0	55-60	30-35	0				7.5-10.0	40-45
A Wilson, Joint Executive Director of Operations and Social Care Lead (December 2019 – March 2020)	0	0				0	0	30-35	0				7.5-10.0	40-45

Paragraph 4 – 16 inclusive of Part 3 of Schedule 8 to the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 requires the disclosure of the remuneration figures detailed above and includes a single remuneration for each senior manager who served during the year in tabular form as shown above.

*Executive Director of Nursing, Professions and Operations B Murphy is on secondment from South London and Maudsley NHS Foundation Trust.

Table B – Senior manager' remuneration – future policy table

Component	Description
Salary and fees	The salary component for executives supports the short and long-term strategic objectives of the Trust as it assists the Trust in attracting and retaining senior managers who have the necessary skills and experience to lead the Trust and take forward the identified objectives. The salary is paid through our normal payroll processes. There is no specified maximum on the level of remuneration which could be paid, but account would be taken of available benchmarking information and the relationship with the salaries available to other staff. There is provision, on termination of the contract, for the non-payment of salary in lieu of outstanding leave.
Other remuneration	No executive currently receives payment under this component.
Taxable benefits	No executive currently receives payment under this component.
Annual performance related bonuses	Performance-related pay is not applied under current arrangements.
Long-term performance related bonuses	Performance-related pay is not applied under current arrangements.
Pension related benefits	There is nothing in addition to the normal NHS pension employer contributions for all staff.

Note: There are no new components of the remuneration package. There have been no changes made to existing components of the remuneration package. The executive directors' remuneration levels are referenced to the Chief Executive's level of remuneration and any increases determined by the Remunerations and Nominations Committee. The remuneration levels for employees are set by Agenda for Change or other relevant agreed contractual arrangements.

The Hutton Disclosure

	01 April 2020 to 31 March 2021	01 April 2019 to 31 March 2020
Band of highest paid director's total (remuneration £000)	185-190	180 – 185
Median total remuneration	27,416	28, 269
Ratio of median remuneration to midpoint of the highest paid director's band	6.8	6.5

In accordance with the Hutton Review of Fair Pay, reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the medium remuneration of the organisation's workforce.

The median remuneration is based on full time equivalent directly employed staff as at 31 March 2021, excluding the highest paid director (as per the guidance).

In this calculation total remuneration includes salary, non-consolidated performance related pay, benefits in kind as well as severance payment. It does not include 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.

Directors and governors expenses

	2020/21 £00	2019/20 £00
Expenses shown in £00s		
Aggregate sum of expenses paid to governors	**0**	1
Aggregate sum of expenses paid to directors	**2**	25
Total	**2**	26

	Number who held office during the year		**Number who claimed expenses during the year**		**Amount claimed in total £00**	
	2020-21	2019/20	**2020-21**	2019/20	**2020-21**	2019/20
Governors	**48**	44	**1**	3	0	1
Executive directors	**9**	8	**1**	5	2	25

Table C – Pension benefits

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

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension at 31 March 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2021 £000	Cash equivalent transfer value at 31 March 2020 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
J Ditheridge, Chief Executive (from March 2020)	5.0-7.5	17.5-20.0	65-70	195-200	1,600	1,397	179	0
C Clarke, Deputy Chief Executive, Executive Director of Operations and Social Care Lead (up to September 2020)	0-2.5	0	35-40	90-95	823	768	42	0
P Easthope, Executive Director of Finance	0-2.5	0	30-35	55-60	451	416	28	0
Dr M Hunter, Executive Medical Director								
B Murphy, Executive Director of Nursing, Professions and Operations (from September 2020)								
D Gilderdale, Executive Director of Nursing, Professions and Care Standards (May to July 2020)	0	0	0	0	0	0	0	0
L Lightbown, Associate Executive Director of Nursing, Professions and Care Standards (up to September 2020)	0-2.5	2.5-5.0	50-55	160-165	1,191	1,110	62	0

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension at 31 March 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2021 £000	Cash equivalent transfer value at 31 March 2020 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
C Parry, Executive Director of People (from May 2020)	0-2.5	0	0-5	0	62	39	23	0
M Fearon, Joint Executive Director of Operations and Social Care Lead (December 2019 to August 2020	0-2.5	0-2.5	20-25	30-35	288	251	33	0

Note: 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 of 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. A small number of staff (48) are, however, members of South Yorkshire Pensions scheme. Further details can be found in the Annual Accounts in note 1.6 and notes 29 and 29.1.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

There is no data for the Executive Medical Director, as Dr M Hunter opted out of the NHS Pension in 2017.

There is no data for the Executive Director of Nursing, Professions and Operations, as B Murphy is on secondment from South London and Maudsley 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.

Service contract obligations

There is a requirement to notify of any outside business interests, contracts or proposed contracts where there is a financial interest. Prior written consent is required for engaging in any other business, profession, trade or occupation.

The intellectual property created during the course of employment belongs to the Trust and there is provision for payment to Trust for any remuneration which arises from such intellectual property.

Policy on payment for loss of office

There is a requirement on each side to provide six months' written notice. The principles for approaching payment for loss of office will be those arising from the legal obligations of the Trust under normal contractual or statutory provisions.

The Trust reserves the right to terminate the contract forthwith for offences of gross misconduct and other similar situations such as serious breach of the contract, becoming bankrupt, being convicted of a criminal offence, becoming permanently incapacitated or becoming disqualified from holding office as an executive director.

Statement of consideration of employment conditions elsewhere in the Trust

The committee took explicit account of the Agenda for Change pay award which was effective from 01 April 2018.

Senior manager remuneration policy

Our objective is to promote diversity and equal opportunity across groups where there is evidence of underrepresentation.

This is identified through a review of data, in particular metrics found in the Workforce Race Equality Standard, the Workforce Disability Equality Standard and Gender Pay Gap review.

Action is identified annually and progress is reported through reports, including the diversity of Board representation in terms of race and disability.

Some of our commitments to diversity and equal opportunity include:

- Members of the Remuneration and Nominations Committee will be compliant with the legal duties incumbent upon them set out in the Equality Act 2010 and related regulations, in particular the duty to have due regard to preventing discrimination and promoting equality of opportunity where people share specific characteristics.
- The committee may consider the use of positive action in recruitment and promotion in line with section 158 and section 159 of the Equality Act 2010.
- The committee will review the diversity of membership of the committee, executive directors and non-executive directors when undertaking its duties and consider appropriate action that may be taken in response.

Jan Ditheridge
Chief Executive
Date: Wednesday 09 June 2021

3.3 Staff Report

3.3.1 Staff numbers and staff costs

Over the past 12 months we have seen a slight increase in substantive staff, and an increase in the use of agency staff.

Average number of employees (whole time equivalent basis)	Permanent number	Other number	2020/21 total number	2019/20 total number
Medical and dental	78	85	**163**	162
Administration and estates	556	88	**644**	623
Healthcare assistants and other support staff	541	94	**635**	611
Nursing, midwifery and health visiting staff	482	26	**508**	501
Nursing, midwifery and health visiting learners	-	15	**15**	12
Scientific, therapeutic and technical staff	273	31	**304**	280
Total average numbers	**1,930**	**339**	**2,269**	**2,189**
Of which:				
Number of employees (WTE) engaged on capital projects	2	1	3	14

Note: staff figures from previous year have been reinstated and adjusted for 2019/20 due to a change in the way the data was sorted.

As of 31 March 2021 the gender ration of staff is 74.51% female and 25.49% male.

Of our directors, eight are female and four are male. Of our other senior managers, 43 are female and 21 are male.

	Permanent £000	Other £000	2020/21 Total £000	2019/20 Total £000
Salaries and wages	87,302	663	**87,965**	79,485
Social security costs	8,366	-	**8,366**	7,495
Apprenticeship levy	411	-	**411**	370
Employer's contributions to NHS pensions	14,790	-	**14,790**	13,511
Pension cost – other	55	-	**55**	48
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	315	-	**315**	161
Temporary staff	-	4,721	**4,721**	4,096
Total gross staff costs	**111,239**	**5,384**	**116,623**	**105,166**
Recoveries in respect of seconded staff	-	-	**-**	**-**
Total staff costs	**111,239**	**5,384**	**116,623**	**105,166**
Of which				
Costs capitalised as part of assets	296	83	**379**	723

3.3.2 Sickness absence

The sickness absence rates for the Trust can be found on the NHS Digital website by following the link below:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

3.3.3 Supporting disabled employees

We have now started to report detailed information about disability as part of the Workforce Disability Equality Standard (WDES).

Although several of our Workforce Disability Equality Standard metric scores are concerning as an organisation the percentage of our staff who report disability is 7% which is encouraging compared to the national average of 0.9% to 9.4%.

We have a target to improve the percentage of staff whose disability status is 'not known' to below 8% by 2024 – it is currently 15%.

In 2020 we undertook action to improve reporting which identified that staff felt that the national electronic staff record system was difficult to update. We are continuing to focus on improving this.

Other highlights of 2020/21 include:

- The relaunch of our Disability Staff Network Group

- The Disability Staff Network Group produced and launched a Workplace Adjustment and Wellbeing Passport. The passport is a document that explains what workplace adjustments have been made for an employee with a disability, long-term health condition, impairment or neurodiversity. The aim is to support staff to access the right provision and development opportunities, and remove or reduce barriers that employees with an impairment or disability may face in their workplace.
- Our Lived Experience Staff Network Group continued to develop and influence areas such as policy development and our new People Strategy.
- Disability Sheffield completed a review of evidence we provided to support us moving to being a Disability Confident Leader and confirmed that they will support our application.
- COVID-19 has been a challenge but has also led to opportunities to involve more people in our staff network groups.
- At the request of carers in our organisation a Carers Staff Network Group was launched. This was particularly important because we know that a number of our staff care for a relative or friend who is disabled, and areas such as flexible working and support, are essential so that people can continue to work despite their unpaid carer role.
- Reviewed and updated our Disabled Staff Policy in collaboration with the Disability Staff Network Group.

You can read more about our work in this area on our website at www.shsc.nhs.uk/about-us/equality-diversity-and-inclusion

3.3.4 Staff engagement and involvement

The Trust has a range of methods for keeping staff informed on matters of concern to them as employees. These include:

- A weekly email from the Chief Executive
- Regular COVID-19 information briefings
- A weekly all staff newsletter
- An extranet where the latest news, events and documents are shared
- Monthly leadership engagement meetings with the Chief Executive
- Engagement with various staff network groups on specific areas of concern.

In March 2019 the Trust adopted the Listening into Action programme, with a focus on staff engagement and empowerment. This model of staff engagement has been our focus for the past two years. The programme was introduced on the basis of our deteriorating results in the national NHS Staff Survey, and is designed to address the priority areas highlighted by staff in the feedback they shared in the survey.

The first step of Listening into Action involved a pulse check to gauge how staff felt about working at the Trust. A number of key themes emerged from the feedback and work began across the organisation to address them. One of the main focuses was engaging with our senior leaders to help them create a dialogue between staff and leaders, and to enable them to respond to and engage with staff concerns and ideas for improvement. The past year has seen the further embedding of collaborative work across the Trust in relation to:

- Reviewing and enhancing our approach to dealing with bullying and harassment
- Improving the visibility and engagement of senior leaders and staff in clinical teams through visits to services and leadership forums
- Reviewing and enhancing our Trust-wide approach to supervision and reflective practice
- Reviewing processes and enhancing the experience of staff experience joining the Trust
- Introduction of trained and supported culture champions across the Trust
- Improving relationships and connections across the Trust via the introduction of the ‘Coffee and Connections’ initiative, as well as initiatives focused on fostering connections between staff
- A month long health and wellbeing festival for staff, with a focus on resilience and intervention. We held more than 60 online sessions for staff join live or access recordings of.

In addition to organisation wide initiatives, the focus has also been on introducing initiatives to support individual empowerment and engagement of staff, with a focus on devolving decision making and supporting staff to feel able to lead on change and improvement.

Using the Listening into Action ‘7 Steps’ methodology, small teams of staff came forward with innovative ideas for change within the organisation. The methodology aimed to support teams and help unblock the barriers they faced to make those changes. Examples of work undertaken via this process include:

- Career development opportunities for administrative staff
- Introduction of a physical health check for clinic for service users
- Electric bike trial for staff to use for clinical visits
- Development of the Peer Worker role
- Introduction of a ‘Walking Alongside’ mentoring scheme
- Introducing pet therapy to an inpatient setting.

Contracting with the Listening into Action approach has now come to an end.

We now have more than 50 stories of successful initiatives and outputs from this work. The newly emerging approach to staff experience and engagement within the Trust offers a broader perspective and methodology, and draws significantly on the evidence base around staff engagement as outlined by the Kings Fund. This approach offers a similar focus of intervention on tackling Trust wide challenges at an organisation level, while simultaneously empowering and supporting staff to be innovative and lead change.

The organisational development remit has also expanded to include the leadership of the NHS Staff Survey. This, together with an approach to draw together all staff experience feedback and data within the Trust will inform the priorities taken forward in the coming year.

3.3.5 Staff consultation

We engage with Staff Side, the Trust's union representatives, on a continuing basis. This includes established mechanisms such as the Joint Consultative Forum, Joint Policy Group and, for medical staff, the Joint Local Negotiating Committee (JLNC).

In addition, there are specific arrangements put in place for particular issues or topics.

This year we have not only continued to work closely in partnership with Staff Side to co-produce some of our key policies, including our Unacceptable Behaviours Policy and supporting guidance, we have come together to rapidly respond to changes needed to keep staff safe during the pandemic. Staff Side have held a place on key working groups, including our Working Safely Group and supported local consultation forums.

We have continued to work closely with the British Medical Association (BMA) to respond to national NHS decisions relating to Associate Specialists and Local Excellence Clinical Awards.

We have continued to work to develop strong partnership relationships and worked together to support the review of our community mental health teams, as well as embedding our new approach to organisational change agreed in 2020. The re-organisation of our substance misuse services (following the award of a new contract) is a good example of positive partnership working and meaningful staff engagement. This process is still underway, however, close working relationships with Staff Side have enabled us to work through the complexities of this particular change process, ensuring staff voices are heard and are influencing the change process.

We are currently establishing mechanisms to ensure that Staff Side are engaged in organisational change projects from the beginning, ensuring that they are involved in activities such as establishing timetables for change and reviewing staff mapping into new structures.

3.3.6 Education, training and development

Mandatory training

We have a dedicated education, training and development department which commissions and delivers core mandatory, clinical skills and specialist training for our staff to ensure that they meet the essential training requirements for their roles. Our aim is to ensure we always have the staff with the rights skills at the right time to provide high quality, safe care to our services users. We have maintained excellent compliance with mandatory training with 21 subjects at 89.89% at end of December 2020 up from 84% in December 2019.

Due to COVID-19 face-to-face training was paused in March 2020. Corporate induction and 18 subjects were reviewed and online content with assessments introduced to ensure staff could continue to access training despite the pandemic. In August 2020 we restarted face-to-face training for Respect, Immediate Life Support and Moving and Handling with smaller groups using enhanced PPE.

The new ways of working have been positively received by staff across the Trust. The training programmes can be accessed by all staff including those working from home and shielding. Over the next year we plan to embed this new way of working enhancing the programmes and adding as many programmes as possible to our Electronic Staff Record (ESR) system.

Apprenticeships

We currently have 76 staff studying on 17 different apprenticeships within the Trust. In 2020/2021 we had 49 apprentices join the organisation. Apprenticeships are currently used to support recruitment and retention of Registered Nurse, Support Worker and Pharmacy Technician roles in a response to workforce shortages, as well as for new role development including Trainee Nursing Associates (TNA) and Clinical Associate Psychologist (CAP). Apprenticeships also support staff retention and career progression in estates, IT and human resources roles, as well as for leadership development from level 3 to level 7. The COVID-19 pandemic has had some impact on apprenticeships with delayed start dates, apprentices placed on pause and learners needing extra time, however, our retention rate has been unaffected.

Recovery Education Unit

The Recovery Education Unit (REU) is founded on the principles of co-production, with the team made up by staff with academic and professional credentials and the credentials of lived experience. Over the years, we have trained many staff from SHSC and other NHS trusts across Yorkshire and the Humber in recovery-based practice. The range of training includes short recovery-based practice courses to the postgraduate MSc programme which has inspired many completing the programme to go into leadership roles and further influence practice. The inclusivity and attendance of all the courses has seen staff from variety of roles and backgrounds including support workers, nurses, social workers, occupational therapists, psychiatrists and psychologists.

During 2020/21 the team had to adapt to the many challenges imposed through the pandemic. Homeworking saw all courses adapted to be delivered online in order for programmes to be continued to be delivered. Students who ordinarily would be taught face-to-face had to adapt to the online platforms.

Changes to funding for the Recovery Education Unit has led to a reduced team composition and the way in which the team provide courses. During this transition phase, the team have been busy supporting the Trust's 'Back to Good' programme. A Trust-wide supervision course was developed by the team and continues to be rolled out weekly. The team have also supported staff in inpatient settings with recovery care plans, induction of student nurses and assisting with the implementation of the peer support training programme.

Cognitive Behavioural Psychotherapy Education

The Cognitive Behavioural Psychotherapy Training Department is accredited with the British Association for Behavioural and Cognitive Psychotherapies at level 2, so graduates can be accredited with the BABCP as qualified therapists at the end of the course.

Two of the department's most popular courses in ACT and Mindfulness, this year were accepted as modules at Sheffield Hallam University. Students can now claim academic credit and use these courses towards broader qualifications. The department also runs an online 'Introduction to CBT' course for healthcare staff. As the content is mostly delivered online through learning materials, online discussion and regular video supervision of clinical learning, this course has forged ahead with minimal disruption.

This year, as the team adapted to the pandemic, teaching moved online without a break, initially using Zoom and then Microsoft Teams. All students completed the course on schedule, a testament to the resourcefulness, adaptability and hard work of the students and staff involved. As with other years, 100% of graduates went into CBT roles either before or shortly after completing studies.

Due to changes in Health Education England funding and other clinical pressures the decision was made not to continue the Cognitive Behavioural Postgraduate Diploma this year and we did not run the Year 1 course. Like everyone else, students are having to adapt their clinical work to constantly changing circumstances. Despite moving fully online again due to further lockdowns, students are on course to complete this year.

Nursing – pre-registration training and new role developments

Pre-registration mental health nursing

COVID-19 restrictions, coupled with the skill mix within some teams, led to a significant drop in placement capacity earlier this year although we have now restored our capacity to pre-COVID-19 levels and provided placements for all second and third year students enabling them to progress through training without any delay to their qualification. Key to the expansion of our placement capacity is the

development of our practice supervisor workforce. We are also exploring how students can be rostered more efficiently to ensure they are allocated across all available shifts maximising capacity whilst mitigating the risk of having too many learners on shift at any given time.

In January 2021 we saw the launch of Aspirant Excellence Centre project at Firshill Rise. In collaboration with Sheffield Hallam University, the ICS Learning Environment and Placements consortia (LEAPS), local PIVO providers and linking to the North East and Yorkshire region RePAIR programme we aim to develop alternative sustainable placement delivery models which can be utilised across the fields of nursing to increase placement capacity.

Open University Registered Nurse Degree Apprenticeship (RNDA)

We currently have 14 apprentices on the Open University Registered Nurse Degree Apprenticeship programme, one of whom is our first trainee within learning disability services. Utilising additional Health Education England financial support we have been able to increase our intake from two to 10 within the current academic year which will take our total cohort size to 19 by the autumn. Our first two apprentices are on track to qualify by early 2022. All apprentices have been recruited internally and to date we have zero attrition from the programme. It is our expectation that a number of Nursing Associates will take the opportunity to progress onto RNDA in the future.

Trainee Nursing Associates

The first cohort of four trainees successfully completed their training in January 2021. We currently have 12 members of staff enrolled on the two-year apprenticeship, two of whom are training for roles within learning disability service. A further five apprentices have been recruited to commence their training in March 2021. Some apprentices were unable to access alternative placement experiences during the pandemic and we are currently working on placement recovery plans to enable them to achieve the required number of hours to graduate on schedule.

Advanced Clinical Practice

In collaboration with the South Yorkshire and Bassetlaw Advanced Clinical Practice Faculty, Primary, Community and Mental Health Care Project the Trust is supporting 14 members of staff to study the Advanced Clinical Practice MSc with Sheffield Hallam University. Our involvement in the project is helping to shape future mental health advanced practice education with the introduction of specific mental health modules to the MSc programme.

Medical education

We have a well-established relationship with the University of Sheffield’s Medical School, leading on teaching in psychiatry to undergraduate medical students across the five-year course we will support around 240 students per year (increasing to 310 over the next three years) as the lead organisation for clinical placements in the region. This year we are also providing placements for approximately 40 Physician

Associates in conjunction with the University of Sheffield and Sheffield Hallam University.

Additionally, we run several recruitment initiatives to encourage students and doctors to consider psychiatry as a career and offer selected student-selected components.

We have two undergraduate Clinical Tutors, a Patient Ambassador with lived experience and a Nurse Educator to support the development and improvement of undergraduate medical and physician associate education. We have a number of volunteer service users providing support to medical and physician associate students.

We have also recruited six undergraduate Consultant or SAS Medical Placement Leads from across the Trust to ensure students get a broad and supported learning experience on placement. Many trainees are involved in supporting medical education projects and we have actively supported a curriculum review process in the Medical School to enhance students' exposure to mental health, social accountability and psychiatry themes.

Psychiatry is considered a hard to fill training specialty and we have recruited Clinical Fellows on fixed term contracts over the last year to be able to overcome the challenges of low recruitment. They are being supported to develop skills in psychiatry and three have now joined the training scheme. We have also recruited 11 qualified Physician Associates (PA) to support the care of patients in our inpatient wards, learning disability and recovery services. Educational input for them is being provided by colleagues in the Medical Education department and we plan to recruit a lead PA tutor this year. We are also supporting the educational needs of Advanced Clinical Practitioners as part of workforce development initiatives. We have received good feedback from the South Yorkshire and Bassetlaw Faculty of Advanced Practice in relation to our ACP and PA programmes.

We are the lead employer for the postgraduate psychiatry training scheme in South Yorkshire and have a dedicated team to ensure a high quality and varied training experience. We have 13 foundation posts, 14 core posts and 14 higher training posts in old age, general adult and specialist areas.

We have a robust teaching programme which includes regular Continuing Professional Development sessions and we also hold local and regional teaching events with service user involvement. We successfully moved the delivery of all teaching to a virtual method within two weeks of the COVID-19 pandemic to allow continuation of teaching. We have provided all doctors in training with a laptop to allow accessibility to online teaching and a more flexible approach to work.

We offer varied special interest opportunities in medical education (including medical student teaching), research and quality improvement. At a recent Health Education England quality visit, foundation and core trainees reported feeling well supported with sufficient learning opportunities and there are no open conditions. The GMC National Training Survey and HEE Education and Training Survey have shown trainees are happy with their training experience.

Enhanced support is provided to black and minority ethnic trainees and international medical graduates, and we have a Less Than Full Time Work champion who is supporting the increasing number of doctors who choose to train part time.

We provide a monthly medical education meeting for trainees hosted by the Director of Medical Education and a weekly doctor's call for all doctors hosted by the Medical Director.

Following the publication of 'Supported and Valued' by the Royal College of Psychiatrists, we host a quarterly Enhanced Junior Doctor Forum led by higher trainees to improve communication between trainees and senior management.

We work closely with the University of Leeds to deliver the Core Psychiatry Training Course to help prepare core trainees for college exams and life as a higher trainee. We also host guest lecturers and use videoconferencing facilities to take advantage of clinical expertise in the region.

3.3.7 Health and safety

We aim to maintain an environment and practices which are safe and supportive for service users, staff and visitors.

The Trust has an established Health and Safety Committee with representatives from managers, staff and trade unions, which is chaired by an executive director and which has recently revised its terms of reference.

The role of the committee is to provide the Trust with an overarching view of health and safety performance and to provide assurance that health and safety risks are effectively managed, to promote co-operation across the Trust on all matters of health and safety and to monitor and escalate any significant health and safety compliance risks to the People Committee.

Work within the last year has included implementation of a robust health and safety workplace risk assessment process and the provision of additional training to support this.

A new post of Health and Safety Manager has been created and appointed to oversee this work.

3.3.8 Occupational health

Our approach to occupational health involves the following strands:

- Occupational health service – provided by People Asset Management (PAM) since 01 September 2018, and includes Level 1 and 2 of the Psychological Stepped Care Model. PAM also provided risk assessments for shielding staff returning to support workplace adjustment.
- Workplace Wellbeing – this is our own free, confidential staff counselling and consultation service which is available to both individuals and groups of staff as well as bespoke stress resilience sessions for teams. In addition, we have been able to access the South Yorkshire and Bassetlaw Integrated Care

System's Psychological Wellbeing Hub which we have used to support our own capacity and demand.

- Health and wellbeing – we provide a dedicated page on our staff extranet which helps direct staff to a range of useful local, regional and national resources and tools to assist with promoting a healthy and active lifestyle, including the free access to the wellbeing apps such as Sleepio and Headspace.
- Training and interventions – we provide specific training on key health related areas such as back care, manual handling, stress awareness, dealing with conflict, coping with COVID-19 and this year we launched a month long winter wellbeing event with over 60 online sessions for staff to access everything from yoga to physiotherapy. Many of the sessions were run by staff of the Trust and represent a huge collaboration.
- COVID-19 - this year we set up a COVID-19 staff support forum for staff who were shielding and for those affected by COVID-19. We also provided risk assessments for all extremely clinically vulnerable and vulnerable staff.
- Our flu campaign for 2020/21 was the most successful we have ever had with over 82% of the workforce being vaccinated.

3.3.9 Countering fraud, bribery and corruption

The Director of Finance is responsible for ensuring compliance with the NHS Counter Fraud Authority strategy for countering fraud, bribery and corruption and the application of the related NHS Counter Fraud Authority Standards for Providers. Our Counter Fraud Service is provided by 360 Assurance and the Local Counter Fraud Specialist attends meetings of the Audit and Risk Committee to provide updates on progress against the annual work plan and compliance with Standards for Providers in the following areas:

- Strategic governance
- Inform and involve
- Prevent and deter
- Hold to account

Staff are trained in fraud awareness and we actively promote the mechanisms for staff to report any concerns. All concerns of fraud, bribery and corruption at the Trust are referred to the Local Counter Fraud Specialist and addressed in accordance with the Trust's Fraud, Bribery and Corruption Policy. The Local Counter Fraud Specialist reports annually on all work undertaken, including the outcome of investigations.

3.3.10 Gender Pay Gap

Information on the Trust's Gender Pay Gap data can be found at https://gender-pay-gap.service.gov.uk

You can find out more about the Trust's approach to equality and the Gender Pay Gap at www.shsc.nhs.uk/about-us/equality-diversity-and-inclusion

3.3.11 Staff Survey

The NHS Staff Survey is conducted annually. From 2019 onwards, the results from questions have been grouped to give scores against theme areas. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The response rate to the 2020 Staff Survey among our staff was 41%, up slightly from 40% in 2019. Scores for each indicator together with that of the survey benchmarking group (mental health/learning disability) are presented below. Please note the theme 'Quality of Appraisals' has been removed for 2020.

	2020/21 2020 Survey		**2019/20 2019 Survey**		**2018/19 2018 Survey**	
	Trust	Benchmark Group	Trust	Benchmark Group	Trust	Benchmark Group
Equality, Diversity and Inclusion	**8.8**	9.1	**8.9**	9.0	**9.0**	8.8
Health and Wellbeing	**6.0**	6.4	**5.7**	6.0	**5.8**	6.1
Immediate Manager	**7.1**	7.3	**7.2**	7.3	**7.2**	7.2
Morale	**6.1**	6.4	**6.1**	6.3	**6.0**	6.2
Quality of Appraisals	**N/A**	N/A	**5.1**	5.8	**5.1**	5.7
Quality of Care	**6.8**	7.5	**6.9**	7.4	**6.6**	7.3
Safe Environment – Bullying and Harassment	**7.9**	8.3	**7.9**	8.0	**7.9**	7.9
Safe Environment – Violence	**9.3**	9.5	**9.3**	9.3	**9.3**	9.3
Safety Culture	**6.1**	6.9	**6.1**	6.8	**6.2**	6.7
Staff Engagement	**6.6**	7.2	**6.7**	7.0	**6.7**	7.0
Team Working	**6.7**	7.0	**6.7**	7.0	**6.8**	6.9

The Trust Benchmark Report is available online at https://www.nhsstaffsurveyresults.com/homepage/local-results-2020/benchmarking-organisation-overview-2020/

Our results in 2020 showed very little difference to those of 2019. Only one theme (health and wellbeing) was shown to statistically change over the year. Although this was a marginal improvement it was encouraging to see. All other themes were reported similarly to or marginally down on 2019.

A refreshed approach to leading the NHS Staff Survey within the Trust has been introduced throughout the latter part of 2020. This new approach has placed greater focus on outreach engagement with leaders, managers and teams and has already been piloted across the organisation.

Greater transparency of result reporting, at an organisation level as well as a local team level has been introduced, including:

- Full Trust results available to staff on the extranet
- Local team (pathway) results available on the extranet
- Staff Survey engagement posts have been piloted to engage with and support teams to take action at a local level
- A greater focus on engagement and co-ownership with leaders and managers, to take forward organisation wide improvements
- A refreshed terms of reference for the Staff Survey Steering Group with a focus on outreach engagement across the Trust.

Priorities for 2021/22

A refreshed approach to leadership of the Staff Survey and staff engagement via the organisational development team aims to embed the outreach approach described above throughout 2021 to review Staff Survey process across the Trust.

This will include the production of local team feedback reports and engagement around local priorities for change.

A cultural transformation project introduced to address significant areas of negative feedback within the results which will include:

- Trust-wide culture and leadership development programme, based on the NHS Improvement framework for compassionate and inclusive leadership (developed with the Kings Fund and The Centre for Creative Leadership to help Trusts to develop cultures that enable and sustain continuously improving, safe, high quality and compassionate care)
- Refresh of the Trust’s values and the embedding of a behavioural framework to underpin

- Create consistent, safe and inclusive work environments where everyone can flourish and do their best work
- Continue the ‘Big Conversation’ to tackle direct and systemic racism, which is aligned with our Equality, Diversity and Inclusion Strategy and Workplan
- Delivery of refreshed staff experience and engagement work plan with a focus on aligning collated staff feedback from across the Trust with the known psychologically informed evidence base on staff motivation and engagement, to inform significant areas for intervention.

This work is a key strand of the Organisational Development Enabling Strategy 2021-2023, of which the key aims is to enable the delivery of our Trust’s People Strategy and support all leaders and staff to develop our workplace culture to consistently support the delivery of high quality, compassionate care.

3.3.12 Trade Union Facility Time

All public-sector organisations that employ more than 49 full-time employees are required to submit data relating to the use of facility time in their organisation as per the Trade Union (Facility Time Publication Requirements) Regulations 2017.

The current reporting year is for the 12 months from 01 April 2019 to 31 March 2020. ‘Facility time’ is the provision of paid or unpaid time off from an employee’s normal role to undertake trade union duties and activities as a trade union representative.

There is a statutory entitlement to reasonable paid time off for undertaking trade union duties. There is no statutory entitlement to paid time off for undertaking trade union activities. The data below relates to the period 01 April 2019 to 31 March 2020 – this is known as the relevant period.

Relevant union officials

Number of employees who were relevant union officials during the relevant period	21
Full-time equivalent employee number for the Trust	21

Percentage of time spent on facility time

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

Percentage of time	Number of employees
0%	0
1% - 50%	18
51% - 99%	1
100%	2

Percentage of pay bill spent on facility time

Total cost of facility time	£104,951
Total pay bill	£104,565,394
Percentage of the total pay bill spent on facility time	0.10%

Paid trade union activities

The number of hours spent by employees who were relevant union officials during the relevant period on paid trade union activities as a percentage of total paid facility time hours.

Time spent on paid trade union activities as a percentage of total paid facility time hours	8.87%

3.3.13 Expenditure on consultancy

In 2020/21 the Trust spent £703,833.33 on consultancy. Consultancy work carried out for the Trust included project management for the Leaving Fulwood project, strategic human resources and workforce advice and the development of a new physical health platform.

There was also consultancy carried out to review and develop proposals for new agile ways of working post COVID-19.

3.3.14 Off-payroll engagements

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

Table 1: For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2021	**0**
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed between one and two years at time of reporting	0
Number that have existed between two and three years at time of reporting	0
Number that have existed between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2020 and 31 March 2021, for more than £245 per day and that last longer than six months.

Number of new engagements, or those that reached six months in duration, between 01 April 2020 and 31 March 2021	**0**
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to the entity) and are on the entity'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 01 April 2020 and 31 March 2021.

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	**1**
Number of individuals on payroll and off-payroll that have been deemed 'Board members, and/or, senior officials with significant financial responsibility', during the financial year. These figures should include both off-payroll and on-payroll engagements.	**6**

The single off-payroll engagement is in relation to the secondment of the Executive Director of Nursing, Professions and Operations from another NHS body as disclosed in the Remuneration Report. For tax and National Insurance purposes this transaction forms part of the NHS payroll system, however, declared as "off-payroll" from SHSC's position at the end of the reporting period. In addition to this, the Executive Director of Nursing, Professions and Operations has been appointed permanently by the Trust on 16 March 2021, therefore effectively on-payroll from April 2021.

3.3.15 Exit packages

Staff exit packages

Reporting of compensation schemes - exit packages 2020/21

Departures disclosed below are the legacy of the previous service restructure after exhausting all possible redeployment options within the Trust.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	-	**1**
£10,000 - £25,000	-	-	**-**
£25,001 - £50,000	1	1	**2**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**3**	**1**	**4**
Total cost (£)	£153,000	£49,000	**£202,000**

Reporting of compensation schemes - exit packages 2019/20

Departures disclosed below are the legacy of the previous service restructure after exhausting all possible redeployment options within the Trust.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	-	**1**
£10,000 - £25,000	-	-	**-**
£25,001 - £50,000	1	1	**2**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**3**	**1**	**4**
Total cost (£)	£123,000	£36,000	**£159,00**

	2020/21		2019/20	
	Payments agreed number	**Total value of agreements £000**	**Payments agreed number**	**Total value of agreements £000**
Voluntary redundancies including early retirement contractual costs	-	-	1	38
Contractual payments in lieu of notice	1	49	-	-
Total	**1**	**49**	**1**	**38**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

3.3.16 Staff turnover

Information on our turnover of staff can be found on the NHS Digital website at digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

3.3.17 Equality, diversity and inclusion

You can find out more about our approach to equality, diversity and inclusion, including our performance against national targets, barriers we have identified and our plans to overcome them in our dedicated Equality Report in Section 3.8 of this report, or by visiting our website at www.shsc.nhs.uk/about-us/equality-diversity-and-inclusion

3.4 Code of Governance Disclosures

Our commitment to good governance

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance followed by all those who play a part in the conduct of the Trust's business.

The Board recognises that the purpose of the NHS Foundation Trust Code of Governance (the Code), published by NHS Improvement, the independent regulator of NHS Foundation Trusts, is to assist NHS Foundation Trust Boards and their governors to improve their governance practices by bringing together the best practices from the public and private sectors.

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

Application of the main and supporting principles of the Code of Governance

The Board implements the main and supporting principles of the Code through a number of key governance documents, policies and procedures, including:

- the Trust's Constitution
- the Standing Orders of the Board of Directors and the Council of Governors
- the Scheme of Reservation and Delegation of Powers of the Board of Directors
- the Standing Financial Instructions
- the Annual Governance Statement
- Codes of Conduct and Standards of Business Conduct
- the Annual Plan and the Annual Report
- authority structures and terms of reference for the Committees of the Board of Directors and Council of Governors.

Compliance with the provisions of the Code

In 2020/21 the Trust complied with all relevant requirements of the Code with the exception of one provision, save that the organisation has retained an arrangement whereby non-executive directors serve a term of four years, rather than three as per the Code, as a review in 2019/20 found that this provided a greater degree of stability and continuity without compromising independence.

It should also be noted that during 2020/21, the organisation has been through a period of significant change in relation to governance arrangements, among other things, arising from an improvement programme developed in response to a Care Quality Commission inspection which took place in 2019/20.

Disclosure of corporate governance arrangements

In accordance with the disclosure requirements of the Code, the Board of Directors makes the following disclosures:

In accordance with the disclosure requirements of the Code, the Board of Directors makes the following disclosures:

A.1.1 Statements on how the Board of Directors and the Council of Governors operate, including high level statements of which types of decisions are to be taken by each one of them and which are to be delegated to the management by the Board of Directors, are contained in Sections 3.1.7 and 3.1.20 of this report. A statement describing how any disagreements between the Council of Governors and the Board of Directors will be resolved is contained in Section 3.1.20.

A.1.2 The names of the Chair, the Vice-Chair, the Chief Executive, the Senior Independent Director, Chairs and members of the Board of Directors' Remuneration and Nomination Committee, the Council of Governors' Nominations and Remuneration Committee and the Audit and Risk Committee are contained Sections 3.1.2, 3.1.3, 3.1.11 and 3.1.20.4.4 of this report. The number of meetings of the Board of Directors, its committees and the attendance by individual directors are shown in Sections 3.1.8 and 3.1.10 of this report.

A.5.3 The names of the governors, details of their constituencies, whether they are elected or appointed, the duration of their appointment and details of the nominated Lead Governor are contained in Section 3.1.20.2 of this report. The number of meetings of the Council of Governors and the individual attendance by governors and directors is also contained in Section 3.1.20.2.

B.1.1 The Board considers the following non-executive directors to be independent in character and judgement:

I. Mike Potts (Chair)
II. Anne Dray
III. Richard Mills
IV. Sandie Keene CBE
V. Heather Smith

The Board holds this view in relation to all of the above-mentioned directors for the following reasons:

- None of them is employed by the Trust or has been in the last five years
- None of them has, or has had, within the last three years, a material business relationship with the Trust, either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust
- None of them has received or receives additional remuneration from the Trust apart from their director's fee. They do not participate in any performance-related pay as no such scheme is run by the Trust nor are they a member of the Trust's pension scheme
- None of them has close family ties with any of the Trust's advisers, directors or senior employees
- None of them holds cross-directorships or has significant links with other directors through involvement (with those other directors) in other companies or bodies
- None of them is a member of the Council of Governors
- None of them has served on the Board of this NHS Foundation Trust for more than 10 years.

B.1.4 Contained in Sections 3.1.11 and 3.1.13 of this report is a description of each director's expertise and experience and a statement on the Board of Directors' balance, completeness and appropriateness. In addition, it also contains information about the length of appointments of the non-executive directors. Information about how non-executive director appointments may be terminated is contained in Section 3.1.20.4.4.

B.2.10 An explanation of the work of the Remuneration and Nomination Committee which oversees the appointment process of executive members of the Board can be found in Sections 3.1.10.2 of this report. The work of the Nominations and Remuneration Committee of the Council of Governors, including the process it has used in relation to Board appointments together with an explanation of whether a search consultancy was used in the appointment of the Chair or the non-executive directors, is contained in Section 3.1.20.4.4 of this report.

B.3.1 The Trust Chair's other significant commitments and any changes to them during the year are contained in the Directors' Register of Interests referred to in Section 3.1.12 of this report.

B.5.6 A statement about how the governors have canvassed the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the Trust's forward plan, including its objectives, priorities and strategy, and how their views were communicated to the Board of Directors is contained in Section 3.1.20.4.2 of this report.

B.6.1 A statement on how the performance of the Board, its committees and individual directors was evaluated is contained in Section 3.1.13 of this report.

B.6.2 Relating to external evaluation of the Trust Board and governance of the Trust a number of activities have taken place.

An improvement programme arising from the 2019/20 CQC inspection of the organisation has been in place throughout 2020/21, with significant monitoring and engagement of NHS Sheffield CCG and the CQC.

In addition, 360 Assurance, the Trust's internal auditors conducted a number of governance reviews. Following each review detailed actions plans were completed and monitored.

C.1.1 An explanation from the directors of their responsibility for preparing the accounts and a statement by the auditors about their reporting responsibilities is contained in Sections 3.1.4 and 3.6 of this report and the approach taken to quality governance is detailed in the Annual Governance Statement in Section 3.7.

C.2.1 A report that the Board has conducted a review of the effectiveness of the Trust's system of internal controls is contained in Section 3.1.10.1 of this report.

C.2.2 The Trust has an internal audit function. Information on how the function is structured and what role it performs is included in Section 3.1.10.1 of this report.

C.3.5 The Council of Governors has not refused to accept the recommendation of the Audit and Risk Committee on the appointment of an external auditor, and this matter is therefore not reported on.

C.3.9 An explanation of the work of the Audit and Risk Committee can be found in Section 3.1.10.1 which includes any significant statements 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 Trust's external audit process and details of the Trust's external audit contract as well as information about any non-audit work that may have been commissioned.

D.1.3 Details regarding director remuneration can be found within the Remuneration Report in Section 3.2 within the salaries and allowances table.

E.1.4 Members who wish to communicate with governors or directors may do so via the Trust's website where contact details are clearly stated.

E.1.5 Board members, and in particular non-executive directors, develop an understanding of the views of governors and members through their attendance at meetings of the Council of Governors. They are further informed of the activities of the Council of Governors through monthly Trust Board meeting updates on the affairs of the Council of Governors and Trust's members as a standing item on the Board's agenda. Board members are appraised of members' opinions at the Annual Members' Meeting where views are canvassed. Further details on how the Board canvass the views of governors and members can be found in Section 3.1.14 of this report.

E.1.6 The Board monitors membership and engagement through monthly reporting processes. Information on monitoring how representative the Trust's membership is and the level and effectiveness of member engagement is contained in Section 3.1.21 of this report.

Detailed information regarding the Trust's membership constituencies and their eligibility, membership numbers, the Membership Strategy and steps taken in year to ensure a representative membership are detailed in Section 3.1.21.

The Council of Governors has not exercised their power under paragraph 10c of Schedule 7 of the NHS Act 2006, and this matter is therefore not reported on.

A statement from the directors that the business is a going concern, together with supporting assumptions or qualifications as necessary, is contained in Section 2.1 of this report.

3.5 NHS England and NHS Improvement's NHS Oversight Framework

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 CQC, in their formal inspection report, received in April 2020, recommended to NHS England and NHS Improvement that the Trust should be placed in special measures for reasons of quality.

This recommendation was formally accepted by the NHS England and NHS Improvement Provider Oversight Committee (POC) on 12 May 2020.

The POC also agreed that the Trust should be placed in Segment 4. We are working closely with our regulators to address the issues raised.

3.6 Statement of the Chief Executive's responsibilities as the Accounting Officer of Sheffield Health and Social Care 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 Sheffield Health and Social Care 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 Sheffield Health and Social Care 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

- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

Jan Ditheridge
Chief Executive
Date: Wednesday 09 June 2021

3.7 Annual Governance Statement

3.7.1 Scope of responsibility

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

3.7.2 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 Sheffield Health and Social Care 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 Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

3.7.3 Capacity to handle risk

3.7.3.1 Senior leadership and structure

I am ultimately responsible and accountable for the Trust's provision of safe services and for ensuring that the systems on which the Board of Directors relies to govern the organisation are effective. I have been supported in these duties by members of the executive team. There have been significant changes to the executive team during 2020-21.

We commenced the year with a separate Deputy Chief Executive role, with the individual also being specified as Gold Commander in response to the COVID-19 incident. The post remained in place until September 2020.

Our Executive Director of Nursing and Professions post was later expanded to also include the responsibilities of the Chief Operating Officer (and renamed Executive Director of Nursing, Professions and Operations). This postholder took on Gold Commander responsibility in relation to the COVID-19 incident following the departure of the Deputy Chief Executive.

Our Director of HR role, previously a non-voting role on the Board of Directors, was replaced in-year with an Executive Director of People. This is a voting role, assuming the allocation freed up by the absorption of the Chief Operating Officer role as described above.

The posts of Executive Director of Finance, IMST and Performance, the Executive Medical Director and the Director of Corporate Governance (Board Secretary), a non-voting Board role, have remained in place throughout 2020-21.

From December 2020, we added additional expertise and senior-level capacity to the executive leadership team, to deliver our strategy development and manage issues in estates with the appointment of a Director of Special Projects (Strategy).

Despite the significant changes we have made during the year and the necessity to utilise secondments and acting-up arrangements to achieve this while we underwent this transition, we ended 2020/21 with all members of the executive leadership team, with the exception of the Director Special Projects (Strategy), under permanent contracts.

Given the organisation's regulatory status, an Improvement Director, appointed by NHS England and NHS Improvement, has been in place for most of 2020/21. There have been two different individuals occupying this role after the initial appointee joined the executive leadership team and became Executive Director of Nursing, Professions and Operations.

3.7.3.2 Risk management roles of leaders

The Trust's corporate and clinical governance teams provide leadership, support, guidance and advice for all matters relating to risk management and corporate and clinical governance. Executive directors are operationally responsible for safety and the effective management of risk within their areas of responsibility. All managers, including team managers, leaders and heads of departments, are responsible for health and safety and the effective management of risks within their teams, services or departments. All Trust staff, including those on temporary contracts, placements or secondments, and contractors must keep themselves and others safe. All staff have a duty of care to provide safe services and do no harm. All health and social care staff working directly with service users and carers are responsible for ensuring that their work is safe and that they use systematic clinical risk assessment and management processes in the delivery of care and treatment.

3.7.3.3 Staff training

Staff training and development needs with regard to risk management and safety are described in the Trust's Mandatory Training Policy. Staff receive appropriate training relevant to their post requirements. All staff receive an introduction to the organisation and core training (risk management, health and safety, equality and human rights, information governance, safeguarding and infection control). More specific training is provided, dependent upon the individual's job role or work location, and includes incident reporting and investigation, Mental Health Act, Mental Capacity Act, First Aid and Life Support (including resuscitation), Clinical Risk Assessment and Management, Medicines Management and Respect (managing violence and aggression).

Following improvements arising from the CQC inspection of five core service and the well-led domain early in 2020, improvements were made to the governance systems

to ensure greater compliance with appropriate training by staff. Overall compliance with mandatory training was at 90.5% by 31 March 2021.

Of the 27 subject areas:

- Six exceeded 95% compliance
- A further five exceeded 90% compliance
- A further nine exceeded 85% compliance
- A further four exceeded 80% compliance

Of the three subjects that were below 80% compliance, training had been suspended for four months of the year arising from COVID-19, and training had recommenced in smaller numbers with enhanced PPE. This area remains under fortnightly review as part of the Trust's improvement dashboard, developed in response to areas requiring urgent action following the CQC inspection.

3.7.3.4 Learning from good practice

The Trust uses a variety of mechanisms for ensuring that good practice and lessons learned are shared across the services. These include:

- Quality Assurance Committee meetings and Significant Issues reports for the Board of Directors
- Quality Improvement Forum
- clinical audit and clinical effectiveness group reports
- serious incident and lessons learned briefings
- patient experience reports
- team and care network governance meeting reports and events
- acute care forum
- lessons learned events
- Listening into Action initiative
- lessons learned sub-group (of the Service User Safety Group)
- service based development forums
- Service User Safety Group reports
- Schwartz Rounds
- Let's Talk Safety initiative
- Service User Engagement Group reports
- safer care conferences

- quality improvement conferences
- Blue Light alerts

3.7.4 The Risk and Control Framework

3.7.4.1 Risk management strategy

The Trust recognises that positive and managed risk taking is essential for growth, development and innovation. Risks are not seen as barriers to change and improvement; instead they are recognised, considered and managed effectively as part of service improvements. The Trust's Risk Management Strategy has been refreshed and is due for consideration by the Audit and Risk Committee and Trust Board in April-May 2021. It describes the Trust's strategic approach to safety and risk management; it also sets out the Trust's governance arrangements, together with defining levels of authority, accountability, responsibility and escalation for risk management.

Risks are assessed using a stepped approach which identifies and analyses the risk, identifies the control measures in place and how effective these are and the actions that need to be taken to reduce/mitigate/remove the risk. Risks are graded according to their severity and likelihood of recurrence, using a 5 x 5 risk grading matrix based upon guidance produced by the former National Patient Safety Agency.

High level risks rated 12 or above as well as risks which affect more than one directorate or care network are considered for entry on to the Corporate Risk Register. Risks are recorded on an electronic risk management database (Ulysses Risk Management System), which is separated into teams and directorates or care networks. All recorded risks have an accountable individual and are reviewed and monitored by the appropriate operational governance group. Risk registers are held at corporate, directorate, care network and team level. Each directorate or care network has a risk register lead responsible for managing and maintaining their risk register. The Corporate Risk Register is administered by the Director of Corporate Governance (Board Secretary).

Risks on the Corporate Risk Register (CRR) are monitored by executive directors and have been reported to Board and its committees approximately quarterly during 2020/21. The approximation arising from changes to the timing of Board meetings mid-way through the year and committee meetings during the final quarter of the year. The new Risk Management Strategy increases this frequency to every meeting.

As at 31 March 2021, there were 20 risks on the Corporate Risk Register. The two highest risks both had a score of 16 based on a perceived severity and likelihood of 4. They were:

- Risk that we are unable to provide sufficient additional nursing associate placement capacity to meet demand (Risk 4409)

- Risk that instability of the patient records system could result in loss of information and risk patient safety.

Both risks were being closely managed on the Ulysees system.

The latter risk is one of three safety-related risks on the CRR at the 31 March 2021 in relation to Information Management Systems and Technology (IMST). Both areas (safety and IMST) receive additional scrutiny through the Quality Assurance Committee and Finance and Performance Committee. Other risks to have featured throughout the year related to the impact of the EU exit, including a risk on the supply of medicated and Falsified Medicines Directive.

All risks on the CRR have a defined 'monitoring group' (assurance committee), enabling committees to quickly identify those for which they are responsible.

The Trust Board reviews its risk appetite annually aligning it to revised strategic objectives and determines whether an individual risk or a specific category of risks are considered acceptable or unacceptable based upon the circumstances and situation facing the Trust. This was undertaken at a Board development session in February 2021 and confirmed at a public Board meeting in March 2021. The outcome is included in the new Risk Management Strategy. The Trust's approach is to minimise exposure to risk that impacts on patient safety and the quality of our services. However, the Trust accepts and encourages an increased degree of risk relating to innovation, provided the innovation is consistent with the achievement of patient safety and quality improvements.

Risks are highlighted via incidents, including serious incidents, complaints, concerns, safeguarding issues, claims and other queries. The Quality Assurance Committee receives quarterly reports on incidents, infection prevention and control, safeguarding, service user experience (including complaints) and clinical audit. Staff are actively encouraged to report all incidents and near misses to enable the Trust to learn from such events and improve service user safety.

An internal audit of the strategic risk management commenced in March 2021 having been delayed by considerable revisions the organisation has made to its governance structure (approved by Board in March 2021). The outcome of the review contributed to the development of the Risk Management Strategy. As part of the governance structure, we have created a Risk Oversight Group (reporting to the Audit and Risk Committee) which will aim to improve compliance around the strategy itself.

3.7.4.2 Board Assurance Framework (BAF)

Assurance is provided to the Audit and Risk Committee every quarter that risks are being addressed and actions completed via amendments to the Corporate Risk Register and Board Assurance Framework (BAF).

The BAF is a document outlining the Trust's strategic aims and objectives and which details principal risks which may inhibit delivery of those objectives. The BAF is used to monitor the levels of assurance received at Board and in committees regarding the robustness of the Trust's system of internal controls and whether or not the risks are being effectively managed.

The BAF was reviewed approximately quarterly (see earlier explanation around approximation) by the Audit and Risk Committee. Each Board committee also received the element of the BAF relevant to their remit. Following committee reviews, the BAF was received by the Trust Board.

A clear link between papers and the BAF is required on each report to demonstrate how they provide assurance to Board and its committees that risks are being managed and mitigated.

At the start of the 2020/21 financial year, the Trust had seven BAF risks to the delivery of strategic objectives, though following review by committees this was extended to nine. This has included a BAF risk focused on 'Getting Through COVID-19 Safely'. This was monitored by the Quality Assurance Committee and Board throughout the year.

In addition, a separate COVID-19 Risk Register was developed in April 2021. This was maintained on a weekly basis by the Silver Command operating in response to the pandemic, and reported to Gold Command, and its content included in reports to Quality Assurance Committee and Board. Consideration was given to absorbing the risk register into the Corporate Risk Register during the year, but it was decided that this in itself would create a risk around the change of focus.

The Trust was not fully compliant with the registration of the Care Quality Commission throughout the whole of 2020/21, arising from a Section 29a notice having been issued in respect of urgent actions required. These were completed by the end of May 2020 and the notice was subsequently set down. Also, as a result of the findings of the CQC inspection, we were unable to confirm compliance against Provider License conditions G6(3) and FT4 for 2019/20 and the same will apply for 2020/21 as the improvement programme did not commence until after the financial year was underway. We were able to confirm compliance against Provider License Condition CoS7.

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

As an employer 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 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. The Board is due to revisit sustainability as part of its Board Development programme in June 2021.

3.7.4.3 Public stakeholder involvement in managing risks

It is an organisational ambition of the Trust to continuously improve our approach to engaging service users, carers, governors and partners, both voluntary and statutory, to learn from individuals' experiences and enable continuous quality improvements in all areas of our business.

Such public voice representatives are members of the governance structures of the Trust and actively take part in groups across the organisation to contribute to planning and service improvement.

The number of service user and carer networks, co-led by service users and carers, has continued to develop, enabling services to improve their care in line with service user and carer experience and feedback. This has also been taken into account as part of the revision of the governance structure approved by Board in March 2021.

Our partnership working has continued to through the Sheffield Accountable Care Partnership (ACP), NHS Sheffield Clinical Commissioning Group, Primary Care Sheffield, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and Sheffield City Council. The regional Integrated Care System (ICS) has consolidated the joint working with stakeholders across the locality through the development of a joint vision and associated work priorities, aiming to improve the health and wellbeing of our collective population.

As a Foundation Trust we have public members and a Council of Governors. The overall role of the Council of Governors is to assist the Trust in the drive to raise standards by providing services of the highest possible quality that meet the needs of the people of Sheffield. The Council of Governors receives updates on the Trust's compliance against regulations and standards and helps plan and steer the Trust and assists in setting priorities for improvements and changes.

3.7.4.4 Quality governance arrangements

During the year, governance arrangements were in place within clinical operations to monitor progress against required quality improvements following CQC inspections. Senior leaders have engaged with regional NHS colleagues and the CQC to report on improvement.

Early in the financial year, a 'Back to Good' programme was developed to identify the various must-do and should-do actions arising from the CQC inspection. These

have been monitored monthly through a Back to Good Board and reported upwards to Quality Assurance Committee and Board.

Separately, a Well-Led Development Plan (WLDP) was agreed in May 2020 and has been reported through to Board, with executive sponsors across a range of actions relating to the 'Well-Led' areas from our Care Quality Commission inspection requiring improvement. With some crossover between this and the Back to Good programme, the WLDP has placed particular focus on senior leadership activity. An 18-month Board development programme commenced during the year as well as a governor development programme and non-executive director development programme. The executive development programme was delayed while the membership of the executive leadership team was revised, but this is now underway. Additional activity has included a programme of service visits by both the executive team (as a whole) and Board members (in pairs of one non-executive and one executive member).

3.7.4.5 Information governance and data security

We have a range of information governance policies which provide a framework covering the creation, use, safe handling and storage of all records and information. The management and monitoring of information risks is the responsibility of the Trust's Senior Information Risk Owner (SIRO) and information risks and incidents are reviewed and monitored through the Data and Information Governance Group which is accountable to the Audit and Risk Committee.

After successfully meeting the required standards of the Data Security and Protection Toolkit, following completion of a work plan, during 2019/20, the Trust has continued to develop work in this area during 2020/21. An Information Security Group meets every six weeks and is focused on the requirements of the toolkit to reach a place of all areas being 'audit ready'. A phishing exercise was undertaken by internal audit which identified fragilities in the organisation's IT security. Changes were made as a result, although a subsequent exercise has identified that further work is still required.

Information governance training is included as part of the core training for new starters and other training sessions have been provided for staff. Information governance is also covered in the Trust's local induction checklist for all new staff.

Information governance and data security incidents and risks are recorded and reported through the Trust's risk management processes.

In May 2020 we suffered an incident where a large number of documents were deleted from our main patient information system. Two other similar incidents on a smaller scale followed in subsequent months. The vast majority of the documents were restored or recreated and we implemented a variety of additional safeguards and notification processes to guard against future recurrences. We notified the Information Commissioners Office of the incidents and they have undertaken an investigation, the outcome of which is currently awaited.

The Trust triangulates service performance across a range of indicators relating to care standards, quality, workforce and finance at service level. During 2020/21, a new performance framework was approved, and the Integrated Performance and Quality Report was developed. Since the end of 2020, this has been reported through sub-committees to Board. The schedule of meetings for the year has been revised to ensure all data can progress from the point of availability to reporting upwards via the necessary groups. This quality assurance step ensures the quality of data received. Service performance reviews have been revived with a new regime commencing in February 2021, chaired by the Chief Executive and engaging all members of the executive leadership to positively challenge performance.

3.7.5 Review of economy, efficiency and effectiveness of the use of resources

The Trust has a robust committee governance structure, which was refreshed following a significant review as part of the WLDP. All assurance committees were consulted on initial proposals and received a series of reports culminating in the approval of a structure beneath committees for each, approved by the committees themselves in January or February 2021. This was then supported at the public Board in meeting in March 2021, when the establishment of an additional new committee, Mental Health Legislation Committee, was also agreed.

The following now report into Board:

- The Audit and Risk Committee
- The Finance and Performance Committee
- The Quality Assurance Committee
- The People Committee
- The Mental Health Legislation Committee
- The Remuneration and Nominations Committee.

A final stage of the refresh will be the review and renewal of terms of reference for all of the above, which it is proposed to complete by the end of May 2021.

The Trust has continued to review a number of operational efficiency metrics throughout the year, as described earlier through the new Integrated Performance and Quality Report and new performance framework. Quality improvement remains a key focus and the organisation has engaged with the Royal College of Psychiatrists on a partnership piece of work to develop this further. This work took place in quarter 4 of 2020/21 and will be progressed in the early part of 2021/22.

The organisation has reviewed and continues to review its leadership at various levels. In addition to the significant changes at executive leadership level, a new operational structure has been introduced with two care networks each led by a triumvirate of Head of Service, Head of Nursing and Clinical Director. A new Director

of Quality began in post early in 2021 and has commenced a restructure in that area, and a new Director of Operations began in March 2021. Within some non-clinical services, reviews of responsibilities are also underway.

Financial sign-off of budgets is undertaken by directors and is performance managed by the respective executive directors. Budget managers are provided with monthly budget reports for their areas of responsibility to assist them in undertaking this role. Performance management reviews, which commenced in February, involve business partners from within the finance directorate to ensure leaders at all levels are properly supported.

Post-year event – Firshill Rise (Assessment and Treatment Service)

It is pertinent to include in this report one matter which developed outside of the 2020/21 year, given that it was initiated in March 2021 when the Executive Director of Nursing, Professions and Operations identified concerns around care quality at Firshill Rise (Assessment and Treatment Service). This concern was shared by the Executive Director with partners and regulators and resulted in the Care Quality Commission (CQC) issuing a letter of possible urgent enforcement action under Section 31 of the Health and Social Care Act 2008 in April 2021. An immediate action plan was drawn up and the matter remained closely monitored by regulators ahead of a CQC inspection which commenced in May 2021. At the time of writing, we continue to work with the CQC to provide evidence of action within agreed timescales and no enforcement action has been taken.

3.7.6 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. 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 and its various committees as described in this document, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

At every committee meeting, members consider matters that have been deemed to be of significant issue to refer to the Board. These may include matters of specific interest, but will also include control issues or areas where there are gaps in assurance. At every Board meeting, the significant issues are reported and considered. Since March 2021, a new approach to this has been trailed where the significant issues were consolidated into a single report with the intention that this would aid triangulation and assist with identifying areas of required focus. This process is still being further developed. This report is in addition to the minutes received from each of those committees. For 2020/21, each committee will also be

asked to undertake self-assessment prior to reporting upwards alongside their annual reports.

The Audit and Risk Committee provides assurance to the Board of Directors through objective review and monitoring of the Trust's internal control mechanisms, such as financial systems, financial information, compliance with the law, governance processes and emergency planning among others. It monitors the effectiveness of the systems in place for the management of risk and governance, and delivery of the Board Assurance Framework. The committee is also responsible for ensuring the integrity and security of Trust data.

The Quality Assurance Committee provides assurance to the Board of Directors on the quality of care and treatment provided across the Trust by ensuring there are efficient and effective systems for quality assessment, improvement and assurance and that service user and carer perspectives are at the centre of the Trust's quality assurance framework.

The Finance and Performance Committee provides assurance to the Board of Directors on the management of the Trust's finances and financial risks, and in relation to performance matters which have developed through the year, as well as progress against transformational projects.

The People Committee provides assurance to the Board of Directors on the human resource structures, systems and processes that support employees in the delivery of high quality, safe patient care and to ensure the Trust meets its legal and regulatory duties in relation to its employees.

The Remuneration and Nomination Committee makes determination on the composition, balance, skill mix and succession planning of the Board, as well as advising on appropriate remuneration and terms and conditions of service of the Chief Executive, executive directors and directors.

The Head of Internal Audit (HOIA) provides me with an opinion based on an assessment of the design and operation of the underpinning assurance framework and supporting processes and an assessment of the individual opinions arising from risk-based audit assignments contained within the internal audit risk-based plan that have been reported throughout the year. This assessment has taken into account the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

The Head of Internal Audit Opinion is based on three elements:

- The design and operation of the BAF and strategic risk management arrangements
- The outcome of individual audit reports
- The extent to which the Trust has responded to audit recommendations.

The Head of Internal Audit Opinion for 2020/21 stated:

"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.

"Whilst I have concluded an overall moderate assurance, there are areas for development identified in each of the three segments of my Opinion and the Internal Audit Plan outturn element is concluded with limited assurance. The Trust has had a significant improvement programme in place throughout the year but given this has been in development, I need to reflect the issues identified in my Opinion which is provided for the period 2020/21.

"In providing our Opinion we consider the three areas outlined below:

Board Assurance Framework and strategic risk management - moderate assurance
"The Trust has been progressing a significant programme to strengthen governance arrangements during 2020/21 and has developed the Back to Good Board to respond to the CQC findings issued in April 2020, alongside dealing with the impact of COVID-19. The Trust has invested significantly in the programme which is progressing and we anticipate that these changes will have a positive impact on 2021/22. The Trust made good progress to develop the BAF early in the year but there is some further development required to strengthen arrangements for the operation and maintenance of the BAF.

Internal audit plan outturn - limited assurance
"The Trust developed the Internal Audit Plan to support development in areas where there were known issues. However, a key theme arising from our work this year is around governance. The Mental Health Act and Mental Capacity Act audit identified two high risks in relation to governance, plus governance issues were identified in the staff engagement and physical health reviews which were assigned limited assurance opinions. During 2020/21, the Trust has been refreshing its governance structures; the Trust is taking forward actions agreed in relation to governance alongside embedding its new arrangements.

Follow-up of internal audit actions - moderate assurance
"The Trust has made progress in the final weeks of the year to get to a reasonable position on follow up, however, progress has been slow throughout the year and despite extending implementation dates by four months at the outset of the pandemic, many actions have not been completed within the agreed dates. There are also some historical actions (i.e. due pre-2020/21) which the Trust needs to address."

Managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, are a further source for assurance. The Board Assurance Framework itself is also a source in relation to the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Reports from the Board of Directors and the Board committees
- Reports from external audit

- Reports from internal audit
- External assessments by the CQC, including Mental Health Act Commissioners
- Full registration with the CQC across all locations
- Clinical audit
- Service user surveys
- NHS Staff Survey
- Data Security and Protection Toolkit.

Conclusion

In my opinion, significant internal control issues identified during 2019-20 continued to persist into the period of 2020-21, largely due to the scale of work required to address these matters.

We have made huge progress in addressing these issues, a challenge which has been made all the more difficult by them coinciding with the COVID-19 pandemic and the enormous impact this has had on all NHS providers. Nonetheless, progress has been made including:

- Significant changes to the executive leadership team and operational leadership arrangements
- Introduction of a new governance structure including groups below committees and the assurance committee arrangements themselves
- Development of an Integrated Performance and Quality Report, including consideration escalation arrangements to ensure data has been subject to appropriate scrutiny and quality control
- Development of a new Risk Management Strategy (implemented for 2021/22) to address pre-existing compliance issues, including the creation of the Risk Oversight Group to oversee this directly
- A Well-Led Development Plan, including work around Board Development, non-executive director development and governor development, in addition to upcoming work around executive development
- The introduction of a Performance Framework and performance management reviews
- The work overseen by the Back to Good Board to address ‘must do’ and ‘should do’ areas of improvement as identified by the CQC.

Jan Ditheridge
Chief Executive

Date: Wednesday 09 June 2021

3.8 Equality Report

Sheffield Health and Social Care is committed to eliminating discrimination, promoting equal opportunity and doing all that we can to foster good relations in the communities in which we provide services and within our services. We aim to recognise and promote the diversity of our organisation with respect to gender, race, ethnicity, ethnic or national origin, citizenship, religion, disability, mental health, age, domestic circumstances, social class, sexual orientation, marriage or civil partnership status and beliefs, and recognise and support trade union membership.

We believe in fairness and equality and aim to value diversity and promote inclusion in all that we do. This is reflected in our values which form the guiding principles and behaviours for the way we do our work.

Our values are:

- Respect
- Compassion
- Partnership
- Accountability
- Fairness
- Ambition.

These values are at the heart of celebrating and promoting the diversity of our organisation. Prioritising equal opportunity is essential to living these values.

We are committed to ensuring that all employees achieve their full potential in an environment characterised by dignity and mutual respect. Within our teams valuing difference is fundamental; it enables staff to create respectful work environments and to deliver high quality care and services while giving service users the opportunity to reach their full potential.

If unlawful discrimination occurs it will be taken very seriously and may result in formal action being taken against individual members of staff, including disciplinary action.

Equal opportunity and dignity statement

Our aim is to promote and ensure equality, diversity and inclusion in all that we do within our diverse organisation.

Key achievements over the past 12 months

- In 2020/21 we launched the NHS Rainbow Badge initiative. Members of our Rainbow Staff Network Group developed a bespoke training package which is delivered by members of the group. By early 2021 nearly 500 people have experienced this training and it has led to an increase in awareness of the

negative experience of LGBTQ+ people in accessing and using health services and what we can all do in response to this.

- In 2020/21 our BAME Staff Network Group and organisational development team worked to take forward a ‘Big Conversation’ about race discrimination in our organisation. This led to development of an action plan that is currently being finalised.
- We have been actively involved in responding to the impact of COVID-19 on BAME communities in Sheffield and NHS workforce nationally through a staffing group established through the Sheffield Accountable Care Partnership.
- In 2020 our Board members took part in focused equality, diversity and inclusion development and our Board members remain involved in our long-term reciprocal mentoring programme.

Examples of positive practice

- Our Community Learning Disability Team have developed a comprehensive plan and guidance for recording of ethnicity for people using their services to underpin their commitment to tackling recognised health inequalities
- The Improving Access to Psychological Services (IAPT) BAME Positive Practice guide was published co-authored by Saiqa Naz who at the time of writing was a Cognitive Behavioural Therapist at the Trust and the Chair of the British Association of Behavioural and Cognitive Psychotherapies (BABCP) Equality and Culture Special Interest Group.
- A number of our BAME staff were involved in a live streamed programme delivered in partnership with ADIRA a survivor-led mental health and wellbeing organisation supporting black people with mental health issues. They worked together to put on the event which aimed to look at ways to engage with the BAME community to build better relationships, break down barriers, dispel any myths about mental health services and build positive relationships with this community. You can watch the event back at blackmentalhealth.live

Find out more

Our annual Equality and Human Rights Report is available on our website at www.shsc.nhs.uk/about-us/equality-diversity-and-inclusion

On this page you will also find our annual Workforce Disability Equality Standard report and action plan, Workforce Race Equality Standard (WRES) report and action plan and our Gender Pay Gap report and action plan.

Section 4.0 Auditor's Report

Independent Auditor's report to the Council of Governors of Sheffield Health and Social Care NHS Foundation Trust.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Sheffield Health and Social Care NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Trust Statement of Comprehensive Income, Trust Statements of Financial Position, Trust Statements of Changes in Equity and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of, the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve control totals delegated to the Trust by NHS Improvement.
- Reading Board and Audit and Risk Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk of incentive for revenue to be manipulated into the wrong period around the year end and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals posted by the Executive Director of Finance and unusual postings to cash accounts.
- Assessing significant estimates for bias.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.
- Sample testing accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Reviewing the completeness of information provided by the Trust as part of the 'NHS Agreement of Balances' exercise to ensure consistency with the information in the accounts.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 97, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They 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; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting

unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

Significant weakness
In April 2020 the Trust received an overall inadequate rating by CQC. The Well-Led domain was rated inadequate as part of this inspection and as a basis of the report, the Chief inspector of Hospitals recommended that the Trust be placed into special measures. The CQC issued one warning notice and eight requirement notices to the Trust. The action related to 47 breaches of legal requirements in five core services and in relation to the overall governance of the Trust.

In response to these issues, the Trust took a series of actions including developing a Well Led Development Plan and Back to Good Programme to address the issues. Each of the actions plans has been regularly reviewed by the Trust's Board and Back to Good Board to ensure appropriate oversight of the progress and issues identified. We note that by reference to the Trust's Back to Good Programme and Well Led Development Plan that progress has been made on actions on both areas however a number of actions remain outstanding and/or still to be quality assured and not embedded into the Trust's arrangements. While it is clear that progress has been made there are significant weaknesses in the Trust's arrangements and we note that as a result of this the Trust will be unable to confirm compliance with its Provider Licence conditions relating to governance and systems for compliance for the year 2020/21.

Consequently our judgement is that during the course of the 2020/21, the Trust had significant weaknesses in its governance arrangements for overseeing the achievement for value for money and significant weaknesses in its arrangements for improving economy, efficiency and effectiveness in respect of ensuring statutory and regularity requirements were met.

Recommendation:
The Trust needs to continue to ensure:
- the significant outstanding issues raised by the CQC are addressed; and
- progress is monitored and scrutinised by the appropriate project groups and the Trust's Board to ensure the actions taken to address the issues raised are effective.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Sheffield Health and Social Care NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Rashpal Khangura
for and on behalf of KPMG LLP
Chartered Accountants
1 Sovereign Square
Leeds
LS1 4DA

17 June 2021

Section 5.0 Annual Accounts

Foreword to the accounts

Sheffield Health and Social Care NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Sheffield Health and Social Care NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

After making enquiries the Directors have reasonable expectation that the NHS Foundation Trust has adequate resource to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Jan Ditheridge
Chief Executive (as Accounting Officer)
Date: Wednesday 09 June 2021

The Accounts of Sheffield Health and Social Care NHS Foundation Trust for the period ending 31 March 2021 follows 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 provided further detail on lines in the four primary statements and are cross referenced accordingly.

The financial statements (accounts) were approved by the Board on Wednesday 09 June 2021 and signed on its behalf by:

Jan Ditheridge
Chief Executive as Accounting Officer)
Date: Wednesday 09 June 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	118,174	105,734
Other operating income	4	35,537	25,741
Operating expenses	6, 8	(149,813)	(126,990)
Operating surplus/(deficit) from continuing operations		**3,898**	**4,485**
Finance income	11	1	322
Finance expenses	12	(22)	(38)
PDC dividends payable		(1,374)	(1,432)
Net finance costs		**(1,395)**	**(1,148)**
Other gains / (losses)	13	(20)	-
Surplus / (deficit) for the year from continuing operations		**2,483**	**3,337**
Surplus / (deficit) for the year		**2,483**	**3,337**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(259)	-
Revaluations	15	7,510	90
Other recognised gains and losses		(521)	(1,165)
Remeasurements of the net defined benefit pension scheme liability / asset	29	(118)	1,368
Other reserve movements		1	-
Total comprehensive income / (expense) for the period		**9,096**	**3,630**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	1,062	1,439
Property, plant and equipment	15	57,810	49,583
Receivables	21	4,554	4,666
Total non-current assets		**63,426**	**55,688**
Current assets			
Inventories	20	67	113
Receivables	21	6,350	7,822
Cash and cash equivalents	22	62,075	51,018
Total current assets		**68,492**	**58,953**
Current liabilities			
Trade and other payables	23	(13,493)	(10,385)
Provisions	25	(613)	(460)
Other liabilities	24	(291)	(25)
Total current liabilities		**(14,397)**	**(10,870)**
Total assets less current liabilities		**117,521**	**103,771**
Non-current liabilities			
Provisions	25	(774)	(678)
Other liabilities	24	(5,265)	(4,769)
Total non-current liabilities		**(6,039)**	**(5,447)**
Total assets employed		**111,482**	**98,324**
Financed by			
Public dividend capital		39,567	35,504
Revaluation reserve		20,355	13,106
Income and expenditure reserve		51,560	49,714
Total taxpayers' equity		**111,482**	**98,324**

The notes on pages 129 to 189 form part of these accounts.

Jan Ditheridge
Chief Executive (as Accounting Officer)
Date: Wednesday 09 June 2021

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**35,504**	**13,106**	**49,714**	**98,324**
Surplus/(deficit) for the year	-	-	2,483	**2,483**
Impairments	-	(259)	-	**(259)**
Revaluations	-	7,510	-	**7,510**
Transfer to retained earnings on disposal of assets	-	(2)	2	**-**
Other recognised gains and losses	-	-	(521)	**(521)**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	(118)	**(118)**
Public dividend capital received	4,062	-	-	**4,062**
Other reserve movements	1	-	-	**1**
Taxpayers' and others' equity at 31 March 2021	**39,567**	**20,355**	**51,560**	**111,482**

Statement of Changes in 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	**34,556**	**13,016**	**46,174**	**93,746**
Surplus/(deficit) for the year	-	-	3,337	**3,337**
Revaluations	-	90	-	**90**
Other recognised gains and losses	-	-	(1,165)	**(1,165)**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	1,368	**1,368**
Public dividend capital received	948	-	-	**948**
Taxpayers' and others' equity at 31 March 2020	**35,504**	**13,106**	**49,714**	**98,324**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		3,898	4,485
Non-cash income and expense:			
Depreciation and amortisation	6.1	3,406	2,657
Net impairments	7	3,152	-
Non-cash movements in on-SoFP pension liability		378	345
(Increase) / decrease in receivables and other assets		1,358	5,225
(Increase) / decrease in inventories		46	(22)
Increase / (decrease) in payables and other liabilities		1,598	1,873
Increase / (decrease) in provisions		255	(673)
Other movements in operating cash flows		(312)	(345)
Net cash flows from / (used in) operating activities		**13,779**	**13,545**
Cash flows from investing activities			
Interest received		9	314
Purchase of intangible assets		(432)	(704)
Purchase of PPE and investment property		(5,151)	(2,368)
Net cash flows from / (used in) investing activities		**(5,574)**	**(2,758)**
Cash flows from financing activities			
Public dividend capital received		4,062	948
PDC dividend (paid) / refunded		(1,210)	(1,650)
Net cash flows from / (used in) financing activities		**2,852**	**(702)**
Increase / (decrease) in cash and cash equivalents		**11,057**	**10,085**
Cash and cash equivalents at 1 April - brought forward		**51,018**	**40,933**
Cash and cash equivalents at 31 March	22.1	**62,075**	**51,018**

Notes to the Accounts

Note 1.1 Accounting policies and other information

Basis of preparation

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Sheffield Health and Social Care NHS FT ("the Trust") achieved foundation trust status on 1 July 2008.

Accounting convention

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

Accounting period

The accounts of the Trust have been drawn up for the year to 31 March 2021.

Note 1.2 Going concern

The Trust’s accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity’s services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is one of the related Charities to Sheffield Hospitals Charitable Trust, under the umbrella registration of 1059043-3. The Trust is not a corporate trustee of the charity. The Trust has assessed its relationship to the charitable fund and determined it not to be a subsidiary because the Trust does not have the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff. The Trust will not be

consolidating the Sheffield Hospitals Charity. The Department of Health and Social Care corresponds directly with NHS charities who are independent of their linked trust (with independent trustees) to obtain the information they require to consolidate the Department of Health and Social Care group. Sheffield Hospitals Charity is one such charity.

Other subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position. The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation. Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

During 2015/16 the Trust established an operating company, 7 Hills Care and Support Ltd wholly owned by the Trust and which has currently remained dormant during 2020/21.

Associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (eg revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, eg, share dividends are received by the Trust from the associate. Associates which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell. During 2020/21 the Trust recognises no Associates.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

2020/21

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

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

Comparative period (2019/20)

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

incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

For 2020/21 and 2019/20

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

The Trust does 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 the Standard, where the right to consideration corresponds directly with value of the performance completed to date.

The FReM has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from research NHS contracts

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

Note 1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training

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

CQUIN Income

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.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

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.

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme, administered by the South Yorkshire Pensions Authority which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. These postings are mostly countered by the terms of the current partnership agreement. The terms of the current partnership agreement with Sheffield City Council ('the Council') provide that any long-term pension liability arising from the scheme will be funded by the Council, with the exception of any pension changes which relate to salary increases in excess of any local government grading agreements. The impact on the current and prior year Statement of Comprehensive Income and Statement of Changes in Taxpayers' Equity relating to the application of IAS 19 - 'Employee Benefits' within the accounts of the Trust is mostly negated by the inclusion of a corresponding non-current receivable with the Council. For further information see note 29 and 29.1

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Discontinued operations

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

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

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

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no

plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

A desktop revaluation was undertaken as at 31 March 2021 and are reflected in these financial statements.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Deprecation

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

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been

recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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

The Trust is not in possession of any donated equipment in relation to the coronavirus pandemic that could be classified as an asset at the end of March 2021.

Useful lives of property, plant and equipment

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

	Minimum life - years	Maximum life - years
Land	n/a	n/a
Buildings, excluding dwellings	15	50
Plant and machinery	5	15
Transport equipment	3	7
Information technology	3	7
Furniture and fittings	7	10

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

Where land and buildings are marked for disposal, the economic life will be re-assessed accordingly and accelerated depreciation might apply.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably and when 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. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

	Minimum life - years	Maximum life - years
Information technology	3	7
Software licences	3	7
Licences and trademarks	3	7

Notes 1.11 Inventories

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

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

Note 1.12 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 1.13 Cash and cash equivalents

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

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

Note 1.14 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost. The Trust has no financial assets at fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost. The Trust has no financial liabilities at fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

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

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

HM Treasury has ruled that central government bodies may not recognise stage 1 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 and 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 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 estimated future cash flows discounted at the financial asset's original effective interest rate.

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

Derecognition

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

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

Note 1.15 Leases

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

The trust as lessee

Finance leases

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

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

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

During 2020/21 the Trust has no finance leases.

Operating leases

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

Leases of land and buildings

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

The trust as lessor

Finance leases

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

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an

operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

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

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

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

Early retirement provisions are discounted using HM Treasury’s pension discount rate of negative 0.95% (2019-20: negative 0.50%) in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

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

Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable. As at 31 March 2021 the Trust has no contingent assets.

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

Contingent liabilities are defined as:

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

Note 1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised

purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax

The Finance Act 2004 amended Section 519A of the Income and Corporation Taxes Act 1998 to provide power to the Treasury to make certain non-core activities of the Trust, which are not related to, or ancillary to, the provision of healthcare and where profits exceed £50,000 per annum, are potentially subject to corporation tax and should be subject to a review.

The Trust has carried out a review of corporation tax liability of its non-healthcare activities. At present all activities are either ancillary to patient care activity or below the de-minimis £50,000 profit level at which corporation tax is due.

Note 1.21 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

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

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

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

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

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are

divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.24 Gifts

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

Note 1.25 Early adoption of standards, amendments and interpretations

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

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

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

IFRS 16 Leases

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

The trust is not an intermediate lessor in material sublease arrangements at the end of the reporting period.

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining

lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The Trust has reviewed all existing contracts and has assessed whether a lease exist and is progressing the implementation of IFRS 16 on a timely manner. Due to the nature of the services provided, the Trust does not incur into lease of medical equipment which minimises the impact of IFRS 16 on the Trust accounts.

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

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	7,793
Additional lease obligations recognised for existing operating leases	(7,563)
Changes to other statement of financial position line items [excluding reserve]	(192)
Net impact on net assets on 1 April 2022	**38**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(816)
Additional finance costs on lease liabilities	(65)
Lease rentals no longer charged to operating expenditure	861
Other impact on income / expenditure [If this line is material, further disclosure should be added and/or this line disaggregated]	(10)
Estimated impact on surplus / deficit in 2022/23	**(30)**
Estimated increase in capital additions for new leases commencing in 2022/23	**-**

The forecast above is subject to changes as it includes estimated calculations for a possible new HQ lease which is to be defined and it reflects the new implied interest rate of 0.91% which is also subject to change before effective implementation of IFRS 16 from April 2022.

Note 1.27 Critical judgements in applying accounting policies

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

The main area of estimation uncertainty within the Trust is the carrying value of the property portfolio and the assumptions used in the determination of fair value at the Statement of Financial Position date, in order to minimise the risk of material misstatement, a desktop property valuation has been commissioned by the Trust as at 31st March 2021.

Provisions have been calculated having recognised an obligating event during the year and include estimates and assumptions relating to the carrying amounts and timing of the anticipated payments.

The litigation provisions are based on estimates from the NHS Resolution and the injury benefit provisions on figures from NHS Business Services Authority. Refer to Paragraph 1.15 for further details.

A further area where estimation is required relates to the net liability to pay pensions in respect of the staff who transferred to the Trust from Sheffield City Council. This estimation depends on a number of complex judgements relating to the discount rate used, the rate at which salaries are projected to increase, changes in the retirement ages, mortality rates and expected returns on pension fund assets. A firm of consulting actuaries is engaged by the South Yorkshire Pensions Authority to provide the Trust with expert advice about the assumptions to be applied. Refer to Paragraph 1.6 and note 29 and 29.1 for further details.

The Trust policy is to perform full revaluations of lands and buildings every 5 years, with an interim revaluation on the third year. In addition, as the full revaluation was undertaken within this timeframe, a review of asset valuation movements using the BCIS indices was undertaken in March 2021 to assess whether asset valuation is likely to have moved materially from those valued in March 2018 and since depreciated. These assessments are reflected on the Trust accounts under the PPE note 15.1.

Note 1.28 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:

The Trust confirms that it has not used any key assumptions concerning the future or had any key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year that need to be disclosed under IAS1.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 15.1

The Trust commissioned a full revaluation of its portfolio of land and buildings, however due to the on-going pandemic it was not possible to perform site visits to assess the current condition of the properties. Instead the Trust valuers “Avison Young” formerly (AVS Grimleys) carried out a desktop valuation on the basis of their knowledge of the existing properties since their full revaluation carried out in March 2018. This was assisted by the provision of a full report of investments to date to assess the valuation, impairments and the economic lives of the Trust portfolio. This desktop valuation will be followed up by site visits once restrictions permits to do so to confirm the valuation dated March 2021. There is a low risk of any material adjustments since the main change is in relation to the increased value of land in the primary and secondary areas of Sheffield in the past 12-24 months, and it is accepted that Covid has slowed down build cost inflation which impacts the DRC valuation, where there are no material movements to report.

Note 2 Operating Segments

The Trust considers that it has one operating segment, that being the provision of health and social care. All revenues are derived from within the UK.

Details of operating income by classification and operating income by type are given in Note 3.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)

Income from patient care activities (by nature)	**2020/21 £000**	**2019/20 £000**
Mental health services		
Block contract / system envelope income*	106,458	93,714
Clinical partnerships providing mandatory services (including S75 agreements)	1,168	1,133
Other clinical income from mandatory services	5,659	6,289
All services		
Private patient income	-	-
Additional pension contribution central funding**	4,505	4,122
Other clinical income	384	476
Total income from activities	**118,174**	**105,734**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

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

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2020/21 £000**	**2019/20 £000**
NHS England	10,829	9,877
Clinical commissioning groups	100,134	90,164
Department of Health and Social Care	-	-
Other NHS providers	-	1
Local authorities	7,211	5,653
Non NHS: other	-	39
Total income from activities	**118,174**	**105,734**
Of which:		
Related to continuing operations	118,174	105,734
Related to discontinued operations	-	-

Note 4 Other operating income

	2020/21			2019/20		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	1,128	-	**1,128**	1,252	-	**1,252**
Education and training	7,389	-	**7,389**	6,295	-	**6,295**
Non-patient care services to other bodies	8,423	-	**8,423**	8,946	-	**8,946**
Provider sustainability fund (2019/20 only)	-	-	**-**	1,202	-	**1,202**
Reimbursement and top up funding	10,375		**10,375**	-	-	**-**
Income in respect of employee benefits accounted on a gross basis	6,048		**6,048**	6,480		**6,480**
Charitable and other contributions to expenditure	-	973	**973**	-	-	**-**
Rental revenue from operating leases	-	-	**-**	-	58	**58**
Other income	1,201	-	**1,201**	1,508	-	**1,508**
Total other operating income	**34,564**	**973**	**35,537**	**25,683**	**58**	**25,741**
Of which:						
Related to continuing operations			35,537			25,741
Related to discontinued operations			-			-

Charitable and other contributions to expenditure is related to personal protective equipment received from DoHSC in response to the coronavirus pandemic.

Other income includes mainly business with Primary Care Sheffield (non-NHS) in relation to the "Clover GP Practice".

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

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	25	25
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2021 £000	31 March 2020 £000
within one year	291	25
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**291**	**25**

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

Note 5.3 Income from activities arising from commissioner requested services

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

	2020/21 £000	2019/20 £000
Income from services designated as commissioner requested services	118,174	105,734
Income from services not designated as commissioner requested services	35,537	25,741
Total	**153,711**	**131,475**

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

The Trust reports the disposal of its 50% share of Heeley building associated to the provision of GP services. This is due to the end of the partnership between SHSC and Primary Care Sheffield. The disposal of Heeley was carried out at the Net Book

Value (NBV) of £183k which does not affect SHSC's provision of services requested from commissioners.

Note 5.5 Fees and charges

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

No material fees and charges to service users to report at 31 March 2021.

Note 6.1 Operating expenses

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	367	697
Purchase of healthcare from non-NHS and non-DHSC bodies	7,782	3,923
Staff and executive directors costs	113,869	103,454
Remuneration of non-executive directors	117	119
Supplies and services - clinical (excluding drugs costs)	1,574	315
Supplies and services - general	1,032	961
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	850	845
Inventories written down	99	8
Consultancy costs	704	449
Establishment	601	659
Premises	6,819	5,391
Transport (including patient travel)	1,187	1,328
Depreciation on property, plant and equipment	3,252	2,539
Amortisation on intangible assets	154	118
Net impairments	3,152	-
Movement in credit loss allowance: contract receivables / contract assets	(131)	42
Increase/(decrease) in other provisions	200	(310)
Change in provisions discount rate(s)	29	50
Audit fees payable to the external auditor		
audit services- statutory audit	95	59
other auditor remuneration (external auditor only)	-	-
Internal audit costs	85	96
Clinical negligence	634	634
Legal fees	224	168
Insurance	186	169
Research and development	1,279	1,075
Education and training	1,760	447
Rentals under operating leases	1,281	1,235
Redundancy	315	161
Car parking & security	164	175
Hospitality	5	46
Losses, ex gratia & special payments	211	125
Other services, eg external payroll	158	150
Other	1,759	1,862
Total	**149,813**	**126,990**
Of which:		
Related to continuing operations	149,813	126,990
Related to discontinued operations	-	-

Other expenditure is not considered a material figure, there are no single significant items of expenditure included in this figure.

Note 6.2 Other auditor remuneration

	2020/21 £000	2019/20 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**-**

Due to the on-going covid19 pandemic, the quality report has been removed from Trust accounts at national level for a second year as advised by the DoHSC. There is no longer a requirement for the Trust to produce quality accounts, which the external auditors would normally audit. This fee has therefore not been incurred for 2020/21.

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7.1 Impairment of assets

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	3,383	-
Changes in market price	(231)	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**3,152**	**-**
Impairments charged to the revaluation reserve	259	-
Total net impairments	**3,411**	**-**

The Trust carried out a review of its "Assets Under Construction" (AUC) due to significant changes to the future of the "Acute Care Modernisation 2" project (ACM II), which clinical design for the building has been deemed as not "fit for purpose". Therefore £2,629k is being reported as an impairment in 2020/21 which was previously reported under Non-Current Assets, in the PPE note, AUC segment.

In addition to the above, the intangible asset in the process of construction known as "Insight II" suffered a major reconfiguration which resulted on the impairment of £754k. This project will now continue under a renewed scope under the name of "New EPR". Insight II was previously reported under Non-Current Assets, in the Intangibles note, AUC segment.

These impairment figures adding to £3,383k are measured at cost.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	87,965	79,485
Social security costs	8,366	7,495
Apprenticeship levy *	411	370
Employer's contributions to NHS pensions	14,790	13,511
Pension cost - other	55	48
Termination benefits	315	161
Temporary staff (including agency)	4,721	4,096
Total gross staff costs	**116,623**	**105,166**
Recoveries in respect of seconded staff	-	-
Total staff costs	**116,623**	**105,166**
Of which		
Costs capitalised as part of assets	379	723

* The apprenticeship levy was introduced in May 2017 and aims to encourage organisations to take on more apprentices by financing their training. It is a tax applied to all employers whose annual wage bill is more than £3m a year.

It amounts to 0.5% of their total payroll and can be used for apprentice training and assessment, but not salaries.

Note 8.1 Directors and Non-Executives Remunerations

	2020/21 Total £000	2019/20 Total £000
Fees to Non-Executive Directors*	105	113
Executive Directors – Salaries **	854	730
Executive Directors – Benefits (NHS Pension scheme)	88	75
	1,047	**918**

* Excludes National Insurance contributions.

** Further information about the remuneration of individual Directors and details of their pension arrangements is provided in the Remuneration Report.

Note 8.2 Retirements due to ill-health

During 2020/21 there was one early retirement from the trust agreed on the grounds of ill-health (one in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £1k (£9k in 2019/20).

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

Note 9 Pension costs

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

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

An outline of these follows:

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations

Note 9.1 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.

	2020/21 £000	2019/20 £000
Employer's Contributions	55	48

The average number of members in FY 2020/21 are 159 (184 in FY 2019/20)

Note 10 Operating leases

Note 10.1 Sheffield Health and Social Care NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Sheffield Health and Social Care NHS Foundation Trust is the lessor.

The Trust subleased surplus space at Sydney Street property to the private sector. However the sublease was ended on 31 March 2020.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	-	58
Total	**-**	**58**

Note 10.2 Sheffield Health and Social Care NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Sheffield Health and Social Care NHS Foundation Trust is the lessee.

The Trust holds operating leases mainly from other DoHSC bodies £747k, and non-WGA £383k. Operating leases are required for premises to deliver patient care services. From Non-WGA organisations the Trust rents accommodation for its Estates Department among others services.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	1,281	1,292
Less sublease payments received	-	(57)
Total	**1,281**	**1,235**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	566	1,305
- later than one year and not later than five years;	1,858	1,694
- later than five years.	5,411	4,980
Total	**7,835**	**7,979**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2020/21 £000	2019/20 £000
Interest on bank accounts	1	322
Total finance income	**1**	**322**

The reduced interest income reported in FY 2020/21 is due to the impact of the COVID-19 pandemic in the wider economy. This prevented the Trust from maximising the benefits of its strong cash position via short term investment with the National Loan Fund.

Note 12 Finance expenditure

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

	2020/21 £000	2019/20 £000
Unwinding of discount on provisions	(6)	(3)
Other finance costs	28	41
Total finance costs	**22**	**38**

* The Finance interest associated with the Local Authority Pension scheme is presented net as a finance cost in line with IAS19. Refer to accounting policy note 1.6 (LGPS)

Note 13 Other gains/(losses)

No liability accruing in year 2019/20 under this legislation as a result of late payments.

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

Note 14.1 Intangible assets – 2020/21

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**716**	**925**	**1,641**
Additions	-	531	**531**
Impairments	(754)	-	**(754)**
Reclassifications	1,262	(1,262)	**-**
Valuation / gross cost at 31 March 2021	**1,224**	**194**	**1,418**
Amortisation at 1 April 2020 - brought forward	**202**	**-**	**202**
Provided during the year	154	-	**154**
Amortisation at 31 March 2021	**356**	**-**	**356**
Net book value at 31 March 2021	**868**	**194**	**1,062**
Net book value at 1 April 2020	**514**	**925**	**1,439**

Impairment is related to the abandonment of asset under construction write-off for the "Insight II" project at £754k. Please see note 7.

Notes 14.2 Intangible assets – 2019/20

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	**297**	**764**	**1,061**
Additions	-	704	**704**
Reclassifications	419	(543)	**(124)**
Valuation / gross cost at 31 March 2020	**716**	**925**	**1,641**
Amortisation at 1 April 2019 - as previously stated	84	**-**	**84**
Provided during the year	118	-	**118**
Amortisation at 31 March 2020	**202**	**-**	**202**
Net book value at 31 March 2020	**514**	**925**	**1,439**
Net book value at 1 April 2019	**213**	**764**	**977**

Note 15.1 Property, plant and equipment – 2020/21

	Land	Surplus Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**11,185**	-	**35,163**	**5,964**	**580**	**216**	**2,068**	**19**	**55,195**
Additions	-		-	6,828	-	-	-	-	**6,828**
Impairments	-		(3,779)	-	-	-	-	-	**(3,779)**
Reversals of impairments	10		1,112	-	-	-	-	-	**1,122**
Revaluations	6,630		880	-	-	-	-	-	**7,510**
Reclassifications	(8,000)	8,000	7,665	(9,353)	250	24	1,379	35	**-**
Depreciation eliminated on revaluation	-	-	(5,913)	-	-	-	-	-	**(5,913)**
Disposals / derecognition	(31)		(442)	-	(91)	(13)	-	-	**(577)**
Valuation/gross cost at 31 March 2021	**9,794**	**8,000**	**34,686**	**3,439**	**739**	**227**	**3,447**	**54**	**60,386**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**-**	**3,833**	**-**	**324**	**167**	**1,272**	**17**	**5,612**
Provided during the year	-	-	2,818	-	50	25	359	0	**3,252**
Revaluation	-	-	(5,913)	-	-	-	-	-	**(5,913)**
Disposals / derecognition	-	-	(290)	-	(72)	(13)	-	-	**(375)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**448**	**-**	**301**	**179**	**1,631**	**17**	**2,577**
Net book value at 31 March 2021	**9,794**	**8,000**	**34,238**	**3,439**	**438**	**48**	**1,816**	**37**	**57,810**
Net book value at 1 April 2020	**11,185**	**-**	**31,330**	**5,964**	**256**	**49**	**796**	**2**	**49,583**

Further to the desktop revaluation of the Trust properties portfolio, Fulwood HQ's land was declared as surplus to the Trust needs, therefore it was revalued at Fair Value under accounting standard IFRS 13 as reflected on the Trust accounts at the end of March 2021.

Note 15.2 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 - as previously stated	**11,185**	**35,370**	**4,040**	**836**	**240**	**2,538**	**25**	**54,235**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2019 - restated	**11,185**	**35,370**	**4,040**	**836**	**240**	**2,538**	**25**	**54,235**
Additions	-	-	2,091	-	-	-	-	**2,091**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	(471)	-	-	-	-	-	**(471)**
Reclassifications	-	264	(167)	-	-	227	-	**324**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(257)	(24)	(697)	(6)	**(984)**
Valuation/gross cost at 31 March 2020	**11,185**	**35,163**	**5,964**	**580**	**216**	**2,068**	**19**	**55,195**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**2,362**	**-**	**533**	**169**	**1,535**	**19**	**4,618**
Provided during the year	-	2,032	-	48	23	434	3	**2,539**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	(561)	-	-	-	-	-	**(561)**
Reclassifications	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(257)	(24)	(697)	(6)	**(984)**
Accumulated depreciation at 31 March 2020	**-**	**3,833**	**-**	**324**	**167**	**1,272**	**17**	**5,612**
Net book value at 31 March 2020	**11,185**	**31,330**	**5,964**	**256**	**49**	**796**	**2**	**49,583**
Net book value at 1 April 2019	**11,185**	**33,008**	**4,040**	**303**	**71**	**1,003**	**6**	**49,617**

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

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Net book value at 31 March 2021								
Owned - purchased	17,794	33,394	3,439	436	47	1,817	36	**56,965**
Owned - donated/granted	-	845	-	-	-	-	-	**845**
NBV total at 31 March 2021	**17,794**	**34,239**	**3,439**	**436**	**47**	**1,817**	**36**	**57,810**

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

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Total £000
Net book value at 31 March 2020								
Owned - purchased	11,185	30,517	5,964	255	48	797	3	**48,770**
Owned - donated/granted	-	813	-	-	-	-	-	**813**
NBV total at 31 March 2020	**11,185**	**31,330**	**5,964**	**255**	**48**	**797**	**3**	**49,583**

Note 16 Revaluations of property, plant and equipment

There are no donations of PPE to report for financial year 2020/21

As a response to the coronavirus pandemic, the Trust is on receipt of some equipment which are below the capital threshold.

Note 17 Revaluations of property, plant and equipment

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets 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 are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations 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. These valuations are carried out by professionally qualified valuers in accordance with Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Further to the latest full revaluation of the estate which was completed in March 2018, the Trust commissioned a new full revaluation of its portfolio by the end of March 2021. However, due to the impact of the on-going pandemic restrictions, the Trust, in agreement with its external auditors and independent valuers carried out a desktop valuation of all its lands and buildings using the BCIS indices. This exercise was completed with no declaration of material uncertainty on the values reported. All but Wardsend Rd, and Fulwood HQ land are specialised asset revalued at their "Depreciated Replacement Cost". This technique involves assessing all the costs of providing a modern equivalent asset using pricing at the valuation date.

Fulwood HQ's land is deemed surplus to the Trust requirements and qualified for a Market value or Fair value under accounting standard IFRS 13 and it is reflected on the PPE note to the accounts.

Wardsend Rd's land and building which host support services was revalued at Market value in use within the PPE note to the accounts.

Note 18 Investment Property

	2020/21 £000	2019/20 £000
Carrying value at 1 April - brought forward	**-**	**200**
Prior period adjustments	**-**	-
Carrying value at 1 April - restated	**-**	**200**
Acquisitions in year	-	-
Movement in fair value	-	-
Reclassifications to/from PPE	-	(200)
Transfers to/from assets held for sale	-	-
Disposals	-	-
Carrying value at 31 March	**-**	**-**

No investments properties to report other than £200 nominal value of shares in 7 Hills Care Support Ltd which remains dormant in 2020/21.

Note 19 Disclosure of interests in other entities

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position. The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation. Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

During 2015/16 the Trust established an operating company, 7 Hills Care and Support Ltd wholly owned by the Trust and which has currently remained dormant during 2020/21

Note 20 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	67	113
Consumables	-	-
Other	-	-
Total inventories	**67**	**113**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £1,609k (2019/20: £742k). Write-down of inventories recognised as expenses for the year were £99k (2019/20: £8k).

Write-down of inventories of £99k includes £87k related to items of personal protective equipment purchased by the DHSC.

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £960k of items purchased by DHSC.

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

Note 21.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	4,610	7,150
Capital receivables	183	-
Allowance for impaired contract receivables / assets	(89)	(472)
Prepayments (non-PFI)	1,036	769
Interest receivable	-	8
PDC dividend receivable	39	203
VAT receivable	543	131
Corporation and other taxes receivable	28	33
Total current receivables	**6,350**	**7,822**
Non-current		
Prepayments (non-PFI)	594	469
Other receivables*	3,960	4,197
Total non-current receivables	**4,554**	**4,666**
Of which receivable from NHS and DHSC group bodies:		
Current	3,623	4,791
Non-current	-	-

* Other non-current receivables is governed by IAS 19 (Employee Benefits), and it is related to the LGPS "back to back" funding agreement with Sheffield City Council.

Note 21.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 01 April - brought forward	**472**	**-**	**710**	**-**
New allowances arising	145	-	232	-
Reversals of allowances	(276)	-	(190)	-
Utilisation of allowances (write offs)	(252)	-	(280)	-
Allowances as at 31 Mar 2021	**89**	**-**	**472**	**-**

The Trust has no material category of receivable which requires generic expected credit losses to be recognised. Receivables are impaired when there is evidence to indicate that the Trust may not recover, in full, sums due. This can be on the basis of legal advice, insolvency of debtors, or other economic factors. Impaired receivables are written off only when all reasonably possible means of recovery have been exhausted. The nature of the Trust's business generally means that no collateral is held against outstanding receivables. Prepayments and accrued income are neither past their due date, nor impaired. Other trade receivables become due immediately as the Trust does not offer extended credit terms.

Note 22 Cash and cash equivalents movements

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

	2020/21 £000	2019/20 £000
At 1 April	**51,018**	**40,933**
Net change in year	11,057	10,085
At 31 March	**62,075**	**51,018**
Broken down into:		
Cash at commercial banks and in hand	90	86
Cash with the Government Banking Service	61,985	50,932
Total cash and cash equivalents as in SoFP	**62,075**	**51,018**
Total cash and cash equivalents as in SoCF	**62,075**	**51,018**

Note 22.1 Third party assets held by the trust

Sheffield Health and Social Care NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2021 £000	31 March 2020 £000
Bank balances	47	52
Monies on deposit	-	25
Total third party assets	**47**	**77**

Note 23 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	2,298	2,077
Capital payables	2,369	593
Accruals	5,168	4,424
Social security costs	1,242	1,147
Other taxes payable	908	815
Other payables	1,508	1,329
Total current trade and other payables	**13,493**	**10,385**
Non-current		
£nil Non-current trade and other payables at 31 March 2021	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	358	767
Non-current	-	-

Note 24 Other Liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	291	25
Total other current liabilities	**291**	**25**
Non-current		
Net pension scheme liability (LGPS)	5,265	4,769
Total other non-current liabilities	**5,265**	**4,769**

Changes in LGPS are the result of independent professional actuary valuation commissioned by South Yorkshire Pension.

Note 25 Provisions for liabilities and charges analysis

	Pensions: injury benefits £000	Legal claims £000	Re-structuring £000	Redundancy £000	Other £000	Total £000
At 1 April 2020	**652**	**38**	**81**	**97**	**271**	**1,138**
Change in the discount rate	29	-	-	-	-	**29**
Arising during the year	11	118	395	-	172	**696**
Utilised during the year	(40)	(28)	(153)	-	(130)	**(351)**
Reversed unused	-	(32)	(81)	-	(6)	**(119)**
Unwinding of discount	(6)	-	-	-	-	**(6)**
At 31 March 2021	**646**	**96**	**242**	**97**	**307**	**1,387**
Expected timing of cash flows:						
- not later than one year;	42	96	242	97	**137**	**613**
- later than one year and not later than five years;	171	-	-	-	**-**	**171**
- later than five years.	433	-	0	-	**170**	**603**
Total	**646**	**96**	**242**	**97**	**307**	**1,387**

A provision of £646,000 relates to Injury Benefits. These are payable to current and former members of staff who have suffered injury at work. These cases have been adjudicated by the NHS Pensions Authority. The value shown is the value of payments due to the individuals for the term. (in 2019/20 - £652,000).

Legal claims relate to claims brought against the Trust for Employer's Liability or Public Liability. These cases are handled by NHS Resolution, who provide an estimate of the Trust's probable liability. Actual costs incurred are subject to the outcome of legal action. The eventual settlement costs and legal costs may be higher or lower than provided.

Costs in excess of £10,000 per case for Employer's liability, and cost is excess of £3,000 per case for Public Liability are covered by NHS Resolution and are not included above.

Restructuring and Redundancy provisions are in line with on-going staff redeployment schemes as a result from previous restructure of services. A level of uncertainty remain with 4 new cases and 1 legacy members of staff and are reflected in the provisions above.

Other provisions are made of various elements related to possible liabilities as a result of the imminent HQ relocation. Some legal cases brought to the Trust which are outside of the NHS Resolution scheme, and dilapidation costs for a property rented by the Trust which required new investment to suit our operational needs.

Note 26 Clinical negligence liabilities

At 31 March 2021, £4,992k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Sheffield Health and Social Care NHS Foundation Trust (31 March 2020: £3,047k).

Note 27 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(22)	(45)
Other	-	-
Gross value of contingent liabilities	**(22)**	**(45)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(22)**	**(45)**
Net value of contingent assets	**-**	**-**

Legal claims contingent liabilities represent the consequences of losing all current third party legal claim cases. The contingent liabilities are based on the estimations provided by NHS Resolution for cases which possibility of an outflow of resources embodying economic benefits are below 50%.

Note 28 Contractual capital commitments

Commitments under capital expenditure at the Statement of Financial Position date were £861,000 (31 March 2020, £593,000)

The major components of these commitments are as follows:	Property, Plant and Equipment 2020/21 £000
MCC – Eradication of dormitories	304
Wardsend Road refurbishment	279
Transport – Electric vehicles	278
Total	**861**

The increase in Capital Commitments of £268,000 between financial years is due to the capital planning and business case approval timings. There is no significant impact from the pandemic on the placement of contractual commitments.

Note 29 Defined benefit pension schemes

South Yorkshire Pensions Fund – Retirement Benefit Obligations

The total defined benefit pension loss for 2020/21 in respect of the local government scheme administered by South Yorkshire Pensions Authority was £639,000 (31 March 2019 gain £203,000). A pension deficit of £5,265,000 is included in the Statement of Financial Position as at 31 March 2021 (31 March 2020 - £4,769,000).

The terms of the current partnership agreement with Sheffield City Council provide that any long term pension liability arising from the scheme will be funded by the Council, with the exception of any pension changes which relate to an increase in salary in excess of any local government grading agreements. The impact on the current and prior year statement of consolidated income and taxpayers equity relating to the application of IAS 19 - 'Employee Benefits' within the accounts of the Trust is therefore partially negated by the inclusion of a corresponding non-current receivable with the Council. As at 31 March 2021, the deficit on the scheme was £5,265,000 (31 March 2020 - £4,769,000 deficit), which is offset by a non-current receivable of £3,690,000 (31 March 2020 - £4,197,000).

Estimation of the net liability to pay pensions depends on a number of complex judgements. A firm of consulting actuaries is engaged by South Yorkshire Pensions Authority to provide expert advice about the assumptions made, such as mortality rates and expected returns on pension fund assets.

Pension increases or revaluations for public sector schemes are based on the Consumer Prices Index ("CPI") measure of price inflation.

The main actuarial assumptions used at the date of the statement of financial position in measuring the present value of defined benefit scheme liabilities are:

	2021	2020
	%	%
Rate of inflation	**2.7**	2.1
Rate of increase in salaries	**4.0**	3.4
Rate of increase in pensions and deferred pensions	**2.8**	2.2
Discount rate	**2.1**	2.4

The current life expectancies at age 65 underlying the accrued liabilities for the scheme are:

Non retired member - Male (aged 65 in 20 years time)	**24.0**	23.9
Non retired member - Female (aged 65 in 20 years time)	**27.2**	27.1
Retired member - Male	**22.5**	22.4
Retired member - Female	**25.3**	25.2

The fair value of the scheme's assets and liabilities recognised in the balance sheet were as follows:

	Scheme assets		Scheme assets	
	%	**2021 £000**	%	2020 £000
Equities	49.18	**12,403**	51.78	11,161
Government Bonds	10.67	**2,690**	10.81	2,330
Other Bonds	11.02	**2,779**	9.94	2,142
Property	9.06	**2,284**	8.96	1,931
Cash / Liquidity/Other	20.08	**5,065**	18.52	3,992
Total fair value of assets	100.00	**25,221**	100.00	21,556
Present value of defined benefit obligation		**(30,486)**		(26,325)
Net retirement benefit deficit		**(5,265)**		(4,769)

IAS19 mean that rather than recognising the expected gain during the year from scheme assets in finance income and the interest cost during the year arising from the unwinding of the discount on the scheme liabilities recognised in finance costs; we now present the net interest cost during the year within finance costs. Actuarial gains and losses are not presented; rather the Re-measurements of the defined benefit plan are disclosed and recognised in the income and expenditure reserve.

Movements in the present value of the defined benefit obligations are:

	2021	2020
	£000	£000
At 1 April	**(26,325)**	(28,528)
Current service cost	**(367)**	(416)
Interest on pension liabilities	**(625)**	(682)
Member contributions	**(72)**	(76)
Past Service cost (gain)	**-**	(186)
Actuarial (losses) / gains on liabilities	**(3,727)**	3,000
Benefits paid	**630**	563
At 31 March	**(30,486)**	(26,325)

Movements in the fair value of the scheme's assets were:

	2021	2020
	£000	£000
At 1 April	**21,556**	22,736
Interest on plan assets	**512**	545
Remeasurements (assets)	**3,609**	(1,632)
Administration expenses	**(6)**	(6)
Employer contributions	**108**	400
Member contributions	**72**	76
Benefits paid	**(630)**	(563)
At 31 March	**25,221**	**21,556**

The net pension expense recognised in operating expenses in respect of the scheme is:

	Year ended	
	2021	2020
	£000	£000
Current service cost	**(367)**	(416)
Pension expense to operating surplus	**(367)**	(416)
Net interest cost	**(113)**	(137)
Administration expenses	**(6)**	(6)
Curtailments	**-**	-
Past service cost (gain)	**-**	(186)
Pension expense	**(119)**	(329)
Net pension charge	**(486)**	(745)

The reconciliation of the opening and closing statement of financial position is as follows:

	2021 £000	2020 £000
At 01 April	**(4,769)**	(5,792)
Expenses recognised	**(486)**	(745)
Actuarial losses recognised: Remeasurements (liabilities and assets)	**(118)**	1,368
Contributions paid	**108**	400
At 31 March	**(5,265)**	(4,769)

Remeasurement gains and losses are recognised directly in the Income and Expenditure reserve. However the majority of the gains and losses are covered by the back to back agreement with Sheffield City Council (further information is provided at note 1.7. At 31 March 2021, a cumulative amount of £1,157,000 was recorded in the Income and Expenditure Reserve (31 March 2020 £518,000).

The history of the scheme for the current and prior year is:

	2021 £000	2020 £000
Present value of defined benefit obligation	(30,486)	(26,325)
Fair value of scheme assets	25,221	21,556
Net retirement obligation	**(5,265)**	(4,769)

Experience gain on scheme liabilities in remeasurement for 2020/21 are £470,000 (year ended 31 March 2020 £1,439,000). Loss on financial assumptions are £4,197,000 (gain at year ended 31 March 2020 £527,000) and no gains/loss on demographic assumptions in 2020/21 (year ended 31 March 2020 gain £1,034,000).

Note 29.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2020/21 £000	2019/20 £000
Present value of the defined benefit obligation at 1 April	**(26,325)**	**(28,528)**
Prior period adjustment		-
Present value of the defined benefit obligation at 1 April - restated	**(26,325)**	**(28,528)**
Present value of the defined benefit obligation at start of period for new FTs	**-**	**-**
Current service cost	(367)	(416)
Interest cost	(625)	(682)
Contribution by plan participants	(72)	(76)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	(3,727)	3,000
Benefits paid	630	563
Past service costs	-	(186)
Present value of the defined benefit obligation at 31 March	**(30,486)**	**(26,325)**

Plan assets at fair value at 1 April	**21,556**	**22,736**
Prior period adjustment		-
Plan assets at fair value at 1 April -restated	**21,556**	**22,736**
Interest income	512	545
Remeasurement of the net defined benefit (liability) / asset:		
- Return on plan assets	-	-
- Actuarial gain / (losses)	3,609	(1,632)
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	-	-
Contributions by the employer	102	394
Contributions by the plan participants	72	76
Benefits paid	(630)	(563)
Plan assets at fair value at 31 March	**25,221**	**21,556**
Plan surplus/(deficit) at 31 March	**(5,265)**	**(4,769)**

Note 29.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2021 £000	31 March 2020 £000
Present value of the defined benefit obligation	(30,486)	(26,325)
Plan assets at fair value	25,221	21,556
Net defined benefit (obligation) / asset recognised in the SoFP	**(5,265)**	**(4,769)**
Fair value of any reimbursement right	3,690	4,197
Net (liability) / asset after the impact of reimbursement rights	**(1,575)**	**(572)**

Note 29.3 Amounts recognised in the SoCI

	2020/21 £000	2019/20 £000
Current service cost	(367)	(416)
Interest expense / income	(113)	(137)
Past service cost	-	(186)
Total net (charge) / gain recognised in SOCI	**(480)**	**(739)**

Note 30 Financial instruments

Note 30.1 Financial risk management

IFRS 7, 'Financial Instruments: Disclosures', 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 international 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 the parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors.

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.

Credit risk

As the majority of the Trust's income comes from contracts with public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at the end of the financial year is in receivables from customers, as disclosed in the receivables note.

Liquidity risk

The Trust's net operating costs are incurred under contract with Clinical Commissioning Groups, Local Authorities, and other government bodies which are financed from resources voted annually by Parliament. The Trust finances its capital expenditure from funds from cash reserves or loans. The Trust is therefore not exposed to significant liquidity risks.

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Trade and other receivables excluding non financial assets	8,664	-	**8,664**
Cash and cash equivalents	62,075	-	**62,075**
Total at 31 March 2021	**70,739**	**-**	**70,739**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Trade and other receivables excluding non financial assets	10,883	-	**10,883**
Cash and cash equivalents	51,018	-	**51,018**
Total at 31 March 2020	**61,901**	**-**	**61,901**

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Total book value £000
Trade and other payables excluding non financial liabilities	11,331	**11,331**
Total at 31 March 2021	**11,331**	**11,331**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Total book value £000
Trade and other payables excluding non financial liabilities	8,423	**8,423**
Total at 31 March 2020	**8,423**	**8,423**

Note 30.4 Maturity of financial liabilities

	31 March 2021 £000	31 March 2020 £000
In one year or less	11,331	8,423
In more than one year but not more than five years	-	-
In more than five years	-	-
Total	**11,331**	**8,423**

The fair value of the Trust's financial assets and financial liabilities at 31 March 2021 equates to book value.

Note 31 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Bad debts and claims abandoned	21	255	20	8
Stores losses and damage to property	56	126	73	79
Total losses	**77**	**381**	**93**	**87**
Special payments				
Compensation under court order or legally binding arbitration award	2	15	12	82
Ex-gratia payments	11	3	18	2
Total special payments	**13**	**18**	**30**	**84**
Total losses and special payments	**90**	**399**	**123**	**171**
Compensation payments received	1	130	-	-

Over the financial year 2020/21 the total value of losses and special payments amounts to £398,402 representing an increase of £228,773 in comparison to year 2019/20. However, the number of cases, which in some instances are grouped together, reports a decrease of 33 at 90 cases compared to the previous year of 123 cases.

The main increase in value is due to the utilisation of the bad debt provision against long outstanding irrecoverable debts from Sheffield City Council. The Finance team has exhausted all avenues to obtain settlement. The total write-off of invoices was for £234,480 at the end of March 2021 and are accounted as 1 incident.

Other movements reported are in line with previous years.

One case of compensation payment received for "right of light" in relation to St. George's site due to a development on north east side of Winter Street, Sheffield.

Note 32 Gifts

No gifts to report for financial years 2019/20 and 2020/21

Note 33 Related parties

Sheffield Health and Social Care NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

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. These are detailed below:

Related party (Register of interest 2020/21)	Receipts from related party £000	Payments to related party £000	Amounts due from related party £000	Amounts owed to related party £000
South Yorkshire Housing Association	3,579	255	96	204
Sheffield Flourish	0	113	0	8
South London and Maudsley NHS FT	0	150	0	0
Sheffield African Caribbean Mental Health Association	0	24	0	18
Nottingham City Care Partnership	0	6	0	0

The relationships are:

- One of the Non-Executive Directors undertakes unpaid consultancy for South Yorkshire Housing Association.
- One of the Non-Executive Directors is a board member Sheffield Flourish
- One of the Executive Directors' is seconded from South London and Maudsley NHS Foundation Trust
- One of the Non-Executive Directors is a board member Nottingham City Care Partnership
- One of the Executive Directors' spouse is a board member Sheffield African Caribbean Mental Health Association.

Amounts owed to related parties are unsecured, interest-free and have no fixed terms of repayment. The balances will be settled in cash. No guarantees have been given or received. No expenses are recognised in year in respect of bad or doubtful debts due from related parties.

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 above, all payments shown have been made by the Trust to the organisations concerned and not to the individual officers.

The value of related party transactions with board members in 2020/21 is £nil (2019/20 £nil). Details of Directors' remuneration and pensions can be found in the Remuneration Report of the accounts. Disclosures relating to salaries of Board members are given in Note 8.1. Further details of Executive and Non-Executive Directors' salaries and pensions can be found in the Remuneration Report in the Annual Report.

Other related parties

The value of the Trust's transactions with other related parties during the year is given below:

	2020/21		2019/20	
	Income	**Expenditure**	**Income**	**Expenditure**
	£000	**£000**	**£000**	**£000**
Department of Health and Social Care	741	0	782	0
Other NHS bodies	130,257	1,944	110,719	2,116
Other WGA	735	1,633	61	2,650
Other bodies	7,703	377	6,198	243
	139,436	**3,954**	**117,760**	**5,009**

The value of receivables and payables balances held with related parties as at the date of the statement of financial position is given below:

	2020/21		2019/20	
	Receivables	**Payables**	**Receivables**	**Payables**
	£000	**£000**	**£000**	**£000**
Department of Health and Social Care	113	0	7	0
Other NHS bodies	3,018	358	4,519	755
Other WGA	1,030	3,658	1,305	3,258
Other bodies	96	321	84	504
	4,257	**4,337**	**5,915**	**4,517**

The value of balances (other than salary) with related parties in relation to the provision for impairment of receivables as at 31 March 2021 have been raised where deemed appropriate.

The Department of Health and Social Care ("the Department") is regarded as a related party. During the year, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

- NHS Sheffield CCG
- Health Education England
- NHS England - Yorkshire and the Humber Local Office
- NHS England - Yorkshire and the Humber Commissioning Hub
- NHS Barnsley CCG
- NHS Derby and Derbyshire CCG
- NHS Rotherham CCG
- NHS Doncaster CCG
- Derbyshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- NHS Litigation Authority
- NHS Business Services Authority

In addition, the Trust has had a number of material transactions with other Government departments and other central and local Government bodies. Most of these transactions have been with HM Revenue and Customs (including National Insurance Funds), the NHS Pension Scheme as well as with Sheffield City Council in respect of joint enterprises and the South Yorkshire Pension Scheme.

Note 34 Prior period adjustments

No prior period adjustments to report at 31 March 2021.

Note 35 Events after the reporting date

No events after the reporting date to declare.

Section 6.0 Glossary

Accounts Payable (Creditor)

A supplier who has delivered goods or services in the accounting period and has invoiced the Trust, but has not yet been paid.

Accounts Receivable (Debtor)

An organisation which has received a service from the Trust in the accounting period and has been invoiced by the Trust, but has not yet paid.

Amortisation

Depreciation of Intangible Assets.

Annual Governance Statement (AGS)

A statement about the controls the Foundation Trust has in place to manage risk.

Annual Accounts

Documents prepared by the Trust to show its financial position.

Annual Report

A document produced by the Trust which summarises the Trust's performance during the year, including the annual accounts.

Asset

Something which is owned by the Trust. For example, a building or a piece of equipment, some cash or an amount of money owed to the Trust.

Audit Opinion

The auditor's opinion of whether the Trust's accounts show a true and fair view of its financial affairs. If the auditors are satisfied with the accounts, they will issue an unqualified audit opinion.

Available Held for Sale (AHFS)

Assets are classed as available for sale if they are held neither for trading nor to maturity. An example of this would be an investment without a maturity date such as an ordinary share.

Budget

Represents the amount of money available for a service in a period of time and is compared to actual spend for the same period.

Capital Expenditure

Money spent on buildings and valuable pieces of equipment such as major computer purchases.

Cash and cash equivalents

Cash includes cash in hand and cash at the bank. Cash equivalents are any other deposits that can be converted to cash straight away.

Cash Equivalent Transfer Value (Pensions)

This is the total value of the pension scheme benefits accrued (i.e. saved up) which are the contributions paid by a member of staff and the Trust over the period of employment.

These funds are invested and valued at a point in time by an actuary. The cash equivalent transfer value is the amount which would be transferred, if a staff member moved to work for a different organisation.

Control Total

An agreed financial control total for all NHS Providers, calculated on a Trust-by-Trust basis and designed to ensure the NHS provider sector achieves financial balance in 2018/19.

Access to the Provider Sustainability Fund is dependent on agreement and delivery of the control total.

Corporation tax

A tax payable on a company's profits. Foundation Trusts may have to pay corporation tax in the future. The legislation introducing corporation tax to Foundation Trust has been deferred and 2011/2012 was the first year that Government introduced corporation tax to Foundation Trusts.

Care Quality Commission (CQC)

The independent regulator of all health and social care services in England.

CQUINs

Commissioning for Quality and Innovation payments framework were set up in 2009/10 to encourage care providers to continually improve how care is delivered.

Current Assets

These are assets, which are normally used or disposed of within the financial year.

Current Liabilities

Represents monies owed by the Trust that are due to be paid in less than one year.

Deferred Income

Funding received from another organisation in advance of when we will spend it.

Depreciation

An accounting charge which represents the use, or wearing out, of an asset. The cost of an asset is spread over its useful life.

EBITDA

Earnings Before Interest, Tax Depreciation and Amortisation – this is an indicator of financial performance and profitability and indicates the ability to pay the dividends due to the Government in respect of the 3.5% return on assets the Trust is expected to achieve.

External Auditor

The independent professional auditor who reviews the accounts and issues an opinion on whether the accounts present a true and fair view.

Finance lease

An arrangement whereby the party leasing the asset has most or all of the use of an asset, and the lease payments are akin to repayments on a loan.

Financial statements

Another term for the annual accounts.

Foundation Trust Annual Reporting Manual (FT ARM)

The guidance document, published annually by NHS Improvement, sets out the accounting requirements for Foundation Trust's Annual Report. Previously included technical guidance on the Accounts, which is now provided within the Department of Health and Social Care (DHSC) Government Accounting Manual.

Going concern

The accounts are prepared on a going concern basis which means that the Trust expects to continue to operate for at least the next 12 months.

DHSC Government Accounting Manual (GAM)

Provides the accounting guidance for all NHS bodies, now including Foundation Trusts. Guidance specific to Foundation Trusts in respect of the Annual Report is still included in the Foundation Trust Annual Reporting Manual (FT ARM).

IFRS (International Financial Reporting Standards)

The professional standards organisations must use when preparing the annual accounts.

Impairment

A decrease in the value of an asset.

Income and Expenditure Reserve

This is an accumulation of transfers to / from the Revaluation Reserve as well as the cumulative surpluses and deficits reported by the Trust, including amounts brought forward from previous years.

Intangible asset

An asset which is without substance, for example, computer software.

Inventories

Stocks such as clinical supplies, medical equipment, pharmacy stock.

Liability

Something which the Trust owes, for example, a bill which has not been paid.

Liquidity ratio

Liquidity is a measure of how easily an asset can be converted into cash. Bank deposits are very liquid, debtors less so. The liquidity ratio is a measure of an entity's ability to meet its obligations, in other words how well it can pay its bills from what it owns.

MEA (Modern Equivalent Asset)

This is an instant build approach, using alternative site valuation in some circumstances.

Net Book Value

The net book value is the lower of the cost to the business to replace a fixed asset or the recoverable amount if the asset was sold (net of expenses).

NHS Improvement (NHSI)

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. From 01 April 2019, NHS England and NHS Improvement came together to act as a single organisation. Their aim is to better support the NHS and help improve care for patients.

NICE

National Institute for Health and Care Excellence. NICE provide independent, evidencebased guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

NIHR

National Institute for Health Research. The NIHR is a large, multi-faceted and nationally distributed organisation, funded through the Department of Health and Social Care to improve the health and wealth of the nation through research.

Non-current assets held for sale

Buildings that are no longer used by the Trust and declared surplus by the Board, which are available for sale.

Non-current asset or liability

An asset or liability which the Trust expects to hold for longer than one year.

Non-Executive Director

These are members of the Trust's Board of Directors, however they do not have any

involvement in the day-to-day management of the Trust. Their role is to provide the Board with independent challenge and scrutiny.

Operating lease

An arrangement whereby the party leasing the asset is paying for the provision of a service (the use of the asset) rather than exclusive use of the asset.

Payment By Result/Payment by Outcomes

A national tariff of fixed prices that reflect national average prices for hospital procedures. Already in use in acute trusts and currently being developed for mental health and learning disabilities services.

POMH

The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice.

Primary statements

The four main statements that make up the accounts: the Statement of Comprehensive Income; Statement of Financial Position; Statement of Changes in Taxpayers' Equity; and Statement of Cash Flows.

Provisions for Liabilities and Charges

These are amounts set aside for potential payments to third parties, which are uncertain in amount or timing, for example, claims arising from litigation.

Provider Sustainability Fund (PSF)

PSF replaces the 'Sustainability and Transformation Fund' (STF) from year 2018/19 and it is the additional funding administered by NHS Improvement, which is intended to incentivise Trusts to achieve their Control Totals. It breaks down into three areas – Finance, General Distribution and Bonus.

Public Dividend Capital (PDC)

This is a type of public sector equity finance based on the excess of assets over liabilities at the time of the establishment of the predecessor NHS Trust. It is similar to a company's share capital.

Public Dividend Capital Payable (PDC Payable)

This is an annual amount paid to the Government for funds made available to the Trust.

Reference Cost

The costs of the Trust's services are produced for the Department of Health for comparison with other similar Trusts.

Revaluation Reserve

This represents the increase or decrease in the value of property, plant and equipment over its historic cost.

Service Line Reporting (SLR)

A system which identifies income and expenditure and then produces gross profit across defined 'business units', with the aim of improving quality and productivity.

Single Oversight Framework

The Single Oversight Framework is designed to help NHS providers attain, and maintain, ratings of 'Good' or 'Outstanding'. The Framework doesn't give a performance assessment in its own right. It applies from 01 October 2016 and replaces the Monitor Risk Assessment Framework and the NHS Trust Development Authority Accountability Framework.

South Yorkshire and Bassetlaw Integrated Care System (ICS)

Integrated Care Systems are a way of working, collaboratively, between a range of health and social care organisations, to help improve people's health. South Yorkshire and Bassetlaw ICS is a group of local Organisations that embrace similar aims in the provision of the broad spectrum of healthcare.

Statement of Cash Flows (SOCF)

Shows the cash flows in and out of the Trust during the period.

Statement of Changes in Taxpayers' Equity (SOCITE)

This statement shows the changes in reserves and public dividend capital during the period.

Statement of Comprehensive Income (SOCI)

This statement was previously called 'Income and Expenditure Account'. It summarises the expenditure on pay and non-pay running costs less income received, which results in a surplus or deficit.

Statement of Financial Position (SOFP)

A year-end statement which provides a snapshot of the Trust's financial position at a point in time. The top half shows the Trust's total net assets (assets minus liabilities). The bottom half shows the Taxpayers Equity or investment in the Trust.

Third Sector Organisations

This is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives.

True and fair

It is the aim of the accounts to show a true and fair view of the Trust's financial position, that is they should faithfully represent what has happened in practice.

UK GAPP (Generally Accepted Accounting Practice)

The standard basis of accounting in the UK before international standards were adopted.

Unrealised gains and losses

Gains and losses may be realised or unrealised. Unrealised gains and losses are gains or losses that the Trust has recognised in its accounts but which are potential as they have not been realised. An example of a gain that is recognised but unrealised is where the value of the assets has increased. This gain is realised when the assets are sold or otherwise used.

Use of Resources Metric

The new approach replacing the previous Financial Sustainability Risk Rating. The Use of Resources rating measures 5 metrics; Capital Service Cover, Liquidity, I&E Margin, I&E Variance from Plan and Agency spend, with equal weightings (1 being the highest overall score). The Financial Sustainability Risk Rating previously only measured the first four on equal weightings.

Section 7.0 Contacts

Address

Sheffield Health and Social Care NHS Foundation Trust
Fulwood House
Old Fulwood Road
Sheffield
S10 3TH

Telephone

0114 2716310 (24 hour switch board)

Website

www.shsc.nhs.uk

Communications

If you have a media enquiry, require further information about our Trust or would like to request copies of this report please contact the Communications Team.

Email: communications@shsc.nhs.uk

Telephone: 0114 2264082

Membership

If you want to become a member of the Trust or want to find out more about the services we provide, please contact the Deputy Board Secretary on 0114 2718825.

Contacting members of the Council of Governors

The Governors can be contacted by emailing governors@shsc.nhs.uk or by phoning 0114 2718825.

Freedom of Information

To make a Freedom of Information Act request, please email FOI@shsc.nhs.uk

For more information or if you would like this document provided in a different language or large print please contact:

Communications Department
Sheffield Health and Social Care NHS Foundation Trust
Fulwood House
Old Fulwood Road
Sheffield
S10 3TH

Telephone: 0114 2264082

Email: communications@shsc.nhs.uk